The Center For Natural Medicine, Inc
1330 SE Cesar E. Chavez Blvd (39th), Portland, OR 97214 • (503)232-1100 •fax (503)232-7751•www.cnmwellness.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:	Date of birth:
Guarantor/Guardian's name if the patient is a minor:	
Home address:	City/St/Zip:
Billing/mailing address:	City/St/Zip:
Social security #:	Email:
Employer:	Employer address:
Best contact number:	May we leave a message for you? __ Yes __ No
Alternate contact number:	May we leave a message for you? __ Yes __ No
How did you hear about us?	

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 12 months, an examination may be necessary to reinstate proper treatment. If you have not been seen for 3 years, you will be considered a new patient.

__ 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 and your visit will be marked as a no-show. Three no-show visits may be ground for dismissal.

__ 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 reimbursement.

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 dependent.

Authorized signature:	**Date:**

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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:	
Policy holder SSN#:	Policy holder date of birth:
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:	
Policy holder SSN#:	Policy holder date of birth:
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:**

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ACKNOWLEDGMENT 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. Our privacy policy may also be found at www.cnmwellness.com on the patient resources page.

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:**

PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand their medical insurance, eligibility, coverage/benefits, and our office policy and medical services. It must be understood that:

__ We render our service on the basis that insurance companies may or may not pay all, or a portion of our charges for your visit(s).
__ Authorizations for medical treatment from your insurance company do not guarantee full payment for authorized services.
__ The patient/guardian is responsible for obtaining prior authorization (when applicable) prior to their visit.
__ Not all insurance companies/third party payers pay for all services. Each polity has its own particular stipulations regarding covered services or amount of coverage. We will make every effort to obtain benefits on your behalf, but it is also your responsibility to know and understand your benefit plan with your insurance company.
__ All insurance companies state that verification of coverage is not a guarantee of coverage and/or payment. Actual benefits are determined by your insurance company after a claim is received.
__ Patients are personally responsible for knowing and understanding their own Insurance policy/plan benefits and eligibility with said insurance company.
__ Patients are responsible for payment of outstanding deductibles and coinsurance.
__ Co-payments will be collected at the time of service.

__ Patients/guardians are responsible for payment for all non-covered services/procedures with their health plan. Any appointment that has been missed/ not canceled within 24 hours of their scheduled appointment will incur a $50.00 charge.
__ Returned checks will incur a $35.00 service fee.
__ Changes in a patient/guardian's insurance must be reported to our front desk staff promptly to avoid financial responsibility. 1330 SE Cesar E. Chavez Blvd. Portland, OR 97214 Phone: 503-232-1100 Fax: 503-232-7751 Web: www.cnmwellness.com

The patient or Patient's Legal Representative (Guardian) hereby acknowledges that he/she is Eligible for Health Insurance Benefits and coverage. That in the event that the patient is not eligible for insurance and coverage with said insurance policy, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services delivered by a Center for Natural Medicine Provider.

Authorized signature:	**Date:**

NOTICE OF MISSED APPOINTMENT POLICY

This form shall serve as Notice to our patients of our missed appointment policy, in compliance with their insurance carrier's guidelines. It must be understood that:

__ At least 24 hours' notice is required for canceling or missing an appointment. Failure to meet the 24-hour requirement will constitute a missed appointment.
__ Missing two appointments in a row after or including your initial visit can result in patient termination with a provider, or with the clinic, as applicable.
__ Missing three appointments over a six-month period may result in termination of care with a provider or with the clinic.
__ If a patient utilizes multiple services, such as naturopathic care, acupuncture, massage, behavioral health, laboratory services or any other service provided by the Center for Natural Medicine not specifically listed here, this policy may be applied to individual services and/or individual providers. For example, if a patient regularly attends their naturopathic visits but has missed either two in a row or three acupuncture appointments over a six-month period, that patient may be terminated with the acupuncture provider and potentially from receiving acupuncture in the future.
__ Any termination of care will be mailed to the patient in writing at the address on file, and will be documented in their file. Certified proof of receipt of the letter by the patient is not required.
__ Patients have the right to appeal termination from the clinic or from individual services to clinic management. This signed document will be transmitted to the patient's insurance carrier as part of documentation in the event of termination of care.

The patient or Patient's Legal Representative (Guardian) hereby acknowledges that he/she has read and understands this Notice of Missed Appointment Policy. In the event this Policy is violated, he/she understands and agrees that his/her relationship with the Center for Natural Medicine and its Provider(s) may be terminated.

Authorized signature:	**Date:**

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COMMUNICATIONS CONSENT AUTHORIZATION

I authorize my provider/clinic to leave a detailed message at the following phone number: _____ regarding all below. Please check all that apply:

__ Date and time of upcoming appointments
__ Laboratory results (blood tests, Pap, urine or other cultures)
__ X-ray, CT scan, MRI, or other radiological results
__ Reminder to schedule recurring screening services or testing
__ Referral information _Any other information pertinent to my care
__ Other: _____

I understand that this authorization will remain in effect until such time that I submit, in writing, revocation of my authorization. I understand that by giving my consent, information about my personal health care could be made available to members of my family and/or others in my home who have access to my voicemail system.

Authorized signature:	**Date:**

__ NO AUTHORIZATION I DO NOT authorize any messages related to my health care to be left on my voicemail.

Authorized signature:	**Date:**

__ AUTHORIZATION REVOKED Message authorization revoked on: _____/_____/_____
__ Initials of staff member receiving revocation: _____

PATIENT CONDUCT AGREEMENT

This is a behavioral agreement between _____ and the Center for Natural Medicine. In order to maintain a safe clinic environment for both patients and staff, the following behavior contract has been implemented. By signing below, I acknowledge my care at the Center for Natural Medicine is contingent on the following expectations:

1. I will not engage in verbal threats or aggressive behavior with staff, providers, or any other person on CNM grounds or over the telephone.
2. I will communicate in a professional way with staff when I am feeling triggered or angry in order to ask for assistance with any issues.
3. I will not use language that may be offensive to staff or other patients that is based on race, gender, sexual orientation, appearance, or religion.
4. I will wait patiently when I present myself for clinic services.
5. I will comply with requests made by CNM staff or providers.
6. I will not consume intoxicating substances on CNM grounds.

By signing below I acknowledge that CNM staff agrees to the following:

1. To meet your needs to the best of our ability given the resources that we have available.
2. To communicate with you in a professional, respectful way.
3. To be available to answer questions about your medical care to the best of our ability.
4. To see you as close to your scheduled appointment time as possible or to communicate to you regarding any delay in your appointment time.
5. To review and discuss all grievances filed by you and respond within 5 business days.

Failure to comply with the above agreement may result in your being asked to leave the clinic for the day. If you are asked to leave the clinic, a warning letter will be issued to you in writing and will be included in your records with CNM. If the conduct is repeated after a one day exclusion from the clinic, a formal dismissal from care will be initiated. Incidents may be reviewed on a case-by-case basis by clinic management and a formal dismissal may be initiated at any time for serious behavioral violations. If care is terminated, you will be permitted to access care for urgent medical issues only for 30 days following the date of termination and you will be provided with a list of outside clinics you may establish care with. It is your responsibility to establish care with another provider during that 30 day grace period.

Authorized signature:	**Date:**

TELEMEDICINE INFORMED CONSENT FORM

The patient has been counseled regarding CNMs telemedicine policy and has verbally agreed to the following:

1. The patient understands that they will be conversing with their physician via a video conferencing system. The providers at CNM use Klara, which the patient consents to use for all telemedicine visits with their CNM providers.
2. The patient understands that meeting invitations will be forwarded to them via text message, which allows them to join the meeting by clicking the link.
3. A meeting is considered an appointment and is subject to CNMs attendance policy.
4. The patient understands that no recording may be made of this consult. They understand that no other person may be in the room out of view. No hidden/off camera people are allowed.
5. The patient understands that their provider will need to confirm identity through visual contact and that the patient should maintain good lighting throughout the duration of their telemedicine visit.
6. The patient understands that some insurance plans may not reimburse for telemedicine. The CNM clinic's biller will submit claim requests to insurance, but the patient is responsible for any balance that is not paid.

Authorized signature:	**Date:**