1330 Cesar E. Chavez Blvd, Portland, OR 97214
Phone: 503-232-1100 Fax: 503-232-7751 Web: www.cnmwellness.com

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 payors pay for all services. Each policy 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 co-insurance.
- 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 cancelled 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.

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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.

Patient Name_____ Date_____

Signature of patient / Guardian_____ Date_____

CNM Staff_____ Date_____

Patient Name: _____

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We consider patient confidentiality to be of utmost importance. In an effort to ensure your privacy is protected, please read and sign the following consent form.

AUTHORIZATION

I authorize my provider/clinic to leave a detailed message at the following phone number (_____) pertaining to the following *(check all that apply)*:

- ___ Date and time of upcoming appointment
- ___ Laboratory results (e.g., blood tests, Pap smear, urine or other cultures)
- ___ X-ray, CT scan, MRI, or other radiological results
- ___ Reminder to schedule recurring screening services or testing (e.g., mammogram, Pap, PSA, colonoscopy, annual health maintenance exam, etc)
- ___ Referral information (appointment with another health care provider at an outside clinic)
- ___ Any other information pertinent to my care
- ___ Other (please list): _____

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 telephone messaging system.

Print Name: _____

Sign Name: _____ **Date:** _____/_____/_____

Witness: _____ **Date:** _____/_____/_____

NO AUTHORIZATION

I **DO NOT** authorize any messages related to my health care to be left on my voicemail/answering machine.

Print Name: _____

Sign Name: _____ **Date:** _____/_____/_____

Witness: _____ **Date:** _____/_____/_____

AUTHORIZATION REVOKED

Message authorization revoked on: _____/_____/_____
Initials of staff member receiving written revocation:_____

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* _____

Center for NATURAL MEDICINE

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Health History Form

TODAY'S DATE: _____

NAME: Last _____ First _____ MI _____ BIRTHDATE: _____

Preferred Name: _____ Preferred Pronoun: _____ Gender Identity: _____ Legal Gender: _____

REFERRING PROVIDER: _____ OTHER PROVIDERS: _____

PRIMARY CARE PROVIDER: _____ PREFERRED PHARMACY: _____

REASON FOR TODAY'S VISIT: _____

Allergies: (include meds, food, environmental) ☐ No Known Allergies	**Medication or Substance**	**Reaction & Age**	**Severity**	**Epi Pen?** ☐

Prescription Medicine: ☐ None ☐ See attached list	**Name**	**Dose**	**Frequency**

Supplements/Vitamins: ☐ None ☐ See attached list	**Name**	**Dose**	**Frequency**

Do you regularly take any of these: ☐ **Tylenol/Acetominophen** ☐ **Ibuprofen/Advil** ☐ **Naproxen/Aleve** ☐ **Aspirin**

Social History

Do you use tobacco products? ☐ Never ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke)
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit ____ Drinks per Day _____ Drinks per Week _____
Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____

Have you ever used injected/IV drugs: ☐ Yes ☐ No Inhaled Drugs? ☐Yes ☐No

Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone) ☐ Other _____

Social History - continued

Relationship Status:

☐ Single ☐ Married ☐ Domestic Partner ☐ Longterm relationship ☐ Monogamous ☐ Polyamorous ☐ Open Relationship

Are you sexually active? ☐ Yes ☐ No Partner(s) anatomy: ☐ Penis ☐ Vagina ☐ Both Contraception: _____

Any concerns about sexual function? ☐Yes ☐ No

Have you ever been physically hurt by a romantic partner? ☐Yes ☐ No

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled ☐ Student

Do you have any hobbies? _____

Do you have adequate social support? ☐ Yes ☐ No

Is stress a major problem for you? ☐ Yes ☐ No

Reproductive Health

	Yes	No	
Never Pregnant	☐	☐	# pregnancies _____ # live births _____
Currently Pregnant	☐	☐	# miscarriages _____ # abortions _____
Menstrual Period	☐	☐	First day of last period _____
Fertility Concerns	☐	☐	Period occurs every _____ days ☐ Irregularly
			Age of first period _____
			Cramps: ☐ Mild ☐ Moderate ☐ Severe
			Flow: ☐ Light ☐ Moderate ☐ Heavy
			Spotting between periods: ☐ Yes ☐ No
Menopause OR	☐	☐	Age of onset _____
Andropause			

If menopausal/andropausal, have you ever used a hormone replacement?

☐ Yes ☐ No If so, what was used? _____

Past Medical History — Please check box for those conditions you have currently (C) or in the past (P)

(C)	(P)		(C)	(P)		(C)	(P)		(C)	(P)	
☐		No Past Medical History	☐	☐	Colon Polyps	☐	☐	Hepatitis B	☐	☐	Pacemaker/ICD
☐	☐	Abnormal ECG/EKG	☐	☐	Congenital Birth Defects	☐	☐	Hepatitis C	☐	☐	Pancreatitis
☐	☐	Alcoholism	☐	☐	Congestive Heart Failure	☐	☐	Hernia Type: _____	☐	☐	Parkinson's Disease
☐	☐	Allergic Rhinitis	☐	☐	COPD	☐	☐	HIV	☐	☐	Polycystic Ovarian Syndrome
☐	☐	Anal Fissure	☐	☐	Coronary Atherosclerosis	☐	☐	High Cholesterol	☐	☐	Pre-Diabetes
☐	☐	Anemia Type:_____	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐	Hypertension	☐	☐	Psoriasis
☐	☐	Anesthesia Problems	☐	☐	Depression	☐	☐	Hyperthyroidism	☐	☐	PTSD
☐	☐	Anxiety	☐	☐	Diabetes Type 1	☐	☐	Hypothyroidism	☐	☐	Pulmonary Arterial Hypertension
☐	☐	Arrhythmia	☐	☐	Diabetes Type 2	☐	☐	Insomnia	☐	☐	Pulmonary Embolism
☐	☐	Arthritis	☐	☐	Diverticulitis	☐	☐	Irritable Bowel Syndrome	☐	☐	Pulmonary Hypertension
☐	☐	Asthma	☐	☐	Down's Syndrome	☐	☐	Kidney Disease	☐	☐	Seizures
☐	☐	Atrial Fibrillation	☐	☐	Eczema	☐	☐	Kidney Stones	☐	☐	Severe Infection/Sepsis
☐	☐	Autoimmune Disease	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Sexual Assault
☐	☐	Barrett's Esophagus	☐	☐	Endometriosis	☐	☐	Lung Disease	☐	☐	Sleep Apnea
☐	☐	Bleeding/Clotting Disorder	☐	☐	Erectile Dysfunction	☐	☐	Lupus/SLE	☐	☐	Stroke
☐	☐	Blood Transfusion	☐	☐	Fatty Liver	☐	☐	Macular Degeneration	☐	☐	Substance Abuse
☐	☐	Breast Mass	☐	☐	Fibrocystic Breasts	☐	☐	Migraines	☐	☐	TIA
☐	☐	Broken Bone(s)	☐	☐	Fibroids	☐	☐	Motor Vehicle Accident	☐	☐	Trauma
☐	☐	Burns	☐	☐	Fibromyalgia	☐	☐	Multiple Sclerosis	☐	☐	Traumatic Brain Injury (TBI)
☐	☐	Cancer Type: _____	☐	☐	Gastric Ulcer	☐	☐	Musculoskeletal Disease	☐	☐	Tuberculosis
☐	☐	Cataracts	☐	☐	GERD	☐	☐	Myocardial Infarction (MI)	☐	☐	Ulcerative Colitis
☐	☐	Cholelithiasis (Gallstones)	☐	☐	Glaucoma	☐	☐	Obesity	☐	☐	Vertigo
☐	☐	Chronic Pain Syndrome	☐	☐	Hearing Impairment/Loss	☐	☐	Osteoporosis	☐	☐	Wound Infection or MRSA
☐	☐	Cirrhosis	☐	☐	Heart Murmur Type: _____	☐	☐	Ovarian Cyst			

Surgical History — Please check box for any surgery you have had, indicate the year

☐ No Past Surgical History	☐ CABG (_____)	☐ Hernia Repair (____)	☐ Prostate Surgery (_____)
☐ Adenoidectomy (_____)	☐ C-Section (_____)	☐ Hysterectomy (____)	☐ Splenectomy (_____)
☐ Adrenalectomy (_____)	☐ Cholecystectomy (_____)	☐ Joint Replacement (____)	☐ Stent Placement (_____)
☐ Anorectal Surgery (_____)	☐ Colon Resection (_____)	☐ Laparotomy (_____)	☐ Thyroidectomy (_____)
☐ Appendectomy (_____)	☐ Cosmetic Surgery (_____)	☐ Liver Resection (_____)	☐ Tonsillectomy (_____)
☐ Back Surgery (_____)	☐ Dental Surgery (_____)	☐ Mohs Surgery (_____)	☐ Tubal Ligation (_____)
☐ Bariatric Surgery (_____)	☐ Gastrointestinal Surgery (_____)	☐ Mole Removal (_____)	☐ Valve Replacement (_____)
☐ Breast Surgery (_____)	☐ Hemorrhoidectomy (_____)	☐ Neck Surgery (_____)	☐ Vasectomy (_____)
			☐ Wisdom Teeth Removal (_____)

☐ Implanted Device(s): _____

☐ Other: _____

Complications from Anesthesia ☐ No ☐ Yes Please explain. _____

Past Imaging and Testing History - include date if known

☐ No Past Imaging or Testing
☐ Resting 12-lead EKG (_____)
☐ EKG Stress Test (_____)
☐ Nuclear Stress Test (____)
☐ Echocardiogram (_____)
☐ Echo Stress Test (_____
☐ Holter Monitor (_____)
☐ Angiogram (____)
☐ CAC Score (____)
☐ CT Scan of: _____
☐ MRI of:_____
☐ Ultrasound of: _____
☐ Chest X-Ray (_____)
☐ X-Ray of: _____
☐ Spirometry (____)
☐ Peak Flow Testing (____)
☐ Barium Swallow (____)
☐ Endoscopy (_____)
☐ Colonoscopy (_____)
☐ EEG (_____)
☐ EMG (_____)
☐ Tilt Table Testing (_____)
☐ Biopsy (_____)

Health Maintenance and Screening

	Yes	No	Normal Results?	Yes	No
Pap Smear	☐	☐	Date: _____	☐	☐
HPV Testing	☐	☐	Date: _____	☐	☐
Mammogram	☐	☐	Date: _____	☐	☐
Colonoscopy	☐	☐	Date: _____	☐	☐
DEXA Scan/Bone Mineral Density	☐	☐	Date: _____	☐	☐
Hepatitis C	☐	☐	Date: _____	☐	☐
Sexually Transmitted Infections	☐	☐	Date: _____	☐	☐
HIV	☐	☐	Date: _____	☐	☐
Do you exercise?	☐	☐	Frequency:_____ Type: _____		

Vaccinations ☐ None ☐ Record attached
☐ Standard childhood vaccinations
☐ Tdap/DTap Date:_____
☐ Tetanus Date:_____
☐ HPV ☐ Pneumovax
☐ Hepatitis A ☐ Hepatitis B
☐ Meningitis ☐ Zoster/Shingles
☐ Chickenpox ☐ Influenza
☐Other: _____
Childhood Illnesses: _____

Diet/Nutrition ☐ Gluten Free ☐ Dairy Free ☐ Vegetarian ☐ Vegan ☐ Ketogenic ☐ Paleo ☐ Other
Food Sensitivities? _____ Caffeine Intake: _____ Water Intake: _____

Safety Screening

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Are you exposed to any toxins? ☐ Yes ☐ No

Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you have stable housing? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
Are there guns in your home? ☐ Yes ☐ No
Do you wear seatbelts? ☐ Yes ☐ No
Do you use a bike helmet or other safety equipment? ☐ Yes ☐ No

Family History – Check all that apply

Relationship	Age (present, or at death)	Status (circle)	No Known Problems	Alcohol/Drug Abuse	Aneurysm	Arthritis	Asthma	Birth Defects	Bleeding Disorder	Cancer	Clotting Disorder	Colitis	COPD	Deep Vein Thrombosis	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hernia	Hyperlipidemia	Hypertension	Kidney Disease	Learning Disability	Lipids/High Cholesterol	Mental Illness	Intellectual Disability	Miscarriages	Obesity	Polyps	Stroke	Thyroid Disease	Vision Loss	Osteoporosis
Mother		alive deceased																															
Father		alive deceased																															
Sister		alive deceased																															
Brother		alive deceased																															
Maternal Grandmother		alive deceased																															
Maternal Grandfather		alive deceased																															
Paternal Grandmother		alive deceased																															
Paternal Grandfather		alive deceased																															

Other (include additional siblings, children, with ages and diagnoses): _____

Review of Systems (current symptoms) – please check only if these are bothering you at this time

System	Symptom	Comments; symptoms/diagnoses not listed
General	☐ Recent Weight Gain or Loss ☐ Fatigue ☐ Trouble Sleeping ☐ Fever ☐ Chills ☐ Night Sweats ☐ Recent Foreign Travel	
Eye/Ear/Nose/Mouth/Throat	☐ Wears Glasses/Contacts ☐ Eye Problems (Tearing, Itching, Dryness) ☐ Hearing Loss/Hearing Aid ☐ Tinnitus ☐ Ear Problems ☐ Nose Problems/Nosebleeds ☐ Mouth Problems ☐ Bleeding Gums ☐ Sinus Problems ☐ Sore Throat ☐ Dental Problems ☐ Dentures ☐ Difficulty Swallowing/Dysphagia ☐ Choking	Last Eye/Vision Exam: _____ Last Dental Exam: _____
Neurology	☐ Problems with Vision ☐ Cognitive Changes ☐ Headaches ☐ Balance Problems ☐ Seizures ☐ Tremors ☐ Dizziness ☐ Fainting/Unconsciousness ☐ Memory Problems ☐ Numbness/Tingling/Weakness	
Heart /Vascular	☐ Chest Pain ☐ Raynaud's Syndrome ☐ Palpitations or Irregular Heartbeats ☐ Heart Murmur ☐ Aneurysm ☐ Rapid Heartbeats (Tachycardia) ☐ Slow Heart Rate (Bradycardia) ☐ Unable to Walk Two Flights of Stairs ☐ Change in Exercise Tolerance ☐ Lower Extremity Swelling	
Lung	☐ Shortness of Breath (day or night) ☐ Wheezing ☐ Snoring ☐ Difficulty Breathing Lying Flat, Have to Prop Up ☐ Lung Problems ☐ Chronic Cough ☐ Head Cold	
Skin	☐ Masses/Bumps/Lumps ☐ Rashes ☐ Lesions/Cuts/Scrapes ☐ Wounds/Blisters ☐ Dry Skin ☐ Stasis Dermatitis ☐ Nail Fungus ☐ Hives ☐ Vitiligo ☐ Changing Moles	
Stomach/ Gastrointestinal/ Colon/Rectum	☐ Stomach/Abdominal Pain ☐ Hiatal Hernia ☐ Heartburn/Indigestion ☐ Nausea ☐ Vomiting ☐ Gas/Bloating ☐ SIBO ☐ Diarrhea ☐ Constipation ☐ Blood in Stool ☐ Mucus in Stool ☐ Jaundice/Yellowing of skin ☐ Parasitic Infection ☐ Hemorrhoids	
Muscles/Bones	☐ Joint Pain Which one(s)?_____ ☐ Back Pain/Disc Disease ☐ Sprain/Strain ☐ Muscle Pain ☐ Stiffness/Arthritis ☐ Artificial Joint(s) ☐ Other Physical Disability	Currently in pain? ☐ Yes ☐ No If yes, Where? Severity (1-10, 10 = worst pain imaginable (you are on the verge of going to the hospital to treat it): ____
Genitourinary	☐ Urinary Problems ☐ Urinary Incontinence ☐ Pain with Urination ☐ Interstitial Cystitis ☐ Kidney Problems ☐ Kidney Stones ☐ Genital Problems ☐ Pain with interrcourse ☐ Fertility Problems ☐ Irregular Discharge/Bleeding ☐ Enlarged Prostate/BPH	
Blood/ Lymph	☐ Anemia ☐ Bleeding Problems ☐ Easy Bruising ☐ Swollen or Enlarged Glands	
Immunological	☐ Hay Fever ☐ Allergies ☐ Get Sick Easily ☐ Lyme Disease ☐ Chronic Post-Viral Fatigue ☐ Autoimmune Disease ☐ EBV or CMV Infection	
Endocrine	☐ Heat/Cold Intolerance ☐ Hot Flashes ☐ Increased Thirst ☐ Insulin Resistance ☐ Metabolic Syndrome ☐ Pituitary Problem ☐ Adrenal Fatigue	
Mental Health	☐ Anxiety ☐ Depression ☐ Grief ☐ Paranoia ☐ Other Concerns ☐ Eating Disorder ☐ OCD	

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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 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. That 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.

Patient Name_____ Date_____

Signature of patient / Guardian_____ Date_____

CNM Staff_____ Date_____

Annual questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○