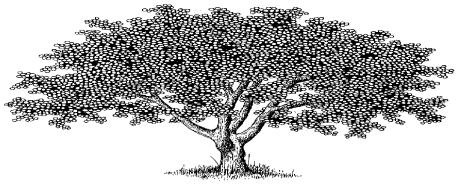

Healing Tree Family Practice, LLC
Jeri Lynn Otterstrom, ND
1000 River Road Eugene, Or 97404
Office (541)688.1569; Fax (541)461.6884
info@drotterstrom.com
Confidential Patient Information

Patient Name _____ Birth Date_____ Age _____ Today's Date_____

Parents/Guardian (if a minor) _____ Spouse/Partner _____

Address _____ City/State _____ Zip _____

Phone: Home _____Work _____

Cell/Pager _____ E-mail _____

Work/Occupation _____ Employer _____

Marital Status _____ Spouse/Partner's Employer _____ Work Phone _____

Emergency Contact Person _____ Phone _____

Relationship _____ Address _____

Race/Ethnicity: White/Caucasian___ Hispanic/Latino___ Black/African American___ American Indian/Alaskan Native____
Asian___ Native Hawaiian/Other Pacific Islander___ Decline to Answer___
Language: English___ Spanish___ Japanese___ Chinese___ French___ Korean___ German___ Russian___ Other_____
Method of Payment: Private Ins___ Self Pay___ Worker's Comp___ Motor Vehicle Accident___ OHP___ Other_____

Insurance Company_____ Policy#_____ Group # _____

Primary Policy Holder _____ Date of Birth _____

How did you hear about the clinic? _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to this physician. I am also financially responsible for non-covered services. I also authorize this physician to release any information required to process this claim.
SIGNATURE _____ Date _____

Current Condition

What brings you into the office today? _____

What are your other three top health concerns?

1)._____

2)._____

3)._____

List any medications you are currently taking or have taken in the last three months including prescription, over the counter and vitamin supplements:_____

_____

_____

List any known allergies to food, drugs, or chemicals: _____

Medical Care

Are you currently under a physician's care? _____Yes_____ No. If yes, physician's name _____

For what Condition(s)? _____

Last physical exam _____ Last women's annual exam _____

Mammogram _____Last menstrual period _____

Last dental exam: _____X-Ray/CT scan/MRI _____

Please turn to the back of form

Medical History (please include dates)

Height _____ Weight _____ Blood Pressure _____

Number of pregnancies _____ Number of Children (names & ages) _____

Major illnesses _____

Past surgeries _____ Hospitalizations _____

School sports played _____ Broken bones _____

Accidents/Injuries _____ Restricted movement _____

Vaccinations: Please circle if you have had the Disease (**D**) or Vaccination (**V**):
Chicken Pox **D V**, DPT **D V**, Hepatitis **D V**, Hib/Influenza **D V**, Measles/Mumps/Rubella **D V**, Tetanus **D V**, Polio **D V**
Please **check** any problems that **you** have now or have had in the past. Please **write (M** Mother / **F** Father / **MGM** Maternal Grandmother / **MGF** Maternal Grandfather / **PGM** Paternal Grandmother / **PGF** Paternal Grandfather / **Sis** Sister / **B** Brother / **D** Daughter / **S** Son / **MA** Maternal Aunt / **MU** Maternal Uncle / **PA** Paternal Aunt / **PU** Paternal Uncle**)** if there is a significant **family history**:

___Alzheimer's Disease / Dementia
___Addictions: Drug / Alcohol / Food
___Allergies / Hay Fever / Hives
___Anemia / Iron Deficiency / Pernicious
___Anesthesia Issues
___Arthritis / Rheumatoid Arthritis
___Asthma / Bronchitis
___Athletes Foot
___Auto-Immune Conditions / Lupus
___Birth Defects
___Blood Sugar Concerns / Diabetes / Type 1 / Type 2 / Hypoglycemia
___Breast D/O's
___Cancer: / Breast / Colon / Lung / Prostate / Ovarian / Other
___Cardiac Disease / High blood pressure/Hypertension (HTN) / Heart Attack / Stroke / High cholesterol
___Colds (Frequent) / Pneumonia / Bronchitis
___Ear Infections
___Eye Conditions / Glaucoma / Cataracts / Glasses / Contacts
___Fatigue / Chronic Fatigue Syndrome / Mononucleosis / EBV / CMV
___Gastrointestinal D/O's / Constipation / Diarrhea / Reflux (GERD) / Heartburn
___Headaches / Migraines / Cluster
___Hearing problems / Hearing Loss / Tinnitus
___Liver Disease / Hepatitis / A / B / C / Cirrhosis
___Immune Deficiency / HIV / AIDS
___Infertility
___Insomnia / Hypersomnia / Apnea
___Kidney Disease
___Lung Disease / Tuberculosis (TB)
___Menstrual D/O / PCOS / Menopausal Difficulties
___Mental / Emotional D/O / Depression / ADD/ADHD / Anxiety
____Muscular / Joint Pain / Fibromyalgia
___Neurological Conditions / Multiple ____Sclerosis (MS)
___Osteoporosis
___Prostate Disease / BPH
___Rheumatic / Scarlet Fever
___Seizures / Epilepsy
___Sexually Transmitted Disease (STD)
___Skin Issues / Eczema / Psoriasis
___Thyroid disorders / Hypo / Hyper / Hashimoto's / Grave's
___Ulcer / Peptic / Gastric
___Urinary Tract Infection (UTI) / Cystitis
___Vaginal Infection
___Varicose Veins / Blood Clots / Deep Vein Thrombosis (DVT)
___Vertigo / Dizziness
___Other:_____

Health Habits

Hobbies/Interests _____

Exercise: Type _____ Frequency _____ Duration_____

Sleep: Avg. # Hours _____ Quality _____

Major Stressors _____

Tobacco: _____ Yes _____ No If yes, how much, how long? _____

Caffeine: _____ Yes _____ No If yes, how much? _____

Alcohol: _____ Yes _____ No If yes, how much? _____

Briefly describe your diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Social and Occupational History:

Level of Education:

_____High School _____Some College _____College Graduate _____ Post Graduate Studies

Job Description: _____

Work Schedule: _____

Recreational Activities: _____

FINANCIAL POLICY

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help patients experience good health and we wish to spend our time toward that end. Therefore, we would like to inform you of our financial policy.

- Any estimates for patient treatment fees, are just an estimate
- Payment is due at the time of your visit
- Nutritional supplements and other supplies must be paid as you take them
- We accept cash, check, VISA, MasterCard and Discover card

SELF PAY PATIENTS If you are paying for services on the day of your visit and we are not billing your insurance company, filling out any type of forms or paperwork or waiting for payment, we offer a bookkeeping discount on some services.

MEDICAL INSURANCE As a courtesy to patients, we will bill your primary insurance carrier, however we do not bill secondary companies except for Medicare patients. Please be aware that any insurance quote for coverage is not a guaranty of benefits. Co-payments, deductibles and percentages that are patient responsibility are due at the time of service. By signing this form, you are authorizing the release of your records to facilitate claims processing and for continuity of care. You are also authorizing that payments be made directly to Healing Tree Family Practice, LLC. We reserve the right to refuse to do business with any insurance company that requires completion of forms regarding permission for us to carry out our patient treatment plan.

PERSONAL INJURY/AUTO INSURANCE Regardless of who the responsible party is a claim will be established with your auto insurance company. Please contact your agent, inform them of your care and request forms to set up a claim. You are still personally responsible for your bill but you will not be required to pay as services are rendered. If your balance reaches $800 and your insurer is withholding payment for any reason, you will be required to start paying for services: we do not hold balances over $800. We require that you sign a lien form assigning payment to Healing Tree Family Practice, LLC from an insurance company or from an attorney in cases where one has become necessary.

WORKER'S COMPENSATION You are not personally responsible for the account unless your claim is partially or totally denied by Worker's Comp. At that point, we can bill your private insurance if you have chiropractic benefits with that company, or we begin collecting from you if no benefits are available.

MEDICARE Naturopathic physicians are not recognized providers by Medicare. Medicare will not pay for the cost of any care and/or services provided to you. You will be required to pay at the time of service for all services or supplies in our office.

Thank you for taking the time to read this policy. If you have any questions, please don't hesitate to ask.

Signature Date

Acknowledgment and Consent

I understand that Jeri Lynn Otterstrom ND (referred to below as *Healing Tree Family Practice, LLC*) will use and disclose **health information** about me.

I understand that my **health information** may include information both credited and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that I *Healing Tree Family Practice* may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that i have the right to receive and review a written description of how *Healing Tree Family Practice* will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of *Healing Tree Family Practice*, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of *Healing Tree Family Practice's* Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that i have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that *Healing Tree Family Practice* is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By _____ Date: _____
(Patient)

By _____ Date: _____
(Patient representative)
Description of Representative's Authority: _____

AUTHORZATION TO DISCLOSE MEDICAL RECORDS

Oregon Revised Statute 192.525, 1997

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. I authorize (Name of Hospital/Health Care Provider)_____ to release a copy of the medical information for:
Name of Patient: _____.
Date of Birth: _____.

TO: Healing Tree Family Practice, LLC
1000 River Road
Eugene, OR 97404-3230
Phone: 541.688.1569Fax: 541.461.6884

The information will be used on my behalf for the following purpose: **EVALUATION**
By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist.

_____ All hospital records (including nursing records and progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five year history
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinician office chart notes
_____ Dental records
_____ Physical therapy records
_____ Emergency and urgency care records
_____ Billing statements
_____ X-ray of the spine
_____ Other

_____ **Please send the entire medical record (all information) to the above named recipient.**

____ *HIV/AIDS-related records
____ *Mental health information
____ *Genetic testing information
____*Must be initialized to be included in other documents
____ **Drug/alcohol diagnosis, treatment or referral information
____**Federal Regulation, 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.
____ This authorization is limited to the following treatment: _____
____ This authorization is limited to the following time period: _____
____ This authorization is limited to a worker's compensation claim for injuries of _____
(Date)

This authorization may be revoked at any time. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
(Date) (Signature of Patient)

_____ _____
(Date) (Signature of person authorized by law)