Dr. Shawnte Yates, ND, LAc
Dr. Sandy Musclow, ND, LAc
Dr. Molly Thelisdort, ND, LAc

Essential Family Medicine
1110 SE Alder St, Suite 201 ~ Portland, OR 97214

Welcome!

NEW PATIENT INTAKE

Patient Information:

Name: _____ Date:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Preferred Phone: (_____) _____ Alternate Phone:(_____)_____

Leaving Voice Message OK: Y N Preferred method of contact:_____

E-mail address: _____

May we send you our e-newsletters? Y N (We never share info. You may request removal at any time.)

Age:_____ Date of Birth:_____/_____/_____

What is your birth sex: female _____ male _____ other_____

What gender do you identify as: female _____ male _____ other _____

What pronouns do you use? female _____ male _____ other_____

Married____ Partnered___ Separated___ Divorced___ Widowed____ Single____

Housing: Spouse/Partner _____Parents _____ Children_____ Friend/Roommate _____ Alone _____

Occupation:_____ Hours per week:_____ Retired:_____

Employer:_____ S.S.#:_____

Emergency contact: _____

Relationship: _____ Phone: (_____)_____

Address: _____

How did you hear about our clinic? _____

Successful health care and preventive medicine are only possible when the physician has an understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your health. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Are you currently receiving healthcare? Y N
If yes, where and from whom:_____
If no, when, where, and why did you last receive health care?

_____

What are your most important health problems? List as many as you can in order of importance:

1) 4)
2) 5)
3) 6)

ALLERGIES

Are you hypersensitive or allergic to...

Any drugs?_____

Any foods?_____

Any environmentals or chemicals?_____

MEDICATIONS, VITAMINS, & SUPPLEMENTS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are ***currently*** taking? **Please list doses and frequency** (EG: Tylenol 325 mg, 3x/day)

1) _____ 6)_____

2) _____ 7)_____

3) _____ 8)_____

4) _____ 9)_____

5) _____ 10)_____

Please list any medications you have taken in the past:_____

Have your medications or supplements ever caused you unusual side effects or problems?

Describe:_____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? YES NO
Have you had prolonged use of Tylenol? YES NO
Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) YES NO
Frequent or prolonged antibiotics? YES NO
Use of steroids (prednisone, nasal allergy inhalers) in the past? YES NO
Use of oral contraceptives YES NO

MEDICAL HISTORY

Please circle if you had any of these as a child or an adult:

Scarlet fever Diphtheria Rheumatic fever Chicken Pox
Mumps Measles German measles

Which immunizations/vaccinations, if any, have you had?

_____

Please list any immunizations you believe you need:

_____
Have you ever had a negative reaction to a vaccination? Yes No

Hospitalization, Surgery, Imaging:
Please list all hospitalizations, surgeries, dental work, X-Rays, CAT Scans, ultrasounds, EEG, EKG's, Mammograms, bone scans, DEXA, colonoscopy, or other tests.

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Major events or health conditions that have occurred during your lifespan:

0-5 years_____

5-10 years_____

10-15 years_____

15-20 years_____

20-30years_____

30-40 years_____

40-50 years_____

50-60 years_____

60+ years_____

REVIEW OF SYSTEMS

PLEASE CIRCLE: Y= Current condition N= Never had P= Past condition

Current Height: Weight:	Recent change in weight? Y N How much?
Weight 1 year ago: lbs	Maximum Weight: When:

Skin

Rashes	Y	N	P	Acne, boils, sores	Y	N	P
Itching	Y	N	P	Hair loss	Y	N	P
Color change	Y	N	P	Lumps, bumps, growths	Y	N	P
Skin cancer	Y	N	P	Night sweats	Y	N	P
Eczema/hives	Y	N	P	Excessive sweating	Y	N	P

Head

Headaches	Y	N	P	Lightheadedness	Y	N	P
Migraines	Y	N	P	Head injury	Y	N	P

Eyes

Floaters/spots in vision	Y	N	P	Blurriness	Y	N	P
Impaired vision	Y	N	P	Double vision	Y	N	P
Corrective lenses	Y	N	P	Excessive tearing or dryness	Y	N	P
Glaucoma or cataracts	Y	N	P	Eye Pain/Strain	Y	N	P

Ears

Hearing loss	Y	N	P	Ringing	Y	N	P
Earache/pain or Itching	Y	N	P	Frequent ear infections	Y	N	P

Nose and Sinuses

Frequent Colds	Y	N	P	Nose Bleeds	Y	N	P
Hay fever/Seasonal allergies	Y	N	P	Stuffiness or discharge	Y	N	P
Loss of smell	Y	N	P	Sinus pain/infection	Y	N	P

Mouth and Throat

Sore tongue/lips	Y	N	P	Frequent sore throat	Y	N	P
Mouth sores	Y	N	P	Hoarseness	Y	N	P
Dry mouth	Y	N	P	TMJ Disease/teeth grinding	Y	N	P
Gum problems	Y	N	P	Dental cavities	Y	N	P

Neck

Swollen glands	Y	N	P	Goiter	Y	N	P
Lumps	Y	N	P	Pain or stiffness	Y	N	P

Respiratory

Cough	Y	N	P	Emphysema	Y	N	P
Asthma or wheezing	Y	N	P	Chronic bronchitis	Y	N	P
Sputum/mucous	Y	N	P	Pneumonia	Y	N	P
Spitting up blood	Y	N	P	Difficulty breathing	Y	N	P
Tuberculosis	Y	N	P	Pain with breathing	Y	N	P

Cardiovascular

Heart disease	Y	N	P	Chest pain	Y	N	P
Murmurs	Y	N	P	High/Low blood pressure	Y	N	P
Rheumatic fever	Y	N	P	Palpitations/fluttering	Y	N	P
Ankle swelling	Y	N	P	High cholesterol	Y	N	P

Blood / Peripheral Vascular

Anemia	Y	N	P	Easy bleeding/bruising	Y	N	P
Blood clots	Y	N	P	Cold hands/feet	Y	N	P
Varicose veins	Y	N	P	Past transfusions	Y	N	P

Immune

Chronic infections	Y	N	P	Autoimmune disease	Y	N	P
Chronic fatigue	Y	N	P	Fever	Y	N	P
Slow wound healing	Y	N	P	Chills	Y	N	P

Gastrointestinal

Difficulty swallowing	Y	N	P	Hemorrhoids or blood in toilet	Y	N	P
Heartburn/Reflux	Y	N	P	Constipation	Y	N	P
Belching or passing gas	Y	N	P	Diarrhea	Y	N	P
Ulcer	Y	N	P	Number of BM's per day:			
Abdominal pain	Y	N	P	Change in bowel habits	Y	N	P
Abdominal cramps	Y	N	P	Dark/black stools	Y	N	P
Nausea/vomiting	Y	N	P	Light/white stools	Y	N	P
Change in appetite	Y	N	P	Liver disease/hepatitis	Y	N	P
Jaundice (yellow skin)	Y	N	P	Gallbladder disease	Y	N	P

Urinary

Pain with urination	Y	N	P	Kidney stones	Y	N	P
Increased frequency (day/night)	Y	N	P	Frequent urinary infections	Y	N	P
Urgency	Y	N	P	Cloudy urine	Y	N	P
Inability to hold urine	Y	N	P	Blood in urine	Y	N	P
Hesitancy or dribbling	Y	N	P	Change in force of stream	Y	N	P

General Reproductive

Are you sexually active	Y	N	P	Chlamydia or gonorrhea	Y	N	P
Type of Contraception:				Genital warts	Y	N	P
Sleep w/ men, women, both?				Herpes	Y	N	P
Low sex drive	Y	N	P	Other sexually transmitted disease	Y	N	P
Have you been recently tested for sexually transmitted diseases?							

Male Reproductive

Hernia	Y	N	P	Sores on penis or testicles	Y	N	P
Testicular pain	Y	N	P	Premature ejaculation	Y	N	P
Lump in testicles	Y	N	P	Erectile dysfunction	Y	N	P
Prostate disease	Y	N	P	Impotence	Y	N	P
Prostate removed	Y	N	P	Discharge	Y	N	P
Fertility issues	Y	N	P	Low sperm count	Y	N	P

Female Reproduction

Age of first menses:				Age of last menses (if menopausal):			
Date of last menses:				Date of last pap exam:			
Duration of bleeding: days				Abnormal PAP ever?	Y	N	P
Length of cycle: days (usu 25-35)				Cervical dysplasia	Y	N	P
Cycles regular	Y	N	P	Vaginal discharge	Y	N	P
Spotting between cycles	Y	N	P	Vaginal itching, pain, burning	Y	N	P
Pain with menses	Y	N	P	Vaginal sores or lumps	Y	N	P
Clotting with menses	Y	N	P	Pain with intercourse	Y	N	P
Heavy flow with menses	Y	N	P	Ovarian cysts/fibroids	Y	N	P
PMS	Y	N	P	Difficulty conceiving	Y	N	P
Menopausal symptoms	Y	N	P	Number of pregnancies:			
Endometriosis	Y	N	P	Number of live births:			
PCOS	Y	N	P	Number of abortions:			
				Number of miscarriages:			

Breasts/chest:

Regular self breast exams	Y	N	P	Breast lumps	Y	N	P
Breast pain/tenderness	Y	N	P	Nipple discharge	Y	N	P

Neurologic

Fainting	Y	N	P	Vertigo or Dizziness	Y	N	P
Paralysis	Y	N	P	Seizures	Y	N	P
Tremors or twitches	Y	N	P	Muscle Weakness	Y	N	P
Loss of Memory	Y	N	P	Numbness/tingling	Y	N	P
Loss of Balance	Y	N	P	Nerve/Sciatic Pain	Y	N	P

Endocrine

Diabetes/High blood sugar	Y	N	P	Excessive thirst or hunger	Y	N	P
Hypoglycemia/Low blood sugar	Y	N	P	Fatigue	Y	N	P
Hypo or hyper thyroid	Y	N	P	Heat or cold intolerance	Y	N	P

Mental/Emotional

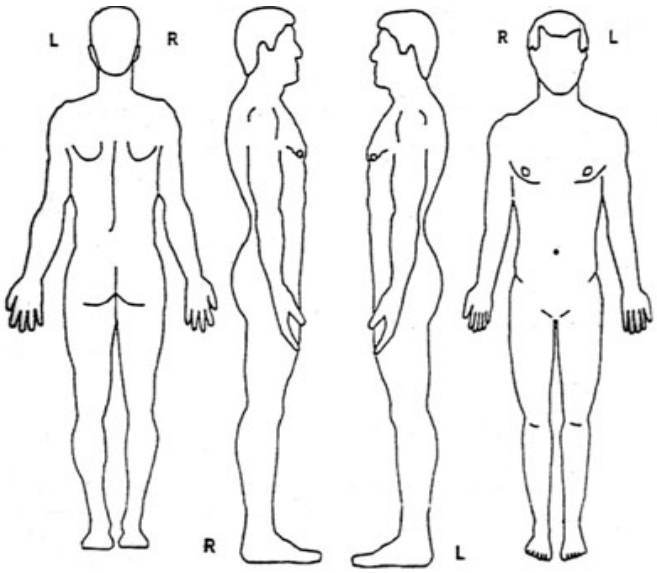
Depression	Y	N	P	Anxiety or nervousness	Y	N	P
Mood Swings	Y	N	P	Tension	Y	N	P
Considered/Attempted suicide	Y	N	P	Poor concentration	Y	N	P
Any major traumas	Y	N	P	History of counseling?	Y	N	P
Have a history of abuse	Y	N	P	Eating Disorder	Y	N	P

Sleep

Insomnia	Y	N	P	Difficulty falling asleep?	Y	N	P
Wake rested?	Y	N	P	Difficulty staying asleep?	Y	N	P
Number of hours you sleep per night?				Do you have low energy during the day?	Y	N	P

Musculoskeletal

Arthritis	Y	N	P	Gout	Y	N	P
Osteopenia/osteoporosis	Y	N	P	Joint pain/stiffness	Y	N	P
Broken bones	Y	N	P	Muscle spasms or cramps	Y	N	P
Heaviness of the limbs	Y	N	P	Muscle weakness	Y	N	P



Please place a mark on the image where you have muscle or joint pain.

Use an X to describe sharp/stabbing pain

Use a P to describe pins and needles

Use a D to describe dull/aching pain

Use an N to describe numbness

HABITS & LIFESTYLE

PLEASE CIRCLE: Y= Current condition N= Never had P= Past condition

Do you exercise?	Y	N	P	Do you use tobacco	Y	N	P
How often do you exercise?				Smoked for how many years?			
How much do you watch TV daily?				How many packs per day?			
Do you enjoy your work?	Y	N	P	Do you drink alcohol?	Y	N	P
Do you take vacations?	Y	N	P	How much alcohol per week?			
Do you have a spiritual practice?	Y	N	P	Do you use recreational drugs?	Y	N	P
Do you eat 3 meals a day?	Y	N	P	Treated for dependency?	Y	N	P
Do you eat out often?	Y	N	P	Do you drink coffee?	Y	N	P
Do you eat protein at each meal?	Y	N	P	Do you drink soda?	Y	N	P
Do you think you are under or over weight?	Y	N	P	How much water do you drink per day?			
Do you eat a special diet?							
What is a typical breakfast for you?							
What is a typical lunch for you?							

What is a typical dinner for you?
What snacks do you eat?

What expectations do you have for this visit?

What long-term expectations do you have for your health?

What is your level of commitment to address underlying causes of your signs and symptoms that relate to your lifestyle (diet, exercise, stress reduction, etc)? (Rated 0 to 10; 10 being 100% committed)

What behaviors or lifestyle habits do you currently engage in regularly that support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

Is there anything else you would like me to know?

FAMILY HISTORY

Do you have a family history of any of the following? (**Please circle**)

Cancer	Epilepsy	Asthma
Diabetes	Arthritis	Anemia
Heart Disease/Heart attack	Glaucoma	Autoimmune disease
High Blood Pressure	Kidney Disease	Tuberculosis
High Cholesterol	Stroke	Mental Illness

Family Member	**Age**	**Major Health Issues**	**If applicable, cause & age of death**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			
Other			

Thank you for taking the time to fill out this questionnaire. I look forward to working with you!

Dr. Shawnte Yates, ND, ~ Dr. Molly Thelisdort ND, LAc ~ Dr. Sandy Musclow ND, LAc

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Essential Family Medicine and you may obtain one at any time. This Notice goes into effect January 19, 2012.

Uses and Disclosures

We may use and disclose your health information for different reasons.

• Treatment: To assist in your diagnosis and treatment.

• Payment: In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.

• Health Care Operations: For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan. Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes. We must disclose, when required by law, for the following examples:

• Avoid threat to health or safety. To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.

• Coroners, Funeral Directors, Organ Donation. To said professionals such that they can carry out their duties.

• Health oversight activities. To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.

• Health-related benefits or services. For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.

• Law Enforcement, judicial and administrative proceedings. In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.

• National security and intelligence. As required by military officials for security and military purposes.

• Public health activities. To public health agencies for reasons such as preventing or controlling disease, injury or disability.

• Research. For medical research – Such circumstances include taking steps to protect your privacy.

• Victims of abuse, neglect or domestic violence. To government agencies and law enforcement personnel as required by law.

• Workers' compensation. In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Essential Family Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via email than by regular mail. To verify or modify where or how you would like communication sent, contact Essential Family Medicine. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

Right to inspect and copy: Includes the rights to see and get copies of your information that we maintain. Submit

your request in writing to Essential Family Medicine and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Essential Family Medicine. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) not correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.
Right to receive an accounting of disclosures: This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before January 19, 2012). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice: At any time even if you previously agreed to receive an electronic copy.
Right to file a complaint: If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us, contact Essential Family Medicine. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I _____, herby declare that I have received a copy of my privacy rights as determined by HIPPA, Health Insurance Portability and Accountability Act of 1996.

_____	_____	_____
Print Name of Patient	Signature of Patient	Date

Dr. Shawnte Yates, ND, ~ Dr. Molly Thelisdort ND, LAc ~ Dr. Sandy Musclow ND, LAc

Informed Consent for Naturopathic Treatment

I, _____, do voluntarily, knowingly and willingly give my consent to treatment by Naturopathic Medical Care. A number of different approaches are used. Diet and nutritional supplements, botanical medicine, homeopathy, hydrotherapy, physical medicine and lifestyle counseling are the mainstays of naturopathic medicine. Pharmaceutical medicines may be employed if absolutely necessary. Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.
We will take a thorough case history, do pertinent physical examinations, and may take blood and urine samples. If your case requires, the physical may include more specific examinations.
Even the gentlest therapies may have complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies should be used with caution in certain diseases such as diabetes, heart, liver or kidney disease.
Please inform your Naturopathic Doctor immediately of any disease that you are suffering from, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:
- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture
- Risks and Side Effects associated with pharmaceutical medicines

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.
I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants. If I have any of the above conditions, I have listed them here: _____

By voluntarily signing below I, _____, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Print Name of Patient	Signature of Patient	Date

Dr. Shawnte Yates, ND, ~ Dr. Molly Thelisdort ND, LAc ~ Dr. Sandy Musclow ND, LAc

Informed Consent for Chinese Medicine Treatment

I _____ hereby agree and consent to the performance of Chinese Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, direct or indirect moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, Shiatsu and Sotai (Japanese Massage), Chinese herbal medicine, and nutritional counseling based on classical Chinese medical theory.

Acupuncture is a technique utilizing fine sterilized stainless steel needles inserted at specific points in the body to correct various ailments. I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, pneumothorax, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

Cupping utilizes round suction cups over a large muscular (such as the back) to enhance blood circulation to the designated area. Potential risks include bruising, mild skin irritation or rarely a skin burn.

Moxibustion is the use of a form of compressed herb (mugwort) that is lit and placed either, directly or indirectly over acupuncture points. Potential Risks include skin irritation or burn.

Shiatsu and Sotai are different forms of Japanese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.

- I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.
- I am relying on the practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that Chinese Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants. If I have any of the above conditions, I have listed them here:

_____

By voluntarily signing below I, _____, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Print Name of Patient	Signature of Patient	Date

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

• Financial options extended to me are based on the personal identification information and documentation I have provided.

• I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.

• I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amounts owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees.

• I hereby authorize Dr. Shawnte Yates ND, LAc - Dr. Molly Thelisdort ND, LAc – Dr. Sandy Musclow and Essential Family Medicine to release information necessary to secure payment.

• I understand that there will be a minimum $60 fee for any appointment not canceled or rescheduled within 48-business hours (Monday – Friday 9-5pm) of the scheduled appointment.

• Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

I understand and agree to the following with regards to current and/or future insurance billing:

• The verification of my health, motor vehicle accident, or worker's compensation insurance is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier. I am fully responsible for being aware of any coverage exclusions.

• I am responsible for providing in a timely manner all accurate and thorough documentation required to verify my insurance coverage and/or bill my insurance carrier, including all relevant Coordination of Benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.

• I understand that Dr. Shawnte Yates– Dr. Molly Thelisdort – Dr. Sandy Musclow and Essential Family Medicine can require presentation of proof of insurance at any time, and that my insurance may need to be re-verified for specific coverage details as often as every six months.

• I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified, or not provided in a timely manner and has resulted in Dr. Shawnte Yates– Dr. Molly Thelisdort – Dr. Sandy Musclow or Essential Family Medicine inability to directly bill for and/or receive reimbursement from my insurance carrier.

• I am responsible for full and timely payment of all insurance co-pays, deductibles, and coinsurance balances due, including any and all services not covered or paid by my insurance carrier (subject to individual provider insurance contract provisions).

• I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.

• I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to Dr. Shawnte Yates– Dr. Molly Thelisdort – Dr. Sandy Musclow. This release applies to support the insurance billing process only.

• I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) or Parent, Guardian Signature Date

_____

Please Print Name

Health Insurance Disclaimer

Essential Family Medicine, Dr. Shawnte Yates, Dr. Sandy Musclow, and Dr. Molly Thelisdort will be following protocols for verifying your insurance coverage. Insurance information given to us by your insurance company is not a guarantee of payment. This includes information provided about covered services, copays, coinsurance, deductibles and pre-authorizations. Any charges that are not covered by the given insurance company will be billed to you. It is your responsibility to read your policy, to know your coverage and to review explanation of benefits statements regarding payments.

I have fully read and understand the above disclaimer.

_____	_____	_____
Print Name of Patient	Patient (18 years or older) or Parent, Guardian Signature	Date

HIPAA – Notice of Privacy Practices & Consent

I hereby consent to the use and disclosure of my protected health information by Dr. Shawnte Yates– Dr. Molly Thelisdort – Dr. Sandy Musclow and Essential Family Medicine (EFM) for the purposes of treatment, payment and healthcare operations, and as otherwise required by law.

• I acknowledge that Dr. Shawnte Yates- Dr. Sandy Musclow–Dr. Molly Thelisdort and EFM has provided me with a copy of the Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I have a right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed copy of the Notice of Privacy Practices.

• I have the right to request restrictions to the usage and disclosure of my health information.

• I have the right to request an alternative to the standard method of communication of my protected health information.

• I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Dr. Shawnte Yates –Dr. Molly Thelisdort – Dr. Sandy Musclow and EFM may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by EFM at the following address: 1110 SE Alder St, Suite 201 - Portland, OR 97214

• I understand that if I have any questions or complaints I may submit them in writing to the address above or contact EFM by phone at 503-477-5051.

• I am aware that Dr. Shawnte Yates– Dr. Molly Thelisdort – Dr. Sandy Musclow and EFM reserves the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, EFM will make available a revised Notice of Privacy Practices for my review.

_____	_____
Patient (18 years or older) or Parent, Guardian Signature	Date

_____

Print Name

E-Mail Authorization and Consent Agreement

Between Essential Family Medicine
Dr. Molly Thelisdort, Dr. Shawnte Yates, Dr. Sandy Musclow and Patient

Notice of Email Usage Policy and Consent

My practitioner will only initiate email communication for scheduling or other uses not involving medical information. I understand that I have the option to send emails to my practitioner if s/he agrees. If I choose to initiate a conversation about my health concerns via email, my practitioner will NOT respond via email and will contact me via the phone number I provide with information related to my health concerns. There is no guarantee of when a response will be given. I have been advised that Email is never, ever appropriate for urgent or emergency problems. Email is NOT confidential. Employers have a legal right to monitor email if they choose; system operators for most email systems have access to all email that passes through their systems. Email communications travel across the public Internet. It is not always possible to verify that email is actually received, opened and read by the addressee. There is not a way to assure the privacy of the email on a shared computer or email account. All email correspondence may become part of my medical record.

IT IS EXTREMELY IMPORTANT THAT YOU PUT YOUR PRACTITIONER'S NAME ON

EACH AND EVERY EMAIL YOU SEND TO YOUR PRACTITIONER.

Since email may not be monitored while my practitioner is not in the office, I will follow up by telephone or in person if I do not receive a response within a week. I understand that there are many potential issues with putting sensitive, personal health information in the public communication space, including but not limited to potentially waiving my physician-client privilege in the event of any legal proceeding. I understand that I may revoke my consent to use email communication for health information at any time, whether I have previously sent emails regarding my health information, by contacting my practitioner directly and providing such revocation in writing.

Name: _____ DOB: _____

Signature: _____ Date: _____

Practitioner(s): _____