NATIONAL UNIVERSITY OF Natural Medicine

Patient 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: _____ (For your identity privacy at NUNM and is used solely for that purpose)

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 was your assigned sex at birth? □ Male □ Female Other (specify) _____
What gender do you identify as? □ Male □ Female Other (specify) _____
What pronoun do you use? □ He/Him/His □ She/Her/Hers 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 Health Centers.

☐ 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.

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PATIENT REGISTRATION FORM CONTINUED

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): _____

City: _____ State:_____ Zip: _____

Social Security Number: _____ Gender: □ M □ F DOB: _____

Guarantor Primary Language: _____

The NUNM Health Centers 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 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**

NATIONAL UNIVERSITY OF Natural Medicine

PERSONAL HEALTH HISTORY

Patient: _____ _____ _____ Date of Birth _____
Last Name First Name Middle Name

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

_____

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

☐ Sulfa ☐ Penicillin ☐ Tetracycline ☐ Morphine ☐ Aspirin ☐ Codeine
☐ NSAIDS ☐ Latex ☐ Lidocaine ☐ Contrast Dye ☐ Sulfites ☐ Pollen
☐ Cats ☐ Dogs ☐ Mold ☐ Dust ☐ Bees ☐ Soy
☐ Wheat ☐ Shellfish ☐ Fish ☐ Peanuts ☐ Eggs ☐ Milk
☐ 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)**

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke
☐ Asthma ☐ COPD ☐ Diabetes ☐ Cancer
☐ Depression/Anxiety ☐ Liver Disease ☐ Digestive Problems ☐ Thyroid Disorder
☐ Adrenal Disorder ☐ Kidney Disease

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

☐ Appendectomy ☐ Brain Surgery ☐ Breast Surgery ☐ C-Section
☐ CABG ☐ Cholecystectomy ☐ Colon Surgery ☐ Cosmetic
☐ Eye Surgery ☐ Fracture Surgery ☐ Hernia Repair ☐ Hysterectomy
☐ Joint Replacement ☐ Prostate Surgery ☐ Small Intestine Surgery ☐ Spine Surgery
☐ Tonsillectomy ☐ Tubal Ligation ☐ Valve Replacement ☐ Vasectomy
☐ 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												

Over the past 2 weeks, how often have you been bothered by any of the following problems? (PHQ-2)

1. Little interest or pleasure in doing things	☐ nearly every day ☐ more than half the days ☐ several days ☐ not at all
2. Feeling down, depressed, or hopeless	☐ nearly every day ☐ more than half the days ☐ several days ☐ not at all

Continue to pages 3 & 4 →

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

Do you drink alcohol?	☐ Yes	☐ No

If "YES", how many of the following per week: ____glasses of wine _____shots of liquor _____cans of beer

Are you sexually active?	☐ Yes	☐ No	☐ Not Currently
Partners?	☐ Male	☐ Female	☐ 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 ☐ Ecstacy ☐ 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

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

Abdominal Pain
Low/high blood pressure
Blood clots
Heart disease

Respiratory
Cough
Shortness of breath
Asthma
Coughing up Blood
Wheezing
Sputum Production

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

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

Male Reproductive
Hernias
Testicular masses
Sexual difficulty

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
Joint pain
Neck Pain
Falls
Back Pain
Muscle spasms

Endocrine/Heme/Allergies
Excessive thirst
Cold intolerance
Diabetes _____
Env. Allergies
Excessive hunger
Thyroid problems_____
Easy Bruising/Bleeding
Heat intolerance

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

Emotional (Psychiatric)
Depression
Hallucinations
Memory Loss
Suicidal Ideas
Nervous/Anxious
Mood swings
Substance Abuse
Insomnia
Tension/stressed

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
  - 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 guaranty of success or effectiveness of any specific treatment. I am free to withdrawal my consent or participation in these treatments at any time.

  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

(You will electronically sign the consent forms at the Health Center)

NATIONAL UNIVERSITY OF Natural Medicine

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.

NATIONAL UNIVERSITY OF Natural Medicine

Statement of Financial Responsibility (cont)
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. *

You will electronically sign the consent forms at the Health Center)

NATIONAL UNIVERSITY OF Natural Medicine

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, 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.

(You will electronically sign the consent forms at the Health Center)

NATIONAL UNIVERSITY OF Natural Medicine

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.**

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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: _____

NATIONAL UNIVERSITY OF Natural Medicine

PATIENT'S RIGHTS AND RESPONSIBILITIES

Awareness of patients' rights has been heightened with the rise in health care consumerism. An increase in patient participation in the patient doctor encounter has evened the power relationship with patients demanding the right to become more involved in their own health care decisions.
This has led to more patient autonomy, a more egalitarian relationship, and active participation by patients in making decisions about their health care. The conventional model where the doctor "always knows best" no longer goes unchallenged. Relinquishing power to patients includes acknowledging a patient's bill of rights.

Patient's Bill of Rights:

A patient and/or his/her legal representative has the right to:

- Receive informed consent regarding procedures, risks and alternatives, and receive answers to questions with respect to treatment;
- Refuse treatment and accept the potential consequences of that choice after thorough explanation;
- Expect reasonable safety insofar as the health care environment is concerned;
- Be interviewed and examined in surroundings that permit reasonable visual and auditory privacy;
- Have another person present during examination and/or treatment;
- Expect that all communications and records pertaining to their care should be treated as confidential;
- Receive complete, current information concerning diagnosis, treatment, and prognosis in terms reasonably understood;
- Know the identity and professional status of the individual providing service to them and know who has the primary responsibility for coordinating their care;
- Expect reasonable continuity of care;
- Be fully advised of and accept or refuse to participate in any research project and/or O.B.C.E. approved investigational procedure(s);
- Receive and examine an explanation of charges for services rendered;
- Receive considerate and respectful care;
- Expect not to be denied treatment solely on the basis of race, color, religion or sexual preference.

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PATIENT'S RIGHTS AND RESPONSIBILITIES (cont.)

Patient's Responsibilities:

A patient and/or his/her legal representative has the responsibility to:

- be honest and forthright with the doctor and office staff and to provide accurate and complete information about present complaints, past illnesses, accidents, hospitalizations, medications and any other information related to his/her health;
- Report to the doctor in a timely manner any new incident, trauma or changes in his/her health condition;
- Acknowledge and consider instructions provided by the doctor and/or office staff;
- Request clarification about any aspect of his/her care not fully comprehended;
- Keep scheduled appointments or give adequate notice of delay or cancellation;
- Treat doctors and office staff with respect and courtesy.

***** Considering the above items, lack of cooperation may cause endangerment to the patient's health and/or impaired results of care. Chiropractors have the right to select their cases and patients. It is permissible for the doctor to discontinue treatment of a patient when the patient fails to cooperate in an agreed upon plan of management.