Salem Naturopathic Clinic, P.C.
1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

Dr. Donald McBride, N.D.
Dr. Esther Tak, N.D.

Patient Information

First Name	Middle name	Last Name	Preferred Name	
Date of Birth	Social Security No.	Preferred pharmacy	Gender	Marital Status
Employer		Occupation		
Home Address	City	State	Zip Code	
Mobile Phone	Home Phone	Work Phone		
email	Would you like to receive appointment reminders by text, email and/or phone? May we leave a voicemail message?			

Whom may we thank for your referral today? _____

Emergency Contact Information

Name	Phone	Relationship
May we discuss your billing and/or treatment with the above named?		

Do you have insurance coverage? Yes ☐ No ☐

Insurance Information

The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier.
We cannot guarantee insurance coverage by your insurance carrier.
Please give your insurance card to our receptionist to be copied.

Primary Insurance Carrier	ID #	Group #	Social Security No.
Name of Insured/Subscriber	Relationship to Patient	Date of Birth	Gender M F
Secondary Insurance Carrier (if applicable)	ID #	Group #	Social Security No.
Name of Insured	Relationship to Patient	Date of Birth	Gender M F

Initial	Authorization and Release
	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to **Salem Naturopathic Clinic, P.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account.
	I agree to receive periodic health and wellness information as well as clinic news via email. I understand that I can opt out by unsubscribing to the email.

_____ _____ _____
Patient / Responsible Party Signature Relationship Date

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Marital Status: _____ Spouse's Name:_____
If Applicable

Are Vaccines Current? Y N Declined Last Physical Exam:_____
Or Last Well Child Visit

Height:_____Weight:_____ Gender: Male Female

If Male, Last Prostate Exam/PSA Evaluation: _____

If Female, Last Pap Test: _____ Last Breast Exam:_____

Last Mammogram: _____ Do you do self exams? Y N

Last Chest X-Ray:_____ Last Blood Tests: _____

Last Eye Exam: _____ Last Dental Visit: _____

Any other diagnostic tests in the last 3 years? If so, what test and when?

_____

_____

For Adults, when was your last

Pneumonia Vaccine: _____ Tetanus Booster:_____ Flu Vaccine:_____

Please list ***all*** medications, vitamins, herbs, hormones and other prescriptions you currently take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any past surgeries / hospitalizations, including approximate date:

_____ _____

_____ _____

Do you have a family history of any of the following diseases: (check all that apply)

	Sibling	Mother	Father	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Diabetes							
Cancer							
Heart Disease							
Stroke							
Other							

Date of Last Medical Care:_____Who Treated You?_____

Primary Care Medical Provider:_____

Please list all your known allergies – drug, food, insect/animal, etc.:

_____

_____

I have questions about:

Diet Exercise Vaccinations Current Medications

Prevention of_____ Other_____

What are your major health complaints, listing the most important first?

_____

_____

_____

What treatments have you tried for the above complaints?

_____

_____

Hobbies:_____

What type of exercise do you participate in?_____

Is there anything else you think would be helpful for us to know in assessing your care?

_____

Rate the following as: 1=three or four times yearly, 2=monthly, 3=once a week, 4=daily
Please add comments to clarify the symptoms listed, leave blank any that do not apply

Head:
1._____ Headaches
2._____ Dry scalp
3._____ Acne
4._____ Dizzy
Other: _____

Gastrointestinal:
1._____ 'Heartburn'
2._____ Stomach aches
3._____ Gas/bloating
4._____ Fatty meals bother
5._____ Constipation
6._____ Diarrhea
7._____ Blood/mucus in stool
8._____ Vomiting
9._____ Hemorrhoids
Bowel movements:
_____ Daily
_____ Other
Other:_____

Musculo-skeletal:
1._____ Joint pains
2._____ Back pain
3._____ Neck pain
4._____ Muscle aches
5._____ Bruising
6._____ Sprains
7._____ Joint stiffness
8._____ Arthritis
Other:_____

Diet (on an average day):
Breakfast:
_____
_____
Lunch:
_____
_____
Snack:
_____
_____
Dinner:
_____
_____
Liquids:
_____
_____
If you smoke, how much?
_____
If you drink alcohol, how much?
_____
Other:_____
_____

Chest:
1._____Shortness of breath
2._____ Heart pounds
3._____ Heart 'flutter'
4._____ Asthma
5._____ Chest pains
6._____ Wheezing
7._____ Coughing
Other:_____

Urinary Tract:
1._____ Bladder infections
2._____ Kidney infections
3._____ Burning during/after urination
4._____ Frequent urination
5._____ Blood in urine
Other:_____

Energy (check if it applies):
1._____ Sleep soundly
2._____ Wake rested
3._____ Feel energetic in the morning
4._____ Slow starter
5._____ Afternoon slump/tiredness
6._____ Tired all day
7._____ Low energy even with sleep
8._____ Feel restless when trying to sleep
9._____ Wake up easily at night
Other:_____

Male Only:
1._____ Frequent urination (day, night)
2._____ Incomplete urination
3._____ Discharge from urethra
4._____ Trouble initiating urination
5._____ Hernias
6._____ Decrease in sex drive
7._____ Erectile difficulty
8._____ Rectal burning/itch
Other:_____

Eye/Ear/Nose/Throat:
1._____ Vision blurry
2._____ Dry eyes
3._____ Dark circles under eyes
4._____ Ear wax builds up
5._____ Ear aches
6._____ Hearing loss
7._____ Ringing in ears
8._____ Sinus pain/infection
9._____ Nose/sinuses dry
10.____ Nose runs
11.____ Seasonal allergies
12.____ Voice hoarse
13.____ Sore throat
14.____ Post nasal drip
15.____ Nose bleeds
Other:_____

Neuro-Endocrine:
1._____ 'Panic' / anxiety attacks
2._____ Irritability
3._____ Feel bad when not eating regularly
4._____ Weight gain
5._____ Weight loss
6._____ Mood swings
7._____ Snack often
8._____ Increased thirst
9._____ Insomnia
10.____ Increased appetite
11.____ Decreased appetite
12.____ Heart races
13.____ Easy fatigue
14.____ Feel down/depressed
15.____ Poor memory

Female Only:
1._____ PMS symptoms
Duration:_____
2._____ Menses painful
3._____ Menses change
(duration, regularity, flow, pain)
Average Cycle length: _____ days
4._____ Absent menses
Menopause began: _____
5._____ Decrease in sex drive
6._____ Vaginal discharge
7._____ Yeast infections
8._____ Hot flashes
9._____ Acne at/before menses
10.____ Pain in breasts
With cycle or constant?_____
11.____ Hair growth on face
12.____ Difficulty in:
Conception or Carrying to Term?
13.____ Hernias
14. Number of pregnancies_____
15. Number of births_____

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Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality care. We are sure you understand that payment for this service is your responsibility. This policy outlines your financial responsibilities related to payment for professional services. Please read it and ask us any questions you may have. When completed, please sign in the space provided. A copy will be provided to you upon request.

Insurance. We can bill most insurance plans, however are not a contracted Medicare provider and we may not be in-network with your insurance company. We will bill your primary insurance and, if applicable, a secondary insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We will obtain a copy of your photo I.D. and valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges. If you do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may not be covered. You must pay for these services in full at the time of visit or after your insurance has denied them.

4. **Claims submission.** We will submit your claims to assist with payment. Please be aware that your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Claim Payment.** If your insurance company does not pay within a reasonable time period of 90 days, you may be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Failure to provide new insurance information at the time of your appointment may result in payment responsibility to fall to you.

Non-Insurance/Self-Pay. If you do not have insurance or have insurance that does not provide payment for our services, you will be considered a self-pay patient and payment in full is expected at each visit.

Lab Services. We can obtain and process a specimen here in our office and send it to our third-party laboratory for analysis for your convenience. If you wish to go elsewhere, we can provide you with a lab order to take to a lab better covered by your insurance or more convenient for you.

Supplements. Many supplements are available for purchase at Salem Naturopathic Clinic. We do not bill insurance for supplements. Payment for supplements must be made in full at the time of purchase.

Non-Sufficient Funds. If you present a check for payment to Salem Naturopathic Clinic and it is not honored by your bank, a $25 Non-Sufficient Funds charge will be added to your account per occurrence.

Medical Record Copies. Salem Naturopathic Clinic charges $25 per request to copy your medical records for you. (This fee does not apply to records requests from other providers). You must complete a Medical Records Request Form and pay the copying fee prior to our releasing records to you.

Cancellation and Missed Appointment Policy. As a courtesy, we request that you provide us with 24 hours notice if you must cancel or reschedule an appointment. After the second consecutive cancelled or rescheduled appointment with less than 24 hours notice, a $50 late cancellation fee will be added to your account. Payment of the late cancellation fee must be made prior to scheduling your next visit. After a third missed appointment without advanced notice, you may be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment or providing at least 24 hours notice in the event you must cancel or reschedule.

Nonpayment. If you are a self-pay patient and your account is over 90 days past due OR if you are are billing insurance and your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing service. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice. In addition, if your bill is dismissed by a court as part of your bankruptcy, you and your immediate family members will be discharged from this practice. If you are dismissed from this practice, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician(s) will only be able to treat you on an emergency basis.

Thank you for understanding our Payment Policy. Please let us know if you have any questions.

I have read and understand the Payment Policy and agree to abide by its guidelines:

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient Name & Legal Guardian (if applicable) Relationship to Patient

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I have been given the opportunity to read and review a copy of Salem Naturopathic Clinic, P.C.'s Privacy Practices. I have had all questions regarding these procedures answered to my satisfaction. These policies are in accordance with the most current HIPAA guidelines in my State.

Signed by:

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian (if applicable)

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Informed Consent to Naturopathic Medical Care

I hereby request and consent to the performance of evaluation and management services as well as other procedures by my doctor at the Salem Naturopathic Clinic, PC. I understand that I have the right to ask questions and discuss to my satisfaction with Dr. _____ the nature and purpose of naturopathic medical evaluation and treatment and other procedures which my naturopathic physician may administer.

I understand and am informed that:

1. Naturopathic Medicine is the science, philosophy and art of identifying and treating diseases, dysfunctions, disorders and imbalances of normal human physiologic function. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.

2. As with any practice of medicine, it is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

3. I understand that my physician may administer manual therapy using his/her hands. I understand that my physician may use manipulation of joints, tendons, muscles and connective tissue in the body to restore motion / mobility. He or she will use his hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click."

4. It is not reasonable to expect my physician to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.

5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. I agree to communicate any such information to my physician in a timely manner so that changes in my treatment plan, if any, can be made.

6. As with any healthcare procedure, there are certain complications which may arise during any given medical procedure. Those complications from manipulation include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. Complications from injections may include pain at site of injection/infusion, allergy to injectant resulting in anaphylaxis, which may be fatal; light-headedness and weakness after injection. These complications are extremely rare occurrences.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to naturopathic medical evaluation, treatment and management on that basis.

_____ _____
Patient's Name (Printed) Date

_____ _____
Patient's Signature Relationship to Patient