



Intake Date: \_\_\_\_\_  
MRN: \_\_\_\_\_

**NUNM Community Health Centers Registration**  
**PLEASE WRITE LEGIBLY**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last Name First Name Middle Name

What is your preferred first name? (Nickname, Chosen name, etc.) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Preferred Contact Phone Number:  Cell  Home  Work SSN: \_\_\_\_\_

Is it ok if we email you with instructions to sign up for MyChart?  Yes  No

---

**The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Please answer all questions.**

---

What is your birth sex?  Male  Female Other (specify) \_\_\_\_\_

What gender do you identify as?  Male  Female Other (specify) \_\_\_\_\_

What is your preferred pronoun?  He  She Other (specify) \_\_\_\_\_

Interpreter needed?  Yes  No Primary Language: \_\_\_\_\_

Homeless Status?  Not Homeless  Homeless  At Risk  Transitional Housing  Living in Shelter

Seasonal or Migrant Worker?  Seasonal  Migrant  Neither

Ethnic Group (Select One):  Hispanic  Non-Hispanic Are you a US Veteran?  Yes  No

Race (Select all that apply):  Asian  Black  White  Alaskan Native  Pacific Islander  American Indian

Occupation: \_\_\_\_\_ Hours per Week: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

Employment Status (Check one):  Full Time  Not Employed  Part Time  Retired  Seasonal

Self-Employed  Student (Full Time)  Student (Part Time)  NUNM Student

---

**Primary Care Provider (PCP) Information (Please select one of the following):**

I wish to establish Primary Care with NUNM Community Health Center \_\_\_\_\_

I see NUNM for ancillary/adjunctive care only.

My Primary Care Physician (PCP) is: \_\_\_\_\_

At (Clinic Name): \_\_\_\_\_

I do not have a Primary Care Physician and do not wish to establish Primary Care with NUNM at this time.

---

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Legal Guardian?  Yes  No

Guarantor (Person who is financially responsible for the account):

Name: \_\_\_\_\_ Relationship to the patient: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_



Intake Date: \_\_\_\_\_  
MRN: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Gender:  M  F DOB: \_\_\_\_\_  
Guarantor Primary Language: \_\_\_\_\_

The NUNM Clinic Billing Department requires that **all** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit.

**Please provide your insurance information below:**

Insurance Company: \_\_\_\_\_  
Claims Address: \_\_\_\_\_  
Subscriber Name (if other than patient): \_\_\_\_\_ DOB: \_\_\_\_\_  
Member ID # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber ID # \_\_\_\_\_

**\*\*Please be prepared to present your insurance card at check-in at each visit\*\***

**\*\*Although NUNM is not contracted with Medicare, it is our policy to collect all coverage information\*\***

Do you have Medicare?  Yes  No If "yes", is it your primary insurance?  Yes  No

Medicare Plan (check all that apply):  Part A  Part B  Advantage (Part C)  
Subscriber ID # \_\_\_\_\_ Effective Date (if known): \_\_\_\_\_

**I authorize the following individual(s) to arrange appointments at NUNM Clinics on my behalf: (OPTIONAL)**

Name: _____	Name: _____
DOB: _____	DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____

**I certify the above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

## **Informed Consent and Request for Care**

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of the National University of Natural Medicine (NUNM) Health Centers. I understand that patient care is directed by licensed health care providers who are employees of NUNM. I consent to services rendered to me under the instructions of these professionals, as well as volunteer staff physicians who may be associated for the purpose of consulting. I recognize that NUNM is a teaching institution. I agree that persons who are students and resident physicians may participate in my care as part of the educational programs of the institution.

I, \_\_\_\_\_, hereby request and consent to examination and treatment with the providers, students, and affiliated providers at NUNM Health Centers.

I understand I have the right to ask questions and discuss to my satisfaction with the above mentioned providers and/or students:

- My suspected diagnosis(s) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

Medical and Naturopathic evaluation information:

I understand that medical evaluation and/or Naturopathic evaluation treatment may include, but is not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic, and neurological assessments).
- Common diagnostic procedures (including venipuncture, pap smears, laboratory testing of blood, saliva, urine, and stool).
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, muscle energy technique and cranio-sacral therapy).
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements, and intravenous vitamin injections).
- Trigger point injection therapy with or without vitamin substances.
- Botanical/Herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances).
- Counseling (including but not limited to visualization for improved lifestyle strategies).
- Over-the-counter and prescription medications (including only those medications on Formulary of Oregon Naturopathic Physicians with regards to ND's).
- Hydrotherapy procedures which may consist of hot and cold water, baths, sauna, ice, towels and/or sheets and/or hydrocollator packs either heated or cooled, electrical stimulation, ultrasound and diathermy, and other therapies.

Possible risks associated with and complications associated with this procedure may include:

- Mild skin burns or irritation

## Informed Consent and Request for Care (Part 2)

- Overheating
- Contact dermatitis
- Dizziness
- Temporary decrease in blood pressure
- Classical Chinese medicine procedures including, but not limited to acupuncture, moxibustion, cupping, electro-acupuncture, herbology, and massage. I understand that some herbs may be inappropriate during pregnancy. **If I suspect I am pregnant, I will immediately inform my provider or student.** Possible risks and complications associated with these procedures may include:
  - Slight burns
  - Tingling near the needling sites that may last a few days
  - Nausea
  - Infections and blisters
  - Fainting
  - Scarring
  - Bruising
  - Bleeding
- Physical medicine treatments including examination, diagnostic procedures, manipulation and/or mobilization of the neck, spine, and extremities involving movement of the joints and soft tissues, and soft tissue therapies (specifically: manual soft tissue therapies, instrument-assisted soft tissue mobilization (IASTM), percussion/vibration therapy and therapeutic tape procedure). Physical therapy, including exercise, electrical stimulation, hot/cold therapies, ultrasound, diathermy, TENS units, low-level laser therapy, traction, and other therapeutic modalities recommended for my condition may also be used. Possible risks and complications associated with these procedures may include:
  - Soreness
  - Muscle spasms
  - Temporary increase in symptoms
  - Mild to moderate bruising
  - Sprains and strains
  - Dizziness
  - Fractures/joint injury
  - Stroke (has been rarely reported to occur specifically from neck manipulation)
  - Physical Therapy burns (rare)
- Intravenous (IV) Therapy treatments including drips, pushes, and oral & IV chelation (heavy metal detoxification). This treatment involves inserting a needle and injecting a standardized formula into veins or muscles. There may be some discomfort at the site of treatment and it is my responsibility to inform the NUNM student or physician of any burning, pain, or negative reactions that I may be experiencing. During treatment, it is possible for the fluid to leak out of the vein into the surrounding tissue. I understand that although this infiltrated fluid may cause pain, it is not dangerous to my health and my body will absorb the fluid. I realize that during and after my treatment I may experience temporary discomfort at the site of treatment. There is no stated or implied guarantee of success or effectiveness of any specific treatment. I am free to withdrawal my consent or participation in these treatments at any time.

### **Informed Consent and Request for Care (Part 3)**

Advantages of IV Therapy:

- Not affected by stomach or intestinal disease
- Total amount given is available to tissues requiring the constituents
- Force nutrients into the cells by means of a high concentration gradient despite low energy due to illness
- Give doses of nutrients higher than those possible by mouth without intestinal irritation

Possible risks and complications associated with these procedures may include:

- Pain, bruising, or infection at injection site
- Inflammation of vein used for infusion (phlebitis)
- Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death

Alternatives to IV Therapy include:

- Oral supplementation
- Lifestyle and dietary changes

***I have fully read and understand the above agreements and authorizations.***

---

Patient (18 years or older)

Date

---

Parent, Guardian, Responsible Party

Date

## **Statement of Financial Responsibility**

### **I understand and agree to the following general responsibilities:**

- Financial options are extended to me based on the information I have provided.
- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including Medicinary, lab work and tests, and physician ordered add-on lab work and tests.
- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the NUNM Health Centers to release information necessary to secure payment.
- There will be a flat fee of \$20 for any appointment that is either missed or not canceled within 24 hours of the appointment time.

### **I understand and agree to the following with regards to insurance billing:**

- I understand that if I have an insurance plan that is contracted with NUNM, my insurance will be billed for services and I **will not** be eligible for the schedule of discounts for any service that is covered by my insurance.
- The pre-verification by NUNM of my health insurance is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier.
- I understand that the NUNM Health Centers can require presentation of proof of insurance at any time.
- I understand that NUNM Health Centers will not bill motor vehicle insurance.
- I understand that my insurance may need to be re-verified for specific coverage details as often as every six months.
- I am responsible for providing all accurate and thorough documentation required to verify my insurance coverage and/or bill my insurance carrier.
- I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by my insurance carrier.
- I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.
- I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to the NUNM Health Centers. This release applies to support of the insurance billing process only.

### **Financial Options**

Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care. However, in compliance with state and federal guidelines, the National University of Natural Medicine (NUNM) Health Centers does require your social security number before certain financial options can be extended to you. The following are financial options that can be offered if you provide your social security number:

#### **1) If you choose to provide us with your social security number, you can choose to:**

- Bill health insurance (if coverage has been pre-verified by NUNM *before* your appointment)
- Receive standard clinic service and Medicinary discounts
- Be considered for other individual or special options
- Make payment by cash, check, or credit card

#### **2) If you choose to not provide us with your social security number, you may:**

- Make payment by cash or credit card only.

#### **3) Please note:** If you would like to pay by check for services rendered, you must furnish a valid state-issued identification card that shows the same address as the check you are submitting as payment. You will be required to show this identification each time you wish to use a check for payment. \*

**(Signature on pg. 7)**



Intake Date: \_\_\_\_\_  
MRN: \_\_\_\_\_

**Patient Signature of Statement of Financial Responsibility**

*I have fully read and understand the above agreements and authorizations.*

---

Patient (18 years or older) \_\_\_\_\_ Date \_\_\_\_\_

---

Parent, Guardian, Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

## HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my Protected Health Information by National University of Natural Medicine (NUNM) Health Centers for the purposes of **treatment, payment and healthcare operations**, or as otherwise required by law.

- NUNM has posted their Notice of Privacy Practices on the NUNM Health Centers website, [www.nunmhealthcenters.com](http://www.nunmhealthcenters.com), which provides more detailed information about the usage and disclosure of my Protected Health Information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- I have the right to request restrictions to the usage and disclosure of my Protected Health Information.
- I have the right to request an alternative to the standard method of communication of my Protected Health Information.
- I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received by the NUNM Health Centers at the following address: 3025 SW Corbett Avenue, Portland, Oregon 97201
- I understand that while NUNM may honor these requests, they are not required by law to do so.
- NUNM is part of an organized health care arrangement including participants in the Oregon Community Health Information Network (OCHIN) which utilizes the *Care Everywhere* system. A current list of OCHIN participants is available at <http://www.community-health.org/partners.html>. As a business associate of NUNM Health Centers, OCHIN supplies information technology and related services to NUNM Health Centers and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by NUNM Health Centers with other OCHIN and *Care Everywhere* participants only when necessary for health care operations purposes of the organized health care arrangement.
- I am aware that NUNM reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all Protected Health Information that they maintain. In the event of amendments, NUNM will make available a revised Notice of Privacy Practice for my review.

***I have fully read and understand the above agreements and authorizations.***

---

Patient (18 years or older)

Date

---

Parent, Guardian, Responsible Party

Date



## PERSONAL HEALTH HISTORY

Patient: \_\_\_\_\_  



  
 Last Name                      First Name                      Middle Name                      DOB

What is the main reason for your visit to our clinic today?

\_\_\_\_\_

**Allergies:** Do you have any allergies to the following? **(Please select all that apply)**

- |                                      |                                     |                                       |                                       |                                   |                                  |
|--------------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Sulfa       | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Morphine     | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> NSAIDS      | <input type="checkbox"/> Latex      | <input type="checkbox"/> Lidocaine    | <input type="checkbox"/> Contrast Dye | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Pollen  |
| <input type="checkbox"/> Cats        | <input type="checkbox"/> Dogs       | <input type="checkbox"/> Mold         | <input type="checkbox"/> Dust         | <input type="checkbox"/> Bees     | <input type="checkbox"/> Soy     |
| <input type="checkbox"/> Wheat       | <input type="checkbox"/> Shellfish  | <input type="checkbox"/> Fish         | <input type="checkbox"/> Peanuts      | <input type="checkbox"/> Eggs     | <input type="checkbox"/> Milk    |
| <input type="checkbox"/> Other _____ |                                     |                                       |                                       |                                   |                                  |

**Medications:** List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength	Frequency Taken

**Medical Conditions:** Do you currently have or have a history of the following? **(Please select all that apply)**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> COPD                | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Cancer           |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Adrenal Disorder   | <input type="checkbox"/> Kidney Disease      |   |   |

**Surgeries / Hospitalizations:** Have you had any of the following surgeries? **(Please select all that apply)**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Brain Surgery    | <input type="checkbox"/> Breast Surgery          | <input type="checkbox"/> C-Section     |
| <input type="checkbox"/> CABG              | <input type="checkbox"/> Cholecystectomy  | <input type="checkbox"/> Colon Surgery           | <input type="checkbox"/> Cosmetic      |
| <input type="checkbox"/> Eye Surgery       | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Hernia Repair           | <input type="checkbox"/> Hysterectomy  |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Small Intestine Surgery | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Tonsillectomy     | <input type="checkbox"/> Tubal Ligation   | <input type="checkbox"/> Valve Replacement       | <input type="checkbox"/> Vasectomy     |
| <input type="checkbox"/> Other: _____      |   |  |  |

**Family History:** Do you have a family history of any of the following? (Please "X" the boxes that apply to you)

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcohol/ Drug Addiction												
Arthritis												
Asthma												
Cancer												
Heart Disease												
Depression												
Diabetes												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Mental Illness												
Stroke												
Vision Problems												

**Social History:** Please answer the following questions regarding your social history:

In the past year, have you worried you will run out of food before you can afford more?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If "YES", how many of the following per week: \_\_\_\_\_glasses of wine \_\_\_\_\_shots of liquor \_\_\_\_\_cans of beer

Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Currently
Partners?	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Both

**What is your current birth control method? (Please check all that apply):**

- Abstinence     Cervical Cap     Condom     Diaphragm     Hormone Patch     Implant  
 Injection     Inserts     IUD     IUS     Pill     Rhythm  
 Spermicide     Sponge     Surgical     Vaginal Ring     Withdrawal     None

**Do you currently use any of the following recreational or street drugs? (Please select all that apply):**

- Crack     Cocaine     Ecstasy     IV     Heroin     LSD  
 Marijuana     Meth     E-Cigs     Other \_\_\_\_\_

**Do you use any of the following tobacco products? (Please select all that apply):**

- Cigarettes     Cigars     Pipe     Snuff     Chew  
 Other \_\_\_\_\_    Packs per day: \_\_\_\_\_  
 Start Date: \_\_\_\_\_    Years of smoking: \_\_\_\_\_  
 Quit Date: \_\_\_\_\_    Ready to Quit?     Yes     No

**Review of Systems: Please circle below: Y= Yes, present condition. N=No, never had the condition.**

**Constitutional**

Fever                      Y   N                      Chills                      Y   N                      Weight Loss                      Y   N  
 Malaise/Fatigue            Y   N                      Sweating                      Y   N                      Weakness                      Y   N

**Skin**

Rash                      Y   N                      Itching                      Y   N                      Color changes                      Y   N

**Head, Ears, Eyes, Nose, Throat**

Headaches                      Y   N                      Hearing Loss                      Y   N                      Ringing in Ears                      Y   N  
 Ear Pain                      Y   N                      Ear Discharge                      Y   N                      Nosebleeds                      Y   N  
 Congestion                      Y   N                      Stridor                      Y   N                      Sore Throat                      Y   N  
 Migraine headaches            Y   N                      Jaw/TMJ problems                      Y   N

**Eyes**

Blurred Vision                      Y   N                      Double Vision                      Y   N                      Light Sensitivity                      Y   N  
 Eye Pain                      Y   N                      Eye Discharge                      Y   N                      Eye Redness                      Y   N

**Cardiovascular**

Chest Pain                      Y   N                      Palpitations                      Y   N                      Shortness of breath lying down                      Y   N  
 Claudication                      Y   N                      Leg Swelling                      Y   N                      PND                      Y   N

Abdominal Pain	Y	N	Blood clots	Y	N	Heart disease	Y	N
Low/high blood pressure	Y	N						

**Respiratory**

Cough	Y	N	Coughing up Blood	Y	N	Sputum Production	Y	N
Shortness of breath	Y	N	Wheezing	Y	N			
Asthma	Y	N						

**Gastrointestinal**

Heartburn	Y	N	Nausea	Y	N	Vomiting	Y	N
Abdominal Pain	Y	N	Diarrhea	Y	N	Constipation	Y	N
Blood in Stool	Y	N	Black/Tarry Stools	Y	N			
How many bowel movements per day? _____								

**Genitourinary**

Painful Urination	Y	N	Urgency	Y	N	Frequency	Y	N
Blood in urine	Y	N	Flank Pain	Y	N	Incontinence	Y	N
Frequent infections	Y	N						

**Male Reproductive**

Hernias	Y	N	Testicular masses	Y	N	Sexual difficulty	Y	N
---------	---	---	-------------------	---	---	-------------------	---	---

**Female Reproductive**

Age of first menses \_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_ Length of cycle \_\_\_\_\_  
 Duration of menses \_\_\_\_\_ Date of last annual exam \_\_\_\_\_ Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_

**Musculoskeletal**

Muscle Pain	Y	N	Neck Pain	Y	N	Back Pain	Y	N
Joint pain	Y	N	Falls	Y	N	Muscle spasms	Y	N

**Endocrine/Heme/Allergies**

Excessive thirst	Y	N	Env. Allergies	Y	N	Easy Bruising/Bleeding	Y	N
Cold intolerance	Y	N	Excessive hunger	Y	N	Heat intolerance	Y	N
Diabetes _____			Thyroid problems _____					

**Neurological**

Dizziness	Y	N	Tingling	Y	N	Tremor	Y	N
Sensory Change	Y	N	Speech Change	Y	N	Focal Weakness	Y	N
Seizures	Y	N	Fainting	Y	N	Numbness	Y	N
Paralysis	Y	N	Loss of memory	Y	N			

**Emotional (Psychiatric)**

Depression	Y	N	Suicidal Ideas	Y	N	Substance Abuse	Y	N
Hallucinations	Y	N	Nervous/Anxious	Y	N	Insomnia	Y	N
Memory Loss	Y	N	Mood swings	Y	N	Tension/stressed	Y	N

## Compassionate Care Program Application

- Granting of financial assistance is contingent upon meeting eligibility guidelines.
- You will be notified by an NUNM staff member regarding your application status.
- You must provide proof of income with this application.

1. **Patient:** \_\_\_\_\_  
First Name
Last Name
Date of Birth

2. **What county do you currently reside in?** \_\_\_\_\_ **Zip Code?** \_\_\_\_\_

3. **Do you currently have medical insurance of any kind?** Yes  No

If yes, please list name/type of insurance if applicable \_\_\_\_\_

4. **NUNM offers enrollment assistance for Medicaid/Oregon Health Plan. Would you be interested in being connected with an enrollment assistor?** Yes  No

5. **What is your Household size and combined gross household income:**

Combined, Gross Household Income			
# of people in household	Gross Income	Frequency (Circle one)	Employer/Source
	\$	Weekly      Bi-Weekly Monthly      Yearly	

Household Members:	Name(s):	Date of Birth:
Self:		
Spouse:		
Other:		
Other:		
Other:		
Other:		

I certify this information to be a true and accurate account of my household and financial status at this time. I have read and agree to the financial assistance application provisions.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This section to be filled out by administrative personnel only:** MRN: \_\_\_\_\_

1. Financial Assistance: Tier 1 / Tier 2 / Tier 3 / Tier 4 (circle one)
2. Coverage added to EPIC account Yes / No      Date coverage added: \_\_\_\_\_
3. Proof of Income provided: W2 / Paystub / Other: \_\_\_\_\_/Pending
4. Staff Member Name: \_\_\_\_\_

## Compassionate Care Self Declaration of Income Form

- Granting of financial assistance is contingent upon meeting eligibility guidelines.
- You will be notified by an NUNM staff regarding your application status.
- If approved, your application will automatically expire one year from registration and you must reapply.
- You must provide proof of income with this application.

Patient's \_\_\_\_\_  
First Name
Last Name
Date of Birth

**Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your application.**

**My current employer:** \_\_\_\_\_

**What is /are the source(s) of your income:** \_\_\_\_\_

- I get paid in cash
- I do not get checks
- I do not get pay stubs
- I cannot get a letter from my employer - Please explain: \_\_\_\_\_

**My cash income is: \$** \_\_\_\_\_ **How Often? (daily, weekly, monthly):** \_\_\_\_\_

**Applicants/Recipients must read the following and sign below:**

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This section to be filled out by administrative personnel only:** MRN: \_\_\_\_\_

1. Financial Assistance: Tier 1 / Tier 2 / Tier 3 / Tier 4 (circle one)
5. Coverage added to EPIC account Yes / No Date coverage added: \_\_\_\_\_
6. Proof of Income provided: W2 / Paystub / Other: \_\_\_\_\_/Pending
7. Staff Member Name: \_\_\_\_\_