Tranquility Natural Health

4200 SW Mercantile Dr., Suite 750
Lake Oswego, OR 97035
(503) 305-7762
(503) 387-5148 fax

REGISTRATION

General Information

Date _____

Name _____
last first middle preferred

Address _____
street apt city state zip

Date of Birth _____ Age _____

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

A. It's ok to send me weekly or monthly newsletters via email Y / N

B. It's OK to leave a message at my: home / cell / work / other (circle all that apply)

E. How did you hear about us? _____

Birth Gender M / F / T (circle as applicable) Current Anatomical Gender M / F / T

Current Gender Identity M / F / T / Other Preferred Pronoun _____

Occupation _____ Employer _____

Emergency Contact Name _____

Emergency Contact Phone _____ Relationship _____

Marital/Partnership Status _____

Spouse's Name (if applicable) _____

Do you have a primary care physician? Y / N Name _____

Primary Physician Phone_____ Address_____

Is this visit due to an injury? Y / N Date & Time of Injury_____

If 'yes', did the injury occur on the job? Y / N Or as a result of a car accident? Y / N

A report was filed with employer / police / other / none _____

Insurance Information

Company_____ Phone _____

ID Number/Claim Number _____ Group Number _____

Primary Insurance Holder Name _____ DOB _____

Your Relationship to Insured self spouse child other _____

Attestation and Assignment

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me. I assign and grant benefits that I am eligible to receive for professional services rendered to this office. I authorize this office to release medical information necessary to process any insurance claims. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to this office be credited to my account upon receipt. I understand that all services rendered are charged directly to me and are my responsibility, and any portion unpaid by insurance are my financial obligation. I certify that the above is true and correct.

Signed _____ Date _____
Patient or Parent or Guardian

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Chief Complaint

Date _____

Name _____
last first middle preferred

Date of Birth _____ Age _____

Please describe the reason for today's visit: _____

Is your condition due to an accident? No Auto Work Home Other (circle one)

How long have you had this condition? _____ Have you had this condition before? Y / N

What seemed to be the initial cause? _____

Is the condition Improving Getting worse Staying the same? (circle one)

What makes it better? _____

What makes it worse? _____

What have you tried that didn't help? _____

Have you been treated for this problem? Y / N By whom? _____

How willing are you to make lifestyle changes to improve your condition? (1-10, with 10 totally committed) _____

In order of importance, please list any other health concerns or conditions.

1 _____ 2 _____

3 _____ 4 _____

If your condition is related to physical pain, please continue below. If not, please go to the next page.

Does the pain ___Wake you from sleep ___Prevent you from falling asleep ___Feel better after sleep?

Does the pain interfere with work? Y / N _____Days missed

Does it interfere with other activities? Y / N Such as _____

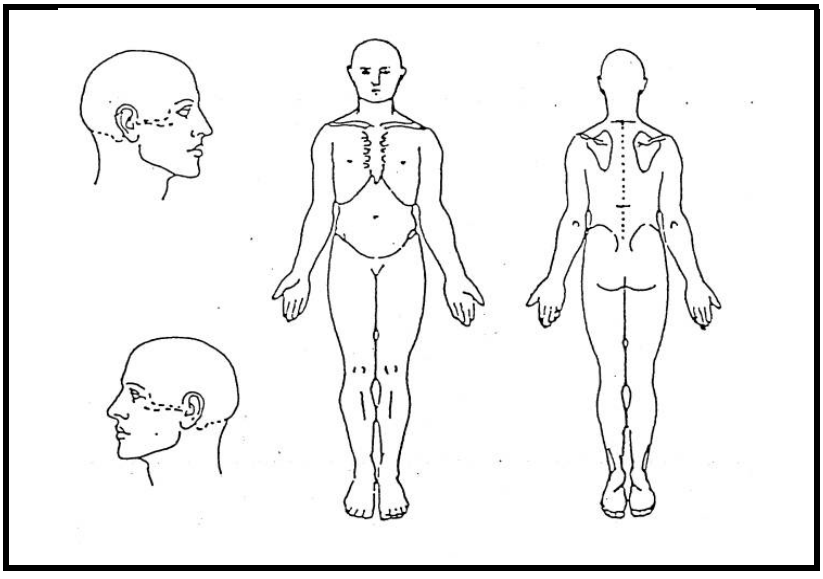
Is the pain _____Constant _____ Comes and goes at regular times _____Happens once in a while?

How would you describe the quality of the pain? _____
Examples include: Dull, Sharp, Aching, Burning, Stinging, Shooting, Stabbing, Etc.

Stabbing	/////
Burning	oooo
Shooting/Radiating	XXXX
Pins & Needles/Tingling	###
Numbness	>>>>>
Dull	DDD

0	No pain
1 to 3	Mild pain
4 to 6	Moderate pain
7 to 9	Severe pain
10	Worst pain possible

Please indicate where your pain is located, using symbols to describe pain, and numbers to indicate severity.



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Health History

General Information

Date _____

Name _____
last first middle preferred

Date of Birth _____ Age _____

Do you regularly see a physician for ongoing care for any partiuclar condition? Y / N

If 'yes,' please list condition(s): _____

_____

_____

Do you smoke? Y / N How much per day? _____ For how many years? _____

Do you drink alcohol? Y / N How many drinks per day? _____ How many per week? _____

Do you consume caffeine? Y / N Coffee / Tea / Soda / Energy drinks / Other _____

How many drinks per day? _____ When do you drink these? _____

Do you consume drinks high in sugar? Y / N How many per day? _____

Are you currently dealing with an unusual or high level of stress? Y / N

Do you exercise? Currently / Before Recent Injury (circle one)

How often and what type of exercise? _____

_____

Please list any medications you are taking. Include over-the-counter medicines and supplements

Medication	Dosage	Frequency	Reason for taking

Use separate sheet if needed. Please move on to page 2.

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Health History

Past Health History

Name_____ DOB_____

Please list any serious accidents, injuries or traumas with date: _____

Please list any surgeries, hospitalizations, or serious illnesses with dates: _____

Please indicate if you have had or now have any of the following conditions. Please circle all that apply, and write 'P' if you've had the condition in the past, or 'C' if you currently have the condition.

General
Dizziness
Fainting
Fatigue
Fever
Headache
Nerve pain
Night sweats
Substance abuse
Shaking/Tremor
Unexplained weight loss
Unexplained weight gain
Firbomyalgia
Gout
Osteoporosis/Osteopenia
Cancer
Allergies_____
Eczema / Psoriasis

Gastrointestonal
Belching/Gas/Bloating
Abdominal pain
Colitis (UC/Crohn's)
Diarrhea
Constipation
Poor appetite
Nausea
Vomiting
Heartburn
Rectal bleeding

Muscle/Joint
Arthritis
Muscle weakness
Neck stiffness
Low back pain
Mid back pain
Muscle spasm
Neck pain
Disc herniation

Pain (P)/Numbness (N)
Tingling (T)/ Swelling (S)
(indicate which sensation)
Upper extremity
Region(s)

Lower extremity
Region(s)

Genitourinary
Incontinence
Kidney infections
Kidney stones
Painful menses
Pregnancy

Autoimmune/Other/Miscellaneous
HIV/AIDS
Autoimmune Disorder _____
_____

Cardiovascular
Heart disease
High blood pressure
Arteriosclerosis
Aneurysm
Pacemaker
Stroke / TIAs
Diabetes
Anemia
Palpitations
Edema/swelling
Poor circulation
Prior heart attack

ENT
Asthma
Emphysema/COPD
Chest pain
Difficulty breathing
Colds
Earache
Sinus infection
Hoarseness
Enlarged glands
Current illness _____

Lyme
Other_____
_____

Please list any illnesses that run in your family: High blood pressure, diabetes, cancer (type), etc.

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Massage and Bodywork Consent Form

I consent to consulatation and/or bodywork at Tranquility Natural Health. The general process and possible results have been explained to me. I understand that these results vary from person to person and that no specific outcomes can be guaranteed.

I understand that massage and bodywork are generall considered safe and effective methods of care. Occasionally,complications may arise, however the risk is very small. Any procedure intended to help may have complications. These include, but are not limited to, soreness, inflammation, soft tissue injury or bruising, dizziness, and temporary worsening of symptoms. More serious complications are very rare.

I understand that my therapist does not diagnose or prescribe for any illness or disease, or any other physical or mental disorder, or condition. Nothing said or done by my therapist should be construed as such.

I understand that I am in charge of my sessions and I take full responsibility for communication to my therapist any concerns I may have during or between the sessions. During a bodywork session, I give the therapist permission to treat me with hands on therapies appropriate for my condition.

I understand that there are alternatives to massage and/or bodywork. These include seeking care from my medical doctor, drug therapies, physical therapy, chiropractic care, acupuncture, and exercise. These may be appropriate in conjunction with massage/bodywork, or may be more appropriate forms of care.

I have read and understand the above statements regarding treatment side effects and options. I also understand that there is no guarantee or warranty for a specific cure or result.

Signed: _____ Date _____

Printed Name: _____

Patient name, if a minor _____ Relationship _____

Therapist's Signature: _____ Date: _____

Tranquility Natural Health
chiropractic | naturopathic medicine | acupuncture | massage

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Financial Policy

Missed Appointments **Appointments that are not cancelled or rescheduled with a 24 hour notice period will be billed a $45 fee for chiropractic, acupuncture, massage and naturopathic medicine. This fee cannot be billed to your insurance company and will be your responsibility to compensate the provider for the time that they have set aside for your care. An exception may be made by the provider(s) in emergency situations.**

Self-Payment A time of service fee is offered to all patients and third party payors (such as your insurance company) if payment is received on the same day of service and with the understanding that our office will not bill your insurance or perform any clerical work for your claim submission. (You may be given a superbill or HCFA form as a receipt if you choose to bill your insurer and be reimbursed by them directly). We cannot offer this fee if you do not pay at the time of service. We cannot offer this fee if we are an in network provider with your insurance company, because to do so would breach our contract with them.

Health Insurance If you have insurance coverage that is verified, we will bill for services. Copayment or co-insurance is expected at the time of service. You are responsible for any unpaid balance by your insurance company. This includes, but is not limited to, services applied to your deductible and services not covered or not included as part of your copay. We always recommend contacting your insurance company yourself to verify your benefits, so that you are aware of what will and will not be covered. Your contract with your insurer is between you and them, and we bill them on your behalf as a courtesy to you. We will do our best to verify your benefits and submit timely and accurate billing. However, you are ultimately responsible for your health and any balance not covered by your insurer. We are happy to give you an estimate of fees for services prior to your appointment, and an itemized bill following services.

Personal Inury and Motor Vehicle Collision Personal injury and auto collision cases will be billed to your auto insurance company, providing that a Personal Injury Protection (PIP) claim has been fild and the appropriate paperwork has been done. If your insurer refuses to pay, or if there is a liability claim, a letter of protection from your attorney and/or a lien on file will be needed to proceed with care.

Workers Compensation Claims All Workers Compensation claims will be billed directly to the insurance company, providing the appropriate paperwork has been filed. You should know that the law in Oregon limits your chiropractic, naturopathic, massage and acupuncture coverage under Workers Compensation. If the claim is denied, we will bill your private health insurance if possible (see policy above). If your claim is denied, you are responsible for the balance.

Miscellaneous Fees Administrative fees may apply in some instances for copying, reports, etc. The most common place you may see these charges is in an EOB (explanation of benefits), or in accounting from your attorney if you have a legal case involving an injury requiring care. We charge fees in accordance with the chiropractic statute governing these fees. We will not write a report without a request either from your attorney or your insurer.

I have read and understand the above financial policy. In the event that I no-show or cancel in less than 24 hours notice, I agree to charge the following card for any missed appointment fee.

Card #_____ EXP___/____ CVV#_____ ZIP_____

Signed: _____ Date _____

Printed Name: _____

Tranquility
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chiropractic | naturopathic medicine
acupuncture | massage

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Tranquility Natural Health is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment or operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated within our office, or outside our office, in order to give you the very best care or provide a referral. It is also our policy to provide a substitute health care provider, authorized by Tranquility Natural Health to provide assessment and/or treatment to you, with or without advanced notice, in the event of your provider's absence due to vacation, sickness, or other emergency situation.

Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure, or reporting to coroners or medical examiners.

Judicial and Law Enforcement: We may disclose your health information in the course of any administrative or judicial proceeding, as required by subpoena or law. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes. It may be necessary to disclose your health information in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Change of Ownership: In the event that Tranquility Natural Health is sold or merged with another organization, your health information/record will become the property of the new owner.

Marketing: We may post your testimonial or picture to market Tranquility Natural Health, with your words or likeness, to promote Tranquility Natural Health, announce any prize winners, or celebrate your success. We will not use your full name, but first name or initials only. Initial here to opt out._____

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chiropractic | naturopathic medicine
acupuncture | massage

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Your Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Tranquility Natural Health amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices: Tranquility Natural Health reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Tranquility Natural Health is required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

If you have questions about any part of this notice or if you want more information about your privacy rights, or you have any complaints about how your private health information has been handled, please contact: Dr. Angela McKaye, DC, ND by calling the office at 503-305-7762. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F
HHH Building
Washington, DC 20201

Restrictions:_____
_____
_____
_____
_____
_____

Signed:_____ **Date:** _____