

## 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 114<sup>th</sup> 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](mailto: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: \_\_\_\_\_

### Patient Intake: Ages 4 to 12

**Patient Information:**

Today's date: \_\_\_\_\_  
 Legal Name First: \_\_\_\_\_ Last: \_\_\_\_\_  
 Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_  
 Sibling Names and Ages: \_\_\_\_\_

**Pediatrician:**

Clinic name and phone number: \_\_\_\_\_

**Medical History:**

What are your child's health concerns (why are you bringing him/her in)?

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list type and dosage of any prescription medications, over the counter medications, vitamins or other supplements you are taking. Please attach a list if necessary.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Known allergies to medications: \_\_\_\_\_

**X-rays and Special Studies:**

If your child has had any imaging studies (x-ray, ultra sound, MRI etc) or special testing done (hearing, reading, psych) please list test, approximate date, and outcome.

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Injuries/Surgeries/Hospitalizations:**

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Immunizations:**

\_\_\_\_\_ measles    \_\_\_\_\_ polio    \_\_\_\_\_ MMR    \_\_\_\_\_ small pox    \_\_\_\_\_ diphtheria  
 \_\_\_\_\_ mumps    \_\_\_\_\_ DPT    \_\_\_\_\_ tetanus    \_\_\_\_\_ influenza    \_\_\_\_\_ other: \_\_\_\_\_

Please note any adverse (bad) reactions to immunizations \_\_\_\_\_

**Childhood Diseases:**

\_\_\_\_\_ chicken pox    \_\_\_\_\_ rubella    \_\_\_\_\_ mumps    \_\_\_\_\_ measles    \_\_\_\_\_ bronchitis  
 \_\_\_\_\_ pneumonia    \_\_\_\_\_ croup    \_\_\_\_\_ scarlet fever    \_\_\_\_\_ other(s) \_\_\_\_\_

Please circle: **Y** = current condition, **N** = never had this condition, **P** = past condition

Hives	Y	N	P	Burning of Urine	Y	N	P
Eczema	Y	N	P	Frequent Urination	Y	N	P
Allergies	Y	N	P	Bloody Urine	Y	N	P
Nose Bleeds	Y	N	P	Vomiting Spells	Y	N	P
Bleeding Gums	Y	N	P	Anemia	Y	N	P
High Fevers	Y	N	P	Stomach Aches	Y	N	P
Rash	Y	N	P	Jaundice	Y	N	P
Acne	Y	N	P	Easy Bruising	Y	N	P
Mouth Sores	Y	N	P	Diarrhea	Y	N	P
Sore Throat/Tonsillitis	Y	N	P	Constipation	Y	N	P
Frequent Headaches	Y	N	P	Gas	Y	N	P
Frequent Colds	Y	N	P	Easy Bleeding or Bruising	Y	N	P
Wheezing or Asthma	Y	N	P	Joint Pains	Y	N	P
Cough	Y	N	P	Dizzy Spells	Y	N	P
Ear Infections	Y	N	P	Motion/Car Sickness	Y	N	P
Unusual Fears	Y	N	P	Change in Appetite or Weight	Y	N	P
Cries Easily	Y	N	P	Heart Murmur	Y	N	P
Nervous or Anxious	Y	N	P	Flat Feet	Y	N	P
Sleep Problems	Y	N	P	Body/Breath Odor	Y	N	P
Night Sweats	Y	N	P	Excessive Fatigue	Y	N	P
Nightmares	Y	N	P	Behavior Problems	Y	N	P
Sensitive to Light or Sound	Y	N	P	Hair Loss	Y	N	P

Any other condition/s not mentioned: \_\_\_\_\_

**Family Medical History (if known):**

If child or parents 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 or hay fever \_\_\_\_\_ High Cholesterol \_\_\_\_\_

Arthritis \_\_\_\_\_ Cancer \_\_\_\_\_

Heart Attack/MI \_\_\_\_\_ Diabetes \_\_\_\_\_

High blood pressure \_\_\_\_\_ Other \_\_\_\_\_

**Birth Mother's Prenatal History (if known):**

Mother's age at child's birth \_\_\_\_\_

Any known problems regarding mother's health during pregnancy? **Y N**

Please note any particular psychological stress, drug, tobacco, or alcohol exposure as well as medical issues or complications of delivery \_\_\_\_\_

**For Young Women Only:**

Have menses started	Y	N	P	If yes, age menses began:			
Cramps	Y	N	P	PMS	Y	N	P