BLUE STAR
NATUROPATHIC CLINIC, PC

Patient Information Form

Last Name_____ First Name _____ Middle Name_____

Date of Birth (Required) _____ /_____/_____ Gender _____ Other names that records may be kept under _____

Address _____ City _____ State _____ Zip _____

SS# _____ Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

May we leave confidential voice messages for you at any of the above numbers? ☐**No** ☐**Yes** (specify) ☐**Home** ☐**Work** ☐**Cell**
Are you currently employed? □ Yes □ No Employer_____

Emergency Contact Name_____ Phone # (_____) _____Relationship_____

How did you hear about us? _____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name_____ First Name_____ Middle Initial _____

Address_____City_____ State_____ Zip_____

Phone (_____) _____Date of Birth (required) ____/____/____ SS#_____ Gender (circle) Male Female

Mother's Name (minors only)_____ Father's Name (minors only)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X_____ _____
Guarantor's Signature (required) **Date**

Terms of Admission

Financial Terms: I understand that if I am insured with a Blue Star Naturopathic Clinic, P.C. (BSNC) contracted insurance company, BSNC will submit claims on my behalf. I also understand that I will be responsible for all charges whether or not they are covered by my insurance. Some procedures may be considered non-covered services and I will be required to make payment in full at the time of service. I understand that there is a cancellation policy and that I may be billed for missed appointments cancelled within less than 24 hours notice. I understand that finance charges will begin accruing on accounts that are 60 days past due at a rate of 1.5% per month. I further understand that overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself; is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Blue Star Naturopathic Clinic, P.C. is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call (541) 389-6935.

I hereby acknowledge that I have received a copy of Blue Star Naturopathic Clinic P.C. Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Blue Star Naturopathic Clinic, P.C. has made good faith effort to obtain my acknowledgment.

X_____ _____
Patient's Signature **Date**

X_____ _____
Guardian/Representative's Signature **Date**

X_____
Relationship to Patient/Representative authority

CONSENT FOR TREATMENT

Please read and sign the following in order to completely understand the risks and benefits of Naturopathic Care

Methods, Procedures and Therapeutic Approaches: Clinicians may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns.

General Diagnostic Procedures: including but not limited to venipuncture, pap smears, radiography, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions; Topical Treatments
Herbs/Natural Medicines: prescribing therapeutic substances which include plants, minerals, and animal materials. Substances maybe given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, liniments, washes, suppositories or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
Dietary Advice and Therapeutic Nutrition: use of foods, diet plans or nutritional supplements for treatment. May include intramuscular, intravenous or subcutaneous injections.
Soft Tissue and Osseous Manipulation: use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.
Electromagnetic and Thermal Therapies: includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies.
Minor Office Procedures: such as ear cleansing, dressing a wound and cryotherapy.

Potential Risks: While not common, can potentially occur from any therapy. Some examples include but are not limited to: pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat or frictional therapies, electromagnetic-and hydrotherapies; loss of consciousness or deep tissue injury from needle insertions or needle breakage; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of a disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. We do not use labor-stimulating acupuncture points or any labor-inducing substances unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Blue Star Naturopathic Clinic, P.C. or any of its personnel regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.
I hereby acknowledge that I am financially responsible for services rendered.

Guardian/ Personal Representative's Name (PRINT)	Patient's Name (PRINT)
Guardian/Personal Representative's Signature	Patient's Signature
Relationship/Representative's Authority	Date

Authorization to Bill Third-Party Payer

SECTION 1: Patient Information

Last Name_____ First Name_____ Middle Initial _____

Date of Birth_____/_____/_____ SS#_____ Daytime Phone (_____) _____

SECTION 2: Benefits and Billing Information

Please notify the front desk staff if your visit is related to an injury or accident

I. Does your insurance have alternative medicine benefits? Yes No

Who is your primary Care Provider? Dr. _____ Clinic Phone (_____) _____

Clinic Address_____ City _____State_____ Zip Code_____

Does your plan require you to have a referral from your Primary Care Provider to receive coverage? Yes* No

*If yes, which licensed provider were you referred to at our clinic? _____

II. Primary Insurance Company and Plan Name_____

ID # _____ Group/Policy #_____

Name of Policy Holder_____ Policy Holder's Date of Birth_____/_____/_____

Policy Holder's Address_____or □ (check if same as patient)

The Policy Holder is my _____(specify relationship) Policy Holder's Gender (circle) Male Female

Is your Primary Insurance Policy a (circle) POS PPO EPO HMO Don't Know Other (specify) _____

III. Secondary Insurance Company & Plan Name _____

ID# _____ Group/Policy #_____

Name of Policy Holder _____ Policy Holder's Date of Birth_____/_____/_____

Policy Holder's Address_____or □ (check if same as patient)

The policy holder is my_____ (specify relationship) Policy Holder's Gender (circle) Male Female

Is your Primary Insurance Policy a (circle) POS PPO EPO HMO Don't Know Other (specify)_____

SECTION 3: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name_____ First Name _____ Middle Initial_____

Date of Birth (required)_____/_____/_____ SS # _____ Gender (circle) Male Female

Address_____ City_____ State_____ Zip _____Phone (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X_____ _____

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Blue Star Naturopathic Clinic, P.C. to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____ _____

Patient's Signature **Date**

X _____ _____

Guardian/Representative's Signature **Date**

_____

Relationship to Patient/Representative Authority

ADULT HEALTH HISTORY

THIS INFORMATION WILL BE CONTAINED IN YOUR CONFIDENTIAL MEDICAL RECORD

Last Name:_____ First Name:_____
Today's Date:_____ Birthdate:_____ Sex: □M □F

Please list in order of importance your chief concerns, main problem, or reasons for seeing the doctor:

1.
2.
3.
4.
5.

What goals do you have for your visit today?_____
_____
Name of your primary doctor:_____
Date of last complete checkup:_____Diagnosis, if any:_____

Please list prescription medications that you are currently taking, with dosages:

1.	2.	3.
4.	5.	6.

Please list vitamins, minerals, herbs, homeopathics or supplements that you are currently taking, with dosages:

1.	2.	3.
4.	5.	6.

Do you have any severe or life threatening allergies, sensitivities, or bad reactions to medications, foods, chemicals, animals or anything else? □YES □NO
If YES, please explain: _____
_____

The general state of my health has been: □Excellent □Good □Fair □Poor
Height:_____ Weight:_____ Weight change in past 12 months: gain_____lbs loss_____lbs

Personal Habits

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____
_____
Caffeine: Coffee _____cups per day Tea _____cups per day
Smoking: Packs per day:_____ Number of years:_____ Years stopped:_____ cigs/pipe/cigar/chew
Alcohol: What type?_____ How much each week?_____
Other: Soft drinks? Energy drinks? What type and how much per day?
_____
Do you exercise regularly? □ YES □ NO If yes, what type? _____
How Long?_____ How Often? _____
How many hours do you sleep?_____
Occupation:_____

Past History

Hospitalizations: _____
_____
Serious Illnesses and Injuries: _____
_____

Family History

Has any family member had any of the following? □ Diabetes □ Heart Disease □ High Blood Pressure □ Thyroid □ Stroke □ Cancer □ Alcoholism/Drug Addiction □ Mental Illness

What are your children's names and ages? _____
_____

System Review: Check if you currently have any symptoms or problems to any important or significant degree.

General:
□ Weight loss/gain
□ Eating disorder
□ Appetite change
□ Tiredness, weakness
□ Sudden energy drop, time of day
□ Fever
□ Sweating at night
□ Sweating when tired
□ Bleeding tendency
□ Bruise easily
□ Poor sleep
□ Strong thirst (for hot or cold?)
□ Cravings

E.E.N.T
DATE OF LAST EYE EXAM:_____
□ Disturbances of vision
□ Red or itchy eyes
□ Loss of hearing
□ Ringing in ears
□ Pain in ears
□ Disturbances of speech
□ Trouble swallowing
□ Sore or dry throat
□ Lip or mouth sores
□ Nosebleeds
□ Nose or sinus problems
□ TMJ
□ Loss of taste or smell
□ Headache
□ Problems with teeth/dentures
DATE OF LAST DENTAL EXAM:_____

Respiratory System:
□ Cough
□ Asthma
□ Chest pain
□ Shortness of breath
□ Rib pain

Gastrointestinal System:
DATE OF last urinary or bladder infection:_____
□ Constipation
□ Diarrhea
□ Blood in stool
□ Hemorrhoids
□ Nausea, vomiting
□ Heartburn
□ Indigestion
□ Abdominal pain/discomfort
□ Gas & bloating
□ Jaundice (yellowing of skin and eyes)

Genitourinary System:
□ Lower abdominal pain
□ Kidney problem
□ Hernia
□ Sexually transmitted disease
□ Pain on urination
□ Inability to hold urine
□ Blood in urine
□ Urethral discharge

Women's Issues:
DATE OF LAST PERIOD:_____
TYPE OF BIRTH CONTROL:_____
DATE OF LAST MAMMOGRAM:_____
□ Painful periods
□ PMS
□ Irregular periods
□ Excessive bleeding
□ Abnormal lack of menses
□ Hot flashes
□ Vaginal dryness
□ Sexual difficulties
□ Painful breasts
□ Lumps in breasts
□ Pregnancy#___

Skin and Hair
□ Rash
□ Oozing skin sores
□ Eczema
□ Loss of hair

Men's Issues:
DATE OF VASECTOMY:_____
□ Prostate problems
□ Sexual difficulties
□ Testicular pain/swelling
□ Penis pain or discharge

Musculoskeletal System:
□ Joint pain, swelling
□ Pain in neck, shoulder, back, arm, hand, hip, buttock, leg, knee, ankle, foot (circle all that apply)
□ Cold hands or feet
□ Pins and needles sensation

Cardiovascular System:
DATE of last EKG:_____
DATE of last Chest X-ray:_____
□ Palpitations
□ Blood pressure problems
□ High cholesterol
□ History or heart murmurs
□ Swollen ankles or feet
□ Blood clots

Central Nervous System:
□ Fainting
□ Convulsions
□ Weakness/paralysis
□ Loss of feeling or function in body part
□ Disturbances of balance
□ Dizziness
□ Light-headedness

Emotional:
□ Worry
□ Moodiness
□ Irritability
□ Nervousness
□ Depression
□ Grief
□ Problems in relationships

Additions to Health History:

PATIENT SIGNATURE:_____ DATE: _____

REVIEWED WITH PATIENT, PHYSICIAN SIGNATURE:_____DATE:_____