Welcome

I welcome you to my private Naturopathic Medical practice. Naturopathic medicine is based on a philosophy that incorporates six vital concepts.

The Healing Power of Nature
First Do No Harm
Identify and Treat the Cause
Doctor as Teacher
Prevention
Treat the Whole Person

As a Naturopathic physician I have been trained in a multitude of disciplines including nutrition, disease diagnosis, botanical medicine, physical medicine, stress management and lifestyle counseling.

Office Location:
15645 SE 114th Ave, Suite 102
Clackamas, OR 97015
503.387.3348p
503.387.3347f

Office Hours are available by appointment only:
Monday - Wednesday 10:00am-6:00pm

24hour notice for cancellation of appointments is required.

Appointments and Fees:
Office visit fees vary depending on complexity and length of appointment. Please request a copy of our fees.

An initial visit lasts 1 hour. Follow-up visits will vary in length, approximately 30 minutes. Times may vary depending upon the condition and your treatment.

Payment is expected at the time of service. Cash, check and credit cards are accepted. We do bill insurance.

I thank you for your interest in health and wellness and look forward to working with you.

Sincerely,

Jennifer L. O'Leary, ND
Naturopathic Physician

PATIENT NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED, AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.

Patient Rights, Uses and Disclosures of Health Information:
During the course of your care with Jennifer O'Leary, ND we may use or disclose personal and health related information.
• Personal health information and clinical records may be disclosed to another health care provider or hospital.
• Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of your services.
• Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care. (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.)

Under federal law, we also may disclose your health information without consent under these circumstances:
• In providing health care services based on the orders of another health care provider.
• In an emergency.
• If we are required by law to provide care, and are unable to obtain your consent.
• If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
• If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

Physician Legal Duties:
We are required by state and federal law to maintain the privacy of your patient file and the protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is en effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

Complaints and Questions:
If you have a complaint regarding our privacy notice or privacy practices, or if you would like more detailed information, please contact: Dr. Jennifer O'Leary at 503.387.3348. This notice is effective as of May 1, 2006. This notice and any alterations or amendments will expire seven years after the date upon which the record was created.

Signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Patient Name (Printed)	Signature	Date
_____	_____	_____
Responsible Party (Printed)	Signature of Responsible Party	Date

PATIENT INFORMATION SHEET

PATIENT:
Last Name: _____ First Name: _____ Middle initial: _____
Gender: M F Date of Birth: _____ / _____ / _____ Age: _____ SS#: _____
Home Address: _____ Apt # _____
City _____ State _____ Zip _____
Telephone: (h) _____ (w) _____ (w II or cell) _____
Email _____ What is the best way to contact you? _____
Employer Name: _____ Occupation: _____
Work Address: _____
Relationship status: Married ___ Separated ___ Divorced ___ Widowed ___ Partner ___ Single ___
Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___ Other ___
How did you hear about our clinic? _____

SPOUSE OR GUARDIAN: *Please circle one.*
Last Name: _____ First Name: _____ Middle initial: _____
Telephone: (h) _____ (w) _____ (w II or cell) _____

EMERGENCY: *Name and address of nearest relative or friend* not living with you:
Last Name: _____ First Name: _____ Middle initial: _____
Telephone: (h) _____ (w) _____ (w II or cell) _____
Relationship to Patient: _____

INSURANCE: *Please present your insurance card(s) to the receptionist.*
Insurance Company 1: _____ Insured's Name: _____
Insured's date of birth: _____ / _____ / _____ ID/Policy # _____ Group #: _____
Insurance Company 2: _____ Insured's Name: _____
Insured's date of birth: _____ / _____ / _____ ID/Policy # _____ Group #: _____

RESPONSIBLE PARTY: *Fill out if you are not the patient but are responsible for the bill.*
Responsible Party: _____ Relationship to the patient: _____
Home Address: _____ Apt # _____
City _____ State _____ Zip _____
Telephone: (h) _____ (w) _____ (w II or cell) _____
Email _____ What is the best way to contact you? _____

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X_____

INSURANCE & FINANCIAL POLICIES
PLEASE READ

Thank you for choosing us for your health care. If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. If you do not, payment is expected at the time of service. Co-pay or co-insurance is also due at the time of service.

Insurance:
In many cases we will be able to call to verify your coverage during your first visit. If we are not able to verify coverage, payment in full is expected at the first visit. If your insurance company remits payment you will be reimbursed. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab tests, well child and annual exams, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your individual policy.

It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment. As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. We are happy to assist you with this process.

Supplements:
Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are prohibited from accepting returns once a safety seal has been broken. There is no requirement to purchase recommended supplements from our office; there are several local stores that may carry similar products. Please call the office or email me directly at ajafamilyhealth@gmail.com to request a refill. It is important that you give a minimum of 72 hour notice for a refill request. Please do not wait until you run out. Refill request must be over email or by phone call. Make sure your refill is ready before stopping by the clinic. *Initial here* _____

Late Cancellation/Missed Appointments:
As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. Patients who do not give 24 hour notice for a missed appointment will be charged a fee of $50.00. After two missed appointments, you will be charged for the entire time reserved for you on the schedule. Please note, we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies. *Initial here* _____

Methods of Payment:
We accept cash, checks, debit, Visa, and MasterCard. There is a $25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made. If you have questions about any of the above please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

Authorizations:
I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.
AND
I authorize the release of any medical or other information necessary to process any claims.
AND
I authorize payment of medical benefits to Jennifer O'Leary, ND for all services rendered.

Patient's or Authorized Person's Signature:
Name (please print): _____ _____Date:_____
Signature: _____

Adult Intake Form

Patient Information: Today's date:_____
Legal Name First:_____ Last:_____
Preferred Name: _____ Date of Birth:_____

Medical History:
What are your most important health concerns?
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you currently receiving health care? Y N
If yes, where and from who?_____
If no, when, where and why did you last receive health care?_____
_____
Medication History:
Please list type and dosage of any prescription medications or over the counter medications, vitamins or other supplements you are <u>currently</u> taking. Please attach a list if necessary.
1. _____ 5._____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Known allergies to medications:_____

Please list type, dosage and time frame for any prescription or over the counter mediation you have taken in the <u>past</u> (IE: steroid 2x/day-asthma 1994-1995)
1. _____ 5._____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

X-rays and Special Studies:
If you have had any imaging studies (x-ray, ultra sound, MRI etc) or special testing done please list test, approximate date and outcome.
1. _____ 3. _____
2. _____ 4. _____

Injuries/Surgeries/Hospitalizations:
1. _____ 3. _____
2. _____ 4. _____

Immunizations:
Are there any recommended immunizations you have not had?_____
Any atypical immunizations you have had?_____
Have you ever had an adverse (bad) reaction to an immunization? Y N
Which childhood diseases have you had? IE: measles, chicken pox_____

Adult Intake Form

Family Medical History: IF KNOWN If you are adopted, please check here_____
Please specify M=mother, F=father, S=sister, B=brother, A=aunt, U=uncle,
PGM or PGF=paternal grandparent, MGM or MGF=maternal grandparent

Allergies/Hay Fever _____High Cholesterol _____
Arthritis _____Cancer_____
Heart Attack/MI_____ Diabetes_____
High blood pressure_____ Other_____

Review of Systems: Although this section is lengthy, it allows the physician to make possible connections between symptoms that have not been noted before and allows more time during the appointment to address current concerns. Thank you. Y: yes/current N: no/never P: past

Emotional

History of Counseling	Y	N P	Eating Disorder	Y	N P
Mood Swings or Depression	Y	N P	Anxiety	Y	N P
Considered/Attempted Suicide	Y	N P	Tension or Nervousness	Y	N P

Endocrine

Thyroid Problems	Y	N P	Heat or Cold Intolerance	Y	N P
High Blood Sugar	Y	N P	Diabetes	Y	N P
Low Blood Sugar	Y	N P	Excessive Thirst or Hunger	Y	N P

Neurologic

Seizure	Y	N P	Loss of Balance	Y	N P
Muscle Weakness	Y	N P	Vertigo or Dizziness	Y	N P
Loss of Memory	Y	N P	Numbness or Tingling	Y	N P
Paralysis	Y	N P	Fainting	Y	N P

Nose/Sinuses

Sinus Pain	Y	N P	Post Nasal Drip	Y	N P
Sinus Infection	Y	N P	Chronic Stuffy Nose	Y	N P
Hay Fever/Nasal Allergies	Y	N P	Loss of Smell	Y	N P

Eyes/Ears

Floaters/Spots	Y	N P	Eye Pain/Strain	Y	N P
Corrective Lenses	Y	N P	Tearing or Dryness	Y	N P
Blurriness or Double Vision	Y	N P	Glaucoma or Cataracts	Y	N P
Hearing Impairment	Y	N P	Ringing in Ears	Y	N P
Excessive Ear Wax	Y	N P	Pain in Ears	Y	N P

Mouth/Throat

Frequent Sore Throat	Y	N P	Hoarse Voice	Y	N P
Grinding Teeth: awake/asleep	Y	N P	Excess Saliva or Dry Mouth	Y	N P
Gum Problems	Y	N P	Mouth Sores: inside/out	Y	N P

Respiratory

Cough	Y	N P	Sputum	Y	N P
Tuberculosis	Y	N P	Wheezing or Asthma	Y	N P
Pain with Breathing	Y	N P	Bronchitis	Y	N P
Shortness of Breath	Y	N P			

Urinary/Kidney

Painful Urination	Y	N P	Inability to Hold Urine	Y	N P
Increased Frequency	Y	N P	Kidney Stones	Y	N P
Frequency at Night	Y	N P	Urinary Tract Infection	Y	N P

Skin

Rashes/Eczema	Y	N P	Lumps	Y	N P
Acne or Boils	Y	N P	Itching or Fungus	Y	N P
Color Change	Y	N P	Psoriasis	Y	N P

Head

Headaches	Y	N P	TMJ Issues	Y	N P
Head Injury	Y	N P	Migraines	Y	N P

Cardiovascular

Heart Disease	Y	N P	Problems with Veins	Y	N P
Murmur or Valve Problems	Y	N P	Chest Pain	Y	N P
Blood Clots	Y	N P	High Blood Pressure	Y	N P
Palpitations or Fluttering	Y	N P	Low Blood Pressure	Y	N P

Gastrointestinal

Trouble Swallowing	Y	N P	Change in Bowel Habits	Y	N P
Liver Disease	Y	N P	Change in Appetite	Y	N P
Nausea or Vomiting	Y	N P	Heartburn or Ulcer	Y	N P
Pain or Cramps	Y	N P	Diarrhea	Y	N P
Black, Green or White Stool	Y	N P	Constipation	Y	N P
Hemorrhoids or Blood in the Toilet	Y	N P	Gallbladder Disease	Y	N P
How often do you have a bowel movement?					

Immune

Chronic Fatigue Syndrome	Y	N P	Sick Often	Y	N P
Chronically Swollen Glands	Y	N P	Autoimmune Disease	Y	N P
Slow Wound Healing	Y	N P	Frequent Infections	Y	N P

General Reproductive

Are You Sexually Active	Y	N P	Sexual Orientation		
Chlamydia or Gonorrhea	Y	N P	Low Sex Drive	Y	N P
Herpes	Y	N P	Genital Warts	Y	N P
Type of Birth Control:					
Have you been recently tested for sexually transmitted infections?					

Female Reproductive

Sexual Orientation:		Still Menstruating Y N	
Regular Menstrual Cycling (timing) Y N P		First Day of Last Menstrual Cycle	
How many days between the first day of one cycle and the first day of the next cycle?			
How many days of bleeding (typically)?			
Pain or Cramps Y N P		PMS Y N P	
Clotting Y N P		Heavy Flow Y N P	
Abnormal PAP Smear Y N P		Endometriosis Y N P	
Ovarian Cysts Y N P		Yeast Infection Y N P	
Menopausal Symptoms Y N P		Vaginitis Y N P	
Nipple Discharge Y N P		Breast Pain Y N P	
Have you adopted any children Y N		Monthly Self Breast Exam Y N P	
# Pregnancies	#Abortions	#Miscarriages	#Live Births

Male Reproductive

Hernia Y N P	Testicle Pain Y N P
Premature Ejaculation Y N P	Testicle Lump Y N P
Prostate Problems Y N P	Impotence Y N P

Musculoskeletal

Joint Pain/Stiffness Y N P	Arthritis Y N P
Broken Bones Y N P	Muscle Pain/Spasm Y N P
Muscle Spasm/Cramping Y N P	Nerve Pain Y N P

Other

Cancer Y N P	Anemia Y N P
Bruising Y N P	Swelling Y N P

Any other condition not mentioned?_____

Habits

Main Interest and Hobbies:		
Regular Exercise Y N P		Hours of exercise per week:
Quality Sleep Y N P		Average hours of sleep per night:
Enjoyable Work Y N P		Is your work stressful Y N P
Spiritual Practice Y N P		If yes, what kind?
How much TV do you watch daily:		Physical or Sexual Abuse Y N P
Regular Vacations Y N P		Supportive Relationships Y N P
Recreational Drugs Y N P		Personal History of Addiction Y N P
Do you think you are overweight? Y N P		Do you think you are underweight? Y N P
Cups coffee per day:	Cups tea per day:	Amount of soda per day:
How much water do you drink per day:		Tap / Filtered / Bottled
Food Intolerances (if known):		

Have you ever seen a Naturopathic Physician before? Y N
Describe your experience_____

What expectations do you have from this visit to our clinic?
_____

What long term expectations do you have from working with me personally as your physician?_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are not helping your health? _____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes that you will be making?_____

Use a scale of 1 to 10 to answer the following two questions:
What is your present level of commitment to improve your health? _____

How much are you willing to change at this time in order to improve your health? _____