



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

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

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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, 8:30am to 4:00pm, 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](mailto: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  
Dr. Jessie Black  
Dr. Heather Crabtree  
Dr. Sarah Silverman



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): \_\_\_\_\_

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### Goals for Treatment

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

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

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

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**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:** \_\_\_\_\_

A Family Healing Center, PC

# HIPAA Privacy Statement & Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

A Family Healing Center, PC respects you and your privacy. We are committed to keeping all information received or created confidential.

We want you to have a clear understanding of how we use and safeguard information about you. This Notice of Privacy Practices describes how we may use and disclose your protected health information in order to carry out services, voucher for payment and for other purposes permitted or required by law. It also describes your rights to access and control your information. We are required by law to maintain the privacy of your protected health information and to provide you with notice of the legal duties and privacy practices with respect to your protected health information.

Health information means any information, whether oral or recorded in any form, that is created or received by A Family Healing Center, PC, relates to the past, present or future physical, mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

## **How Your Protected Health Information May Be Used or Disclosed**

A Family Healing Center, PC use protected health information about you for services, payment and regular health care operation purposes. We do not require authorization to use your protected health information for these purposes.

### **Services**

Providing you with care and services related to your health, such as working with other agencies involved with the delivery of services. We may use electronic communication such as the internet and email to communicate with you or to other authorized individuals you designate to be involved in your care. You understand that reasonable accommodations are made to insure the privacy of documents or communications via internet, but there is no guarantee and in signing do not hold the provider liable for breaches in security.

### **Medical Records**

We use an integrated charting system where all physicians and our behavioral health consultant share and have access to all chart notes.

### **Payment**

Information needed for billing, insurance, or compensation for services, if necessary. We may provide necessary portions of your protected health information to our billing department and to your health plan to get paid/reimbursed for the services we provide to you.

### **Regular Health Care Operations**

Activities that may include quality assessment, program evaluation and auditing.

### **Emergency Care**

To help you obtain treatment in a medical emergency. An authorization is required as soon as reasonably possible after the emergency and the provider should document the reasons as to why the authorization could not be received.

### **When Legally Necessary**

If required by federal, state or local law. We may make disclosures when a law requires that we report information to government agencies or law enforcement personnel about victims of abuse, neglect, domestic violence or to avoid serious threat to health or safety of a person or the public. We may provide protected health information to a family member, friend or other person that you indicate is involved in your services or the payment for your services unless you object, in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION.

IN ADDITION, ANY ALCOHOL OR SUBSTANCE ABUSE RECORDS ARE PROTECTED UNDER FEDERAL REGULATIONS GOVERNING CONFIDENTIALITY. (42CFR Part II)

ANY HIV RECORDS ARE PROTECTED UNDER PUBLIC HEALTH LAW GOVERNING CONFIDENTIALITY. (Article 27-F) and may Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

### **Your Health Information Rights**

- \* You have the right to inspect and obtain a copy of your health information.
- \* You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the requested restriction.
- \* You have a right to request that we amend your health information. An amendment can only be granted if the information requested to be amended is created by A Family Healing Center, PC.
- \* You have a right to receive an accounting of disclosures of your health information. This cannot be longer than six years from this date.
- \* You have a right to receive confidential communications of protected health information and the manner in which it is sent to you. Within reason, you have the right to ask that we send information to you at an alternate address (such as requesting that we send information to your work address rather than your home address) or by alternate means (such as by regular mail versus e-mail, if such methods are reasonably available).
- \* You have a right to a paper copy of this Notice of Privacy Practices. You will be asked to sign an Acknowledgement of Receipt of this Notice.
- \* You have a right to complain if you believe your privacy rights have been violated or if you are dissatisfied with the services you are receiving. You will not be punished in any way for filing a complaint. (Send formal written complaints to A Family Healing Center 2525 NW Lovejoy Suite 208 Portland, OR 97210 or [info@afamilyhealingcenter.com](mailto:info@afamilyhealingcenter.com)).

Behavioral Health Consultant complaints can also be sent to A Family Healing Center, PC at the address or email mentioned above. You may also contact the Oregon Board directly by calling (503) 378-4154 or going to [www.oregon.gov/obpe/pages/investigation.aspx](http://www.oregon.gov/obpe/pages/investigation.aspx).

We are bound by the terms of this notice currently in effect and reserve the right to amend this Notice of Privacy Practices at any time in the future. If such amendment is made, all individuals currently active in our programs will be provided a revised Notice of Privacy Practices by mail or at their next scheduled meeting.

If you have any questions regarding this notice or need further information please contact A Family Healing Center, PC at 2525 NW Lovejoy Suite 208 Portland, Oregon, 97210 or (503) 241-5007.