A Family HEALING CENTER

Portland
2525 NW Lovejoy Ste. 208
Portland, OR 97210
503-241-5007

McMinnville
330 SE Baker St.
McMinnville, OR 97128
503-883-0333

Thank you for making an appointment with A Family Healing Center.

We are committed to providing excellent care, in a compassionate and caring environment. Our mission is to achieve optimal health for the individuals and the community we serve. Our success is measured by your satisfaction.

A Family Healing Center is open Monday through Friday, 9am to 5:00pm, with lunch from 1pm to 2pm.

For your convenience, and to minimize waiting time in our office we have attached forms for you to complete prior to your visit. Please take a few minutes to fill these out and email or fax back to us before your first appointment. The Portland fax number is 971-254-4564 and the McMinnville fax number is 503-857-0622. If you prefer to use email you can return the paperwork to info@afamilyhealingcenter.com. Please arrive 20 minutes early if you will be bringing your paperwork with you to your first appointment to allow us time to process your paperwork.

Cancellation policy: We have a 24 hour cancellation policy. Please call our office within 24 hours of your scheduled appointment to avoid a cancellation fee. **If you no show or cancel with less than 24 hours' notice 3 times we will discontinue your care.**

Prescription refill policy: Our office processes prescription refill requests within 72 hours from receiving them. Please contact your pharmacy a minimum of 1 week before you are completely out of your medication and have your pharmacy fax us a request.

As a reminder, please arrive with the following information for your appointment:
Completed Paperwork
Insurance Card
Photo ID
Copay or Coinsurance
List of medications or supplements you are already on

During your visit, please feel free to ask any questions or share any concerns you may have. Your healthcare is a partnership, and we are counting on you to take an active role. This includes freely discussing symptoms as well as leading a healthy lifestyle. We look forward to meeting you and being a partner in your healthcare.

If you have any questions, do not hesitate to contact our office.

Sincerely,

Dr. Jason Black N.D.
Dr. Jessica Black N.D.
Dr. Colleen Goodwin N.D.
Dr. Andrea Bowden N.D.
Dr. Heather Crabtree N.D.

TODAY'S DATE: _____

PATIENT INTAKE INFORMATION:

Patient's Full Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Email:_____

Home/Cell Phone:_____ Work:_____ Date of Birth:_____

___ **please initial if we *do not* have permission to leave a voicemail**

Marital Status: _____ Social security Number: _____

Employer:_____ Employer Address_____

Referred by: _____

Is your current condition the result of an accident (car, work, fall etc.) ____ Y _____ N?

RESPONSIBLE PARTY INFORMATION (If different from above):

Name: _____ Relationship: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone: _____ Work Phone: _____

Employer: _____ Employer Address_____

INSURANCE INFORMATION:

If you would like your insurance billed for you, the following information *must be complete.*

Primary Insurance Company: _____Address:_____

Employer: _____

Subscriber's Name:_____ Date of birth:_____

Policy Number: _____ Group Number: _____

Does your coverage include Naturopathic Care? Y N **Our office does not bill secondary insurances**
(Unless primary & secondary are same company)

Emergency Information: Person(s) to contact in case of emergency:

Name: _____ City/State: _____ Phone: _____

Name: _____ City/State: _____ Phone: _____

WE WILL BILL **PRIMARY MEDICAL INSURANCE** FOR YOU AT **NO CHARGE**. IF YOU CHOOSE TO PAY FOR YOUR VISIT UP FRONT, WE WILL ENDEAVOR TO HELP YOU IN ANY REASONABLE MANNER TO OBTAIN REIMBURSEMENT FROM YOUR INSURANCE COMPANY; HOWEVER OUR RELATIONSHIP IS PRIMARILY WITH YOU AND OUR STATEMENTS WILL GO DIRECTLY TO YOU AT ALL TIMES. IF YOU ANTICIPATE DIFFICULTY WITH PAYMENT, PLEASE CONTACT OUR OFFICE. IF THE PROBLEM FOR WHICH YOU ARE SEEING US INVOLVES LITIGATION, SUCH AS AUTO ACCIDENT, PLEASE BE ADVISED THAT WE DO NOT WAIT FOR PAYMENT UNTIL LITIGATION IS SETTLED, BUT WILL EXPECT REGULAR MONTHLY PAYMENTS ON THE ACCOUNT. ****Insurance Non-Payment Policy: AFTER 90 DAYS OF NON-PAYMENT FROM YOUR INSURANCE COMPANY, THE BALANCE ON YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR RESPONSIBILITY.****

PATIENT'S SIGNATURE: _____ DATE: _____
(OR CUSTODIAN OF PATIENT)

PATIENT POLICIES

PAYMENT - Payment for all **supplies, lab fees** and **supplements** are due and **payable at the time of Service.** Patients without insurance pay in full at the time of service. Most blood tests are paid for at the time of service or are billed to your insurance company. If you do not have insurance, blood tests must be paid for at the time of service. Our office accepts Visa and MasterCard, cash and personal checks. **Please call 24 hours in advance to cancel an appointment.** If you do not call to cancel, you will be billed a **$50** cancellation/no show fee for return patients and **$110** for new patients. If you provide a credit card upon scheduling, it will be billed the same day the appointment is missed. If you have 3 no shows or cancellations without 24 hour notice your care may be terminated.

INSURANCE - If you carry insurance coverage, the insurance contract is between you and your insurance company. It is your responsibility to see that charges are promptly paid. As a courtesy to you, we bill your insurance for you. **We require you to make co-pay or required percentage payments at the time of service.** It is best if you know which services your insurance will cover before you receive care. That way, there are no surprises. If you are not sure about your coverage, call your insurance company. If we are not contracted with your insurance we will bill as a courtesy to you. You are responsible for anything your insurance does not cover. Many services are not covered by insurance plans. If this is the case, you will be responsible for the full cost.

MEDICINAL RETURNS: We are unable to give refunds or credits on supplements, opened or unopened. By law, A Family Healing Center cannot re-sell nutritional, herbal, or homeopathic products.

LITIGATION - Patients involved in law suits are, as others, are responsible for timely payments of charges incurred. We require monthly payments to be made by the patient.

WORKER'S COMPENSATION - Patients filing worker's compensation claims (on-the-job) do not pay for services directly related to the accident or illness. The employer's insurance carrier is billed weekly. It is your responsibility to record dates of services and mileage to and from A Family Healing Center in order to apply for mileage allowance. We recommend you keep a daily log of expenses and symptoms.

REINSTATED CARE - Unless you are under current care in this office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury or chief complaint requires an examination due to the possibility of structural changes or a change in diagnosis.

PERSONAL HYGIENE - For health considerations and due to the close interpersonal nature of our work, your personal cleanliness is required for a comfortable environment. NO SMOKING or other strong aromatics please.

_____I have read and understand the notice of privacy policies of A Family Healing Center.

_____I understand that insurance may not cover certain diagnostic tests, procedures, IV Therapy, or supplements that may be prescribed by the doctor and I agree to pay for these costs at the time of visit.

_____I have read the policies above and agree to be financially responsible for services provided by this office.

My signature is an acknowledgement that I have read the policies above and agree to abide by them.

PATIENT SIGNATURE_____ DATE _____

If the patient is a minor, permission is given by me to the doctors of this office to treat my child.

HEALTH HISTORY

Patient Name :_____ Birthdate : ___/_____/____ Today's date: _____

Primary care physician: _____
Please list all medicines you are currently taking (including non-prescription drugs): _____
_____
_____
_____
_____

Goals for Treatment
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____
_____
_____

Past Medical History such as cancer, diabetes, ear infections, eczema, accidents, injuries, mono infection surgeries, organ removals, etc…(please list dates of occurrences)

_____
_____
_____
_____
_____

Family History such as cancer, diabetes, heart disease, stroke, migraines, mental illness, or autoimmune condition (please state who in the family had these conditions)

_____
_____
_____
_____

Please list all allergies: _____
_____
Habits such as alcohol, coffee, smoking, etc. _____
Exercise: _____

MEN ONLY: circle "yes" or "no" or leave blank
Urination changes or difficulties….yes no Night urination....yes no Sexual dysfunction….yes no

WOMEN ONLY: circle "yes" or "no" or leave blank
Problems with menstrual cycle…yes no, If yes: _____
Vaginal itching or discharge…yes no Numbers of pregnancies: _____ Live births: _____
Hot flashes or night sweats…yes no If yes, how many per day? _____

To the best of my knowledge, the above information is correct. I understand that giving inaccurate information may harm my (my child's) health. It is my responsibility to inform the doctor of any changes in my or my child's medical status. I authorize the health care staff to perform necessary health care services.

Patient's signature: _____ _____

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What is my Naturopathic Coverage?

Per _____ with your insurance company
(Person you spoke with)

Do I have Naturopathic Benefits? _____
(If you do not then you do not need to ask the remaining questions) You will need to pay cash for your visit.

Your benefit year/benefit reset date is _____

Your deductible is _____. You have met _____ of your deductible as of today.

Office Visit Benefits

Does your deductible have to be met before insurance will start paying towards your visits? Y N

Do you have a set copay for office visits? Y N Your copayment is _____

Do you have to pay a percentage (coinsurance) per visit? Y N Your coinsurance is _____

Procedures, Radiology, Labwork (PRL) Benefits

Does your deductible have to be met before insurance will start paying towards your PRL? Y N

Do you have a set copay for PRL? Y N Your copayment is _____

Do you have to pay a percentage (coinsurance) per PRL? Y N Your coinsurance is _____

****Please note your labwork is billed by the lab company, not our office, and is a separate benefit.**

For all Naturopathic Benefits

Do you have a maximum your insurance will pay for Naturopathic benefits? Y N

Your plan year maximum or office visit max_____

If you have any other questions, please do not hesitate to contact your insurance or our office.