The Center For Natural Medicine, Inc
1330 SE 39th Ave, Portland, OR 97214 • (503)232-1100 • fax (503)232-7751 • www.cnm-inc.com

Welcome to our clinic. We are very pleased to be a part of your choices for health and wellness. The following information must be fully completed before your visit. Please read over our policies and procedures and sign and date in each place indicated so that we may provide you with the care and services you request by becoming our patient. If you have any questions, or need assistance with your intake forms, please ask at the reception desk.

Patient Name (Last, First, Middle) _____ Date of Birth _____

Guarantor/Guardian's Name if Patient is a Minor or Dependant _____

Home Address _____ City/St/Zip _____

Billing/Mailing Address _____ City/St/Zip _____

Patient Social Security # _____ Marital Status _____ Spouse/Partner's Name _____

Patient Employer and Employer Address _____

Best Contact Phone Number _____ May we leave messages for you at this number? Yes _____ No ____

Alternate Phone Number(s) _____May we leave messages for you at this number? Yes _____ No ____

Email Address_____Newsletter Yes___ No___ Products Yes___ No___

Emergency Contact Information (Name, Phone, Relationship) _____

Person(s), if any, authorized to receive private health information and to schedule/confirm appointments on the patient's behalf

(Name, Address/Phone, Relationship) _____

May we use anonymous data from your medical records for the purpose of teaching and research? Yes _____ No _____

How did you hear about our services? _____

CLINIC POLICY AND PROCEDURES

Please read and initial each point, and sign and date below:

____ *The Center for Natural Medicine was carefully designed and constructed to be hypoallergenic for chemically sensitive individuals. For health considerations and due to the close interpersonal nature of our work, your personal cleanliness is required for a comfortable healing environment. Please avoid using strong smelling perfumes, aromatics, lotions, or deodorants on appointment days and please do not smoke on the premises.*

____ *If you have not been seen in this office within the last 6 months, an examination may be necessary to reinstate proper treatment. If you have not been seen for 3 years, you will be charged a new patient visit fee in order to re-establish care.*

____ *In consideration of our doctors and other patients, please call at least 24 hours in advance to cancel or reschedule an appointment. If you do not cancel in a timely manner, you may be billed a fee up to $50 for a missed visit.*

____ *Payment is due at time of service. If you have insurance benefits that cover our unique services, we are happy to bill for you, however please notify us of your complete policy information at least 24 hours before your visit so that we may verify your coverage. If we have not been able to verify your coverage before your visit, you will need to pay at the time of your visit, and we will provide you with a form adequate to bill for your own re-imbursement.*

I have read and understand the stated policies and procedures for The Center for Natural Medicine. My signature below is my acknowledgment and agreement to abide by the policies and to receive medical care as offered by my providers at this clinic. I also agree that I am ultimately responsible for all charges on my account for services received. If the patient is a minor, then my permission is granted as guardian and guarantor for the treatment of my child or dependant.

Patient/Guarantor Signature _____ *Date* _____

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PLEASE BE AWARE OF THE FOLLOWING PAYMENT AND BILLING POLICIES:

- *We offer the complementary service of verifying your insurance benefits before your visit; however this verification is in no way a guarantee of coverage. If you have medical insurance, it is a contract between you and your insurance company, and ultimately it is your responsibility to understand your policy coverage and to see that your balances at CNM are paid promptly. If your claim is denied, you will be billed for your balance.*
- *If your policy requires a co-pay or co-percentage it is due at the time of your visit. If your benefits are subject to a deductible, we will bill for your visit, but payment is expected at the time of service.*
- *Payment for all nutritional supplements, orthopedic supplies and non-covered services is due at time of service.*
- *If you have filed a personal injury claim relating to an auto injury, medical bills are directed to your personal auto insurance policy regardless of fault. If you have filed a worker's compensation claim, your employer's insurance carrier is billed. In both cases, the patient is not required to pay at time of service for care related to the injuries, but will be responsible for charges not covered by the insurance company, regardless of pending litigation or settlements.*

IN ORDER FOR US TO BILL YOUR INSURANCE, YOU MUST COMPLETE THE FOLLOWING INFORMATION IN FULL:

Primary Insurance Name & Address _____

Name and Address of Policy Holder/Subscriber _____

Policy Holder's Social Security # _____ DOB _____ Relationship to Patient _____

Policy or ID # _____ Group # _____ Customer Service Phone # _____

If you have secondary insurance that also covers our services, please provide the following information in full:

Secondary Insurance Name & Address _____

Name and Address of Policy Holder/Subscriber _____

Policy Holder's Social Security # _____ DOB _____ Relationship to Patient _____

Policy or ID # _____ Group # _____ Customer Service Phone # _____

I hereby assign to The Center for Natural Medicine any medical/surgical benefits for services rendered by them to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Authorized Signature _____ *Date* _____

ACKNOWLEGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are obligated by state and federal law to protect and maintain the privacy of your health information. We are also obligated to provide you with notice of our privacy practices and your rights as a patient concerning your personal health information (PHI). Please read the copy provided to you with your intake forms and sign the acknowledgment below.
If you have any questions, would like your own copy of the notice, or would like further explanation of our privacy policy, please ask at the reception desk.
If you would like to request additional restriction, would like to file an objection to the privacy policy, or would like to request an alternative communication of your PHI, please specify here:

_____

As required by the Privacy Regulation, I am aware that the Center for Natural Medicine, Inc has included a provision that it reserves the right to change the terms of its notice, effective for all PHI that it maintains. I understand that this office is not required by law to honor any changes I may request, but does so as a courtesy whenever possible.
By way of my signature, I provide CNM, Inc with my authorization and consent to use and disclose my protected healthcare information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices and as is allowed or required by state and federal law.

Authorized Signature _____ *Date* _____