Soaring Health and Wellness, LLC.
1221 S.E. Madison St. Portland, OR. 97214
PH: (503) 445-7767 FAX: (503) 410-7116

Patient Preferred Contact Form

Name: ____
Last First M.I. Date of Birth

Address: ____
Street City State Zip

		Can We Leave Confidential Messages at this Number? (Circle Yes or No)	Preferred Contact? (Check One)
Home Phone	______________________	Yes No	________
Work Phone	______________________	Yes No	________
Cell Phone	______________________	Yes No	________
Other Phone	______________________	Yes No	________

Email Address ____
(Email is not a secure form of communication! Please choose a phone number above that we may use to relay confidential messages)

Insurance Information

Name of Insurance Company ____

ID Number ____________________________ Group Number ______________________

Member Name (if different than patient's) __________________________________

Are you interested in receiving information about Soaring Health and Wellness, LLC? Yes No

By signing below, you confirm that the information you have provided is both accurate and current to this date.

Signature: ______________________________________ **Date:** ________________

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Patient Information

Date ________________

Patient Name ____
Last Name First Name Middle Name

Sex ___Male ___Female Date of Birth ________________Age ______SS# ___________________
___Single ___Married ___Partner for ______ years ___Separated ___Divorced ___Widowed
___Student ___Not Employed ___Employed Part Time ___Employed Full Time ___Retired
Occupation ___________________________ Employer/ School ______________________________
Address ____
Education ____

How did you hear about us? ____
Spouse/ Parent/ Guardian/ or Significant Other ____
Work Phone ____________________________ Home Phone __________________________________
Person to Contact in Case of Emergency ____
Work Phone ____________________________ Home Phone __________________________________

Health History Questionnaire

Natural medicine health care works best when the physician completely understands the patient physical, mental, and
emotional conditions. The information you provide helps us understand your needs and how to help you reach your
health goals. Please write legibly and mark anything you don't understand.
Thank you for your time and thoroughness and welcome to your journey to vibrant health!

When and where did you last receive medical or health care ___________________________________
____
What was the reason? ____
____
What is your present commitment level at addressing the underlying causes of your health concern?
Please circle. 10% 20% 30% 40% 50% 60 % 70% 80% 90% 100%
Are there any potential obstacles that you foresee may interfere with addressing lifestyle issues that may be contributing to your health
issues____
____
____

Please list your 5 major health concerns in order of importance:
1. ____
2. ____
3. ____
4. ____
5. ____

Family History: *Check all those applicable*

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)						
Health G= good P= poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hay fever, Hives						
Anemia						
Kidney Disease						
Auto-immune Disease						
Tuberculosis						
Age (at death)						
Cause of death						

Personal History:

For the following sections, please circle Y = yes or N = no

Childhood Illnesses:

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

Other____

Hospitalization and Surgery: Please list with dates. ____

____

____

X-rays, CAT scans, or MRI's: Please list with dates. ____

____

____

Electrocardiogram Y N

Electroencephalogram Y N

Immunizations:

Polio	Y N	Pertussis	Y N
Tetanus shot (not antitoxin)	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other ____________________	

Allergies: Please list any foods, drugs or other allergens:____

____

____

Current medications: Please list prescription medications, over-the-counter medications, vitamins or other supplements you are taking: ____

____

____

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Sleeping pills	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N			

Review of Systems

Please circle one: Y = a current condition, P = a past condition, leave blank for never had.

General

Weight ____________ Weight 1 year ago_________ Max weight_________ When___________

Height ________ Fatigue Y P

Skin

Acne	Y	P	Itching	Y	P	Night sweats	Y	P
Color change	Y	P	Lumps	Y	P	Rashes	Y	P
Eczema, Hives	Y	P						

Head

Headache	Y	P	Head injury	Y	P

Eyes

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

Ears

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

Nose and Sinuses

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

Mouth and Throat

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

Neck

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

Respiratory

Cough	Y	P	Spitting up blood	Y	P
Sputum	Y	P	Wheezing	Y	P
Asthma	Y	P	Bronchitis	Y	P
Pneumonia	Y	P	Emphysema	Y	P
Pleurisy	Y	P	Difficulty breathing	Y	P
Pain on breathing	Y	P	Tuberculosis	Y	P
Shortness of breath	Y	P	Short/breath lying down	Y	P
Short/breath at night	Y	P			

Cardiovascular

Heart disease	Y	P	Angina	Y	P
High blood pressure	Y	P	Murmurs	Y	P

- Palpitations, fluttering Y P
- Swelling in ankles Y P
- Rheumatic fever Y P
- Chest pain Y P

Gastrointestinal

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

Urinary

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

Female Reproductive

- Regular cycles Y P
- Painful menses Y P
- Length of cycle _______
- Menopausal symptoms Y P
- Average number of days _______
- Are you sexually active? Y P
- Number of pregnancies _______
- Pain during intercourse Y P
- Number of live births _______
- Difficulty conceiving Y P
- Number of miscarriages _______
- Venereal disease Y P
- Number of abortions _______
- Sexual difficulties Y P
- Excessive flow Y P
- Birth control Y P
- Bleeding between periods Y P
- What type of birth control _____________
- Sexual preference: Heterosexual ____ Bisexual ____ Homosexual ____

Breasts

- Do you do self exams? Y P
- Lumps Y P
- Pain or tenderness Y P
- Nipple discharge Y P

Male Reproductive

- Hernias Y P
- Pain during intercourse Y P
- Discharge or sores Y P
- Difficulty conceiving Y P
- Testicular pain Y P
- Venereal disease Y P
- Are you sexually active? Y P
- Sexual difficulties Y P
- Sexual preference: Heterosexual ____ Bisexual ____ Homosexual ____

Musculoskeletal

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

Peripheral Vascular

- Deep leg pain Y P
- Cold hands or feet Y P
- Varicose veins Y P
- Thrombophlebitis Y P

Neurological

- Fainting Y P
- Seizure Y P
- Paralysis Y P
- Muscle weakness Y P
- Loss of memory Y P
- Numbness Y P

Emotional

- Depression Y P
- Anxiety or nervousness Y P
- Mood swings Y P
- Tension Y P

Endocrine

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

Blood

Anemia	Y	P	Easy bleeding	Y	P

What are you main interests and hobbies? ____

____

____

Do you exercise? Y N What forms?______________________________

____

How often? ____

Do you eat three meals daily	Y	N	Awaken rested	Y	N
Average 6-8 hours sleep	Y	N	Sleep well	Y	N
Enjoy your work	Y	N	Spend time outside	Y	N
Watch television	Y	N	How many hours/day (TV)____________		
Read	Y	N	How many hours/day (Read)___________		
Take vacations	Y	N	Use tobacco	Y	N
Use recreational drugs	Y	N	Been treated for addiction	Y	N
Use alcoholic beverages	Y	N	Been treated for alcoholism	Y	N

I authorize the release of any medical information necessary to process insurance claims. I also authorize payment of medical benefits to Soaring Health and Wellness, LLC for services rendered.

________________________________ ________________________

Patient's or Authorized Person's Signature **Date**

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Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights
to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be
involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. All HIPPA Policies are effective April 14th, 2003

Please direct any questions, concerns or complaints regarding HIPPA policies and procedures to Karen Elder at (503) 445-7767.

Consent for Treatment

Naturopathy, Acupuncture, and Massage Medical Consent: I consent to services rendered and treatment provided by Dr. Stephen Levy at Soaring Health and Wellness, LLC. I recognize that Dr. Stephen Levy is a licensed Naturopathic Physician, Acupuncturist, and Massage Therapist. I have the right to refuse any treatment suggested that I am uncomfortable with. I have the right to ask questions to my satisfaction. Dr. Stephen Levy has the right to treat me within the scope of his practice. Dr. Stephen Levy has the right to refuse rendering of treatment or to make referrals to outside physicians if he feels that they can not be of service to my case.

Patient Name: ____
Patient/ Guardian Signature:____
Relationship to Patient: ____
Date: ____________________________

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Financial Policy

Please initial to show that you have read and understood each section.

• Missed Appointments/ Cancellations __________

- o If for any reason you are unable to make your appointment, **Please give us 24 hours notice.** For any missed appointments or less than 24 hour notice for cancellation your account will be charged 50% of the office time saved for you. (Exceptions will be made for genuine emergences.)
- o If you are late for your appointment, your visit may be shortened and you will also be charged for the reserved time on the schedule.

• Supplements __________

- o All orthopedic supplies, medicinary and supplement items are to be paid in full at the time of purchase. We will only accept a return if the safety seal has not been broken or unwrapped.
- o We ask that you please call in advance when you need a refill on your supplements to ensure we have it on hand or if needed to be ordered. If available you can pick up supplements during office hours. As a courtesy for patients who are unable to pick up these items, we can mail them to you via priority mail. **You will be responsible for the postage.** If mail order is over $75, insurance will be required to ship package.

• Insurance __________

- o If you have insurance, you are required to fill out the insurance verification form to confirm naturopathic coverage.
- o Once you have verified your insurance, you will be responsible for any co-pays, deductibles, and amounts not covered by the insurance at the time of service..
- o In the case of a Motor Vehicle Accident (MVA) or Personal Injury Protection (PIP) claim, you are responsible for any balance that is incurred after the claim has been closed. If the claim goes to litigation, you must pay the balance before litigation starts.

• Payments __________

- o For cash paying patients, a Time of Service discount will be given to you. We accept cash, checks, and credit cards. A payment plan can be arranged if needed (see Payment Plan Arrangement Form). We have the right to agree, or not, to any payment plans.
- o A sliding scale fee schedule based upon the US poverty guidelines is available for those who do not have naturopathic insurance coverage. Household proof of income is required to qualify for discounted rates.
- o **Supplemental telephone calls and emails exceeding 5 minutes are billed at $35 per 15 minute increments.**
- o **Dishonored checks will be charged a $25 fee.**
- o Any balances due on your account will be billed to you every 30 days. Balances that are 90 days past due **may be** submitted to collections if there is no communication.

Please sign and date to say that you have read, understood, and agree to the above policies.

____ ________________________

Patient's or Authorized Person's Signature **Date**

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Release of Records Request

Confidential

Health Care Information Enclosed

Protected health information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent is prohibited, except as permitted by law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

Patient: ___________________________________ DOB ___________________

Release of:

___ Entire Chart ___Chart since/pertaining to________________________

___All Lab work ___Lab work since_______________________

___Other____

Release of records to:
Dr. Stephen P. Levy, N.D., L.Ac., L.M.T.
Soaring Health and Wellness, LLC.
1221 SE Madison St.
Portland, OR 97214

phone:(503) 445-7767
fax:(503) 410-7116

Release of records from:
Dr. ________________________________
at _________________________________
____
____

phone: ______________________________
fax: ________________________________

The following items must be **INITIALED** to be included in the use or disclosure of other health information:
___ *HIV/AIDS related health information and/or records
___ Mental health information and/or records
___ Genetic testing information and/or records
___**Drug/Alcohol diagnosis, treatment and/or referral information

__________________________________ ___________________
Patient Signature **Date**

If there are any questions, please feel free to contact us at (503) 445-7767. Thank you.

IMPORTANT NOTICE: This message is intended for the sole use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately and destroy the related message.