A WOMAN'S TIME ● 2067 NW LOVEJOY ST ● PORTLAND, OR 97209 ● (503) 222-2322 ● WWW.AWOMANSTIME.COM

Clinic use only: Dr: ______ ***Leave message at: Cell Home Work***

Date ______ What is your preferred name? ______
Legal First Name ______ Middle ______ Last ______
Date of Birth ______ Age ____ Sex Assigned at Birth ***(circle one):*** **F** **M**
Current Gender ***(circle one):*** **F M M to F F to M Other** *(Please specify):* ______
What is your preferred pronoun? **He She Other** *(Please specify):* ______
Address ______
City ______ State ______ Zip Code ______
Cell Phone (____)______ Work Phone (____)______
Home Phone (____)______ Other Phone (____)______
Best contact number? **Cell Work Home Other** Best number to leave a message? **C W H O**
May we leave detailed medical information on your voicemail? **Y N**
E-mail Address: ______ May we contact you by email?* **Y N**
**We do not have a secure portal. This is standard email.*
Occupation ______ Hours per week ______ Retired **Y N**
Employer ______ Location ______

What is your relationship status? ***(Please circle one)***:
Single Married Significant Partner Separated Divorced Widowed
Do you live with: ***(Please circle all that apply):***
Alone Spouse/Partner Child(ren) Parent(s) Relative(s) Friend(s) Roommate(s) Pet(s)

Emergency contact ______ Relationship ______
Phone ______ or ______ Location (city, state) ______

I am willing to let my medical records be used anonymously for research purposes. **Y N**
**Research purposes may include student researchers. All information is anonymous and confidential.*

HISTORY QUESTIONNAIRE

Holistic health care and preventive medicine are only possible when the physician has complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. ***Print all information; mark anything you don't understand with a question mark.***
Name of Primary Care Physician: ______
When did you last receive medical/health care? ______
Where? ______
For what reason? ______
What are your most important health issues? List as many as you can in order of importance:
1) ______ 4) ______
2) ______ 5) ______
3) ______ 6) ______
Name of dentist: ______

How did you hear about us? *(Please check if applicable)*
Medical Referral____ Friend____ Who?______ TV____ Radio___
Yellow Pages____ Internet____ Ads____ Which one?______ Other______

Patient name: ______ DOB: ______

Family History: Please check applicable conditions for each family member.

	Father	Mother	Brother	Sister	Father's Mother	Father's Father	Mother's Mother	Mother's Father	Child(ren)
Age if living (**L**) or at death (**D**)									
Health: **G**=Good **P**=Poor									
(If deceased) Cause									
Cancer (Type?)									
Diabetes									
Heart Disease									
High Blood Pressure									
Cholesterol									
Alzheimer's									
Stroke									
Epilepsy									
Mental Illness (Type?)									
Kidney Disease									
Glaucoma									
Osteoporosis									
Tuberculosis									
Alcohol/Drug Addiction									
Other									

For the following sections, please circle Y=Yes or N=No

Childhood Illnesses:

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic Fever	Y N	German Measles	Y N
Mumps	Y N	Measles	Y N	Chicken Pox	Y N		

Other ____

Immunizations:

Polio	Y N	Tetanus Shot (not antitoxin)	Y N	Diphtheria	Y N
Pertussis	Y N	Measles/Mumps/Rubella	Y N	HPV	Y N
Hepatitis A	Y N	Hepatitis B	Y N	Meningitis	Y N
Pneumonia	Y N	Shingles	Y N	Other___________	

Hospitalization and Surgery: Hospitalizations or surgeries you have had and when:______________

____

Major illnesses or injuries:____

Known exposure to toxic substances (heavy metals, paint, pesticides, mold, etc.):

____

Allergies: Please list any foods, drugs, or other allergens, or circle "none known": **None known**

____

____

Mammograms: Last: __________ Where: ______________________ Results: **Normal Abnormal**
Pap Smears: Last: __________ Where: ______________________ Results: **Normal Abnormal**

Patient name: ______________________________________ DOB: ______________

Please list prescription medications, over-the-counter medications, vitamins, or other supplements you take:

____

For the following sections, please circle one of the following:

Y = a condition you have now. **P** = a condition you have had in the past. **N** = a condition you have never had.
Please mark an asterisk (*) by any areas you would like to clarify with the doctor.

General

Weight	_____
Weight 1 yr ago	_____
Maximum weight	_____
What year?	_____
Height	_____
Fatigue	Y P N

Skin

Rashes	Y P N
Eczema, hives	Y P N
Acne, boils	Y P N
Itching	Y P N
Color change	Y P N
Lumps	Y P N
Hot flashes/Nights sweats	Y P N

Head

Headaches	Y P N
Head Injury	Y P N

Eyes

Impaired vision	Y P N
Glasses or contacts	Y P N
Eye pain	Y P N
Tearing or dryness	Y P N
Double vision	Y P N
Glaucoma	Y P N
Cataracts	Y P N

Ears

Impaired hearing	Y P N
Ringing	Y P N
Earache	Y P N
Dizziness	Y P N

Nose and Sinuses

Frequent colds	Y P N
Nose bleeds	Y P N
Stuffiness	Y P N
Hay fever	Y P N
Sinus problems	Y P N

Mouth and Throat

Frequent sore throat	Y P N
Sore tongue	Y P N
Gum problems	Y P N
Hoarseness	Y P N
Dental cavities	Y P N

Neck

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

Respiratory

Cough	Y P N
Sputum	Y P N
Spitting up blood	Y P N
Bronchitis	Y P N
Pleurisy	Y P N
Emphysema	Y P N
Wheezing	Y P N
Asthma	Y P N
Shortness of breath	Y P N
" at night	Y P N
" on lying down	Y P N
" on exertion	Y P N
Difficulty breathing	Y P N
Pain on breathing	Y P N
Pneumocystis	Y P N
Tuberculosis	Y P N

Cardiovascular

Heart disease	Y P N
Chest pain	Y P N
Angina	Y P N
Palpitations, fluttering	Y P N
High blood pressure	Y P N
Heart murmur	Y P N
Rheumatic fever	Y P N
Swelling in ankles	Y P N

Blood

Anemia	Y P N
Bleed or bruise easily	Y P N

Patient name: ______________________________ DOB: ______________

Peripheral Vascular

Thrombophlebitis	Y P N
Cold hands/feet	Y P N
Varicose veins	Y P N

Gastrointestinal

Nausea	Y P N
Vomiting	Y P N
Vomiting blood	Y P N
Bowel movements - how often?	______
Is this a change?	Y N
Blood in stool	Y P N
Gallbladder disease	Y P N
Liver disease	Y P N
Jaundice (yellow skin)	Y P N
Change in thirst	Y P N
Change in appetite	Y P N
Trouble swallowing	Y P N
Belching/passing gas	Y P N
Heartburn	Y P N
Ulcer	Y P N
Hemorrhoids	Y P N

Urinary

Pain on urination	Y P N
Increased frequency	Y P N
Frequency at night	Y P N
Inability to hold urine	Y P N
Frequent infections	Y P N
Kidney stones	Y P N

Neurologic

Fainting	Y P N
Seizures	Y P N
Paralysis	Y P N
Muscle Weakness	Y P N
Numbness or tingling	Y P N
Loss of memory	Y P N

Musculoskeletal

Joint pain or stiffness	Y P N
Arthritis	Y P N
Broken bones	Y P N
Muscle spasms	Y P N
Muscle cramps	Y P N
Weakness	Y P N

Endocrine

Hypothyroid	Y P N
Heat or cold intolerance	Y P N
Excessive thirst	Y P N
Excessive hunger	Y P N
Diabetes	Y P N

Emotional

Depression	Y P N
Mood Swings	Y P N
Anxiety or nervousness	Y P N
Tension	Y P N

Female Reproductive

First day of last menstrual cycle	______
Average number of days	______
Length of cycle	______
Bleeding between periods	Y P N
Are cycles regular?	Y P N
Pain during intercourse	Y P N
Painful menses	Y P N
Excessive flow	Y P N
Do you use birth control?	Y P N
What type?	______________
How long?	______________
Number of pregnancies	______
Number of live births	______
Number of miscarriages	______
Number of abortions	______
Difficulty conceiving	Y P N
Vaginal dryness/pain	Y P N
Are you sexually active?	Y P N
• Partner(s)	______________
• Gender(s)	______________
Sexual difficulties	Y P N
Sexually transmitted infection	Y P N

Breasts/Chest

Do you do a monthly self-exam?	Y P N
Lumps	Y P N
Pain or tenderness	Y P N
Nipple discharge	Y P N

Male Reproductive

Hernias	Y P N
Testicular masses	Y P N
Testicular pain	Y P N
Are you sexually active?	Y P N
• Partner(s)	______________
• Gender(s)	______________
Sexual difficulties	Y P N
Prostate Disease	Y P N
Sexually Transmitted Infection	Y P N
Discharge or sores	Y P N

Patient name: ______________________________ DOB: ______________

Habits

What are your main interests and hobbies?

____
____
____

Do you exercise? Y P N
- Type?_________________________
- How often?______________________

How many meals do you eat daily?_____

Caffeine use Y P N
Sleep well? Y P N
Awaken rested? Y P N
Average 6-8 hours sleep? Y P N
Take vacations? Y P N
Enjoy your work? Y P N
Spend time outside? Y P N

How many hours/day do you:
- Watch television? ______
- Read? ______

Do you use tobacco? Y P N
Use alcoholic beverages Y P N
Use marijuana
Other recreational drug Y P N
Treated for alcoholism Y P N
Treated for drug abuse Y P N

Stress level: high ____ average ____ low ____

Are there any other issues not mentioned that you would like to discuss?____________________

____

Patient name: ____ DOB: ____________________

Dear Patients:

We are writing this letter to re-state our billing/financial policies. There are a few changes so please read this letter carefully to ensure that you know if any of the changes will affect you.

1. We bill insurance as a courtesy to you, our patient. For the most part there is not a need to re-bill or spend a lot of time on the claims. However, there are occasions where it becomes very labor intensive to follow up on, re-bill, call, mail, copy, and call again to get a claim paid. We will, as of this date, send your insurance company the original claim soon after your visit. We will be happy to follow up if payment is not received within 45-60 days. If it becomes necessary to continue to follow up we will at that point, turn the bill over to you to continue pursuing payment from your carrier. We have at time spent over 6 months pursuing a claim and we can no longer continue to do this.

2. If you have a balance due and it goes beyond 60 days, we will begin the collection process so that at 90 days past due there will be 10 days to pay the bill or we will transfer it to our collection company, Quick Collect. We will as usual send you monthly bills to remind you of this timeline and give us both ample opportunities to get any balances paid within a timely manner.

3. If at any point you make payment arrangements and your balance has gone to the 90 day time line, and then you do make the agreed upon payments, we will then immediately go back to the collection process and you will have 10 days to clear up the balance/s you owe and if not paid within that time line then we will turn the bill over to our collection company, Quick Collect.

We know and trust that the majority of you pay on time and we appreciate your continued loyalty and visits to our clinic. We appreciate your understanding of these policies and welcome your questions if you have any.

Karen Hudson
Clinic Director
**Kim Abueg is our clinic manager and is now in charge of all insurance and patient billing and accounts receivable.

SIGNATURE ______________________________ DATE __________

2067 NW Lovejoy St. Portland, OR 97209 • PH: 503-222-2322 • FAX: 503-222-0276
Email: clinicmanager@awomanstime.com • www.awomanstime.com

FINANCIAL RESPONSIBILITY AGREEMENT

Please take the time to read and sign the financial responsibility statements to acknowledge your understanding of them. These are intended to provide you with clear understanding of our financial agreements and billing procedures to prevent misunderstandings. If you have any questions regarding these agreements, please let the staff or your practitioner know.

ALL CO-PAYMENTS, CO-PERCENTAGE PAYMENTS, COSTS OF ALL SUPPLEMENTS AND COSTS OF SERVICES NOT COVERED BY YOUR INSURANCE COMPANY ARE DUE AND PAYABLE AT THE TIME OF EACH VISIT.

If you have insurance that may cover alternative health care, it is your responsibility to fill out the insurance details form and provide your insurance card to the front desk to bill your insurance carrier completely and accurately. When possible, the front desk will call to verify your insurance coverage before the end of your appointment. If benefits cannot be determined at the time of service, and/or when there is any doubt, **payment in full is expected**. (For your convenience, we accept the following types of payment: cash, check, Visa MasterCard, Discover and American Express.)

Please initial here ____________

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a service to you and upon your request we can bill your insurance provider. We ask that you stay involved with the billing process. There are normal and expected times that we will need to re-bill your insurance company. However, if there becomes a time when the costs of completing your billing are over and above the usual and customary time spent to process and follow-up on a claim, we will contact you. **If you would like us to continue to pursue billing your insurance company, you will be charged $20.00 for the additional time spent on the claim, in order to help defray costs of completing the payment for you. This charge will be for each consecutive 60 days that we continue to work on the bill.**

Please initial here ____________

Any balances due to us after your insurance carrier has notified us of payment of non-payment will be billed to you. After thirty (30) days of the first bill, a 1% annual or minimum of $2.50 per month finance charge will begin to apply to the account. Any bill over ninety (90) days past due will be subject to collection procedures. If you need to make payment arrangements, you can do so by signing and agreeing to a payment plan at the time of service. All payment agreements must be followed through within the above timeline. We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic.

Please initial here ____________

You are financially responsible for the cost of supplements. There are only a few known insurance companies that cover these. Where applicable, consider using your MSA/FSA for the purchase of supplements. We can supply you with an itemized receipt to provide proof of purchase.

Please initial here ____________

Upon receipt of payment from your insurance company, you may end up with a credit balance. Any amounts due you will remain on your account as a credit for your use towards future services and/or purchases. If you would like to be issued a refund, please let us know and we will be happy to send you a check.

Please initial here ____________

Please note there are two (2) alternative health care insurance plans that require special forms. You may have additional forms to sign at each visit if you are on one of those plans. Not **all** doctors at this clinic are covered by the same health plan or at the same rates. This may affect how much you owe if you see a different doctor at our clinic.

Please initial here ____________

There will be a $50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice.

Please initial here ____________

You may be charged for phone conversations with your doctor that exceed 10 minutes. This may vary between doctors, so feel free to ask your doctor for their specific procedures regarding phone calls. Generally, these calls cannot be billed to insurance. If you have a matter that is more extensive and you rely on insurance, please make an appointment.

Please initial here ____________

I, ________________________________ (patient's name), a patient of A Woman's Time, acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

________________________________ Patient Signature__________________________ Patient Printed Name

____________________ Date

Patient name: ____ DOB: ____________________

Privacy Disclosure & Policies

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In-Office Security
The notes that are taken during appointments are kept in your chart and are secured in our clinic at all times. If patient charts are in public area, they are kept with the names covered. Access to this office is limited to practitioners, employees, preceptors and supervised guests.

Public Interaction
Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

Consultations
We consult with other healthcare practitioners and clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax or email are confidential and names are not used unless necessary and consent is provided from you either verbally or in writing.

Records Released
Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definitions and Penalties to Comply
Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer life insurer, school or university or healthcare clearing house in the normal course of business, and 2) relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have the practitioners and employees of A Woman's Time maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or the employees of A Woman's Time if I need any special arrangements pertaining to this issue.

Printed Name: ______________________________ **Signed:** __________________________

Date: ____________

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Patient name: ____ DOB: _______________