



bend naturopathic clinic



New Patient Information Form

Dr. Azure Karli, N.D.
715 nw hill street
bend/oregon/97703
541/389/9750
541/389/2250 fx

Welcome to Bend Naturopathic Clinic for your healthcare needs. We appreciate your interest in Naturopathic Medicine and are here to help you obtain your greatest health potential by the safest medical methods possible.

Financial Information: We will apply a 30% discount to your service charges if payment is received in full at the time of service. We are happy to bill your insurance company if you have Naturopathic Care as a covered service. If your insurance company denies coverage for any reason, you will be responsible for payment in full. If you are unsure of your insurance coverage, we suggest paying in full at the time of service to receive the discount and then submit the charges to your insurance company for reimbursement.

Missed Appointments: A 24-hour cancellation policy is necessary so that we may have the opportunity to accommodate other patients. Canceled office visits or phone consults without a 24-hour notice will result in a \$50.00 charge to you for the missed appointment.

Late: If you are more than 10 minutes late, your appointment may be rescheduled and a missed appointment fee may be charged. (See Missed Appointments Above)

Phone Calls: As a courtesy, Dr. Karli is happy to answer questions by phone at any time she is available. However, calls that extend to more than five minutes will be billed at the usual rate. Most insurance companies will not cover phone consults.

Medicinary and Labs: All Medicinary and lab fees are due at the time of service if provided by Bend Naturopathic Clinic.

Returned Checks: A fee of \$30.00 will be assessed for each returned check.

Dr. Karli can take care of your most of your general health care needs including physical exams, pap smears, laboratory work, and others. Please note that we do not have a doctor on call 24 hours. When Dr. Karli is out of town, there will be access to another ND during normal business hours. If you need a provider to be available 24 hours we suggest having an relationship with an additional practitioner that has on call hours. Please feel free to ask about any concerns that you may have.

Statement and Signature: I have read and fully understand the above information. I agree with the policies of Dr. Karli and understand that I am financially responsible for all services rendered. I will be liable for all financial and legal collection fees if applicable.

X _____ Date: ____/____/____

Name: _____ DOB: ____ / ____ / ____

NEW PATIENT INFORMATION

Name: _____ DOB: ____ / ____ / ____ Age: ____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ - _____ Cell / Home / Work (circle one)

Secondary Phone: (_____) _____ - _____ Cell / Home / Work (circle one)

Email Address: _____

Please note that we cannot email medical information to you per HIPPA. If you email us, we will likely call you in response.

Social Security # _____ - _____ - _____

How did you hear about us: _____

Occupation: _____ Full Time / Part Time / Retired (circle one)

Are you:

Married / Separated / Divorced / Widowed / Single / Other (circle one)

Live with:

Spouse / Partner / Parents / Relatives / Friends / Alone / Other (circle one)

Do you give Dr. Karli and/or her staff permission to leave messages stating Dr. Karli's or the clinic's name and reason for calling at the phone numbers listed above?

(Please circle your answer below to the corresponding phone numbers)

Primary Phone Number: Yes / NO (circle one) Secondary Phone Number: Yes / NO (circle one)

Any Specific instructions for leaving a message:

Emergency Contact in case of an emergency:

Name: _____

Relationship: _____

Phone: (_____) _____ - _____

Address: _____

HEALTH CARE QUESTIONNAIRE

Holistic health care and preventative 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. If there is a question that you don't understand, please indicate so with a question mark.

When did you last receive medical care: _____

Where did you receive that care: _____

What was the reason for seeking care: _____

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

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

HOSPITALIZATIONS & SURGERIES

Please list any Hospital Visits/Surgeries you have had that
do not show up in the chart below:

RECENT PROCEDURES

Please list any medical procedures you have had:

Procedure	Dates	Where Was This Performed and briefly, why?
Physical Exam		
Colonoscopy		
MRI		
X-Ray		
Ultra Sound		
Dexa Scan		
Electrocardiogram		
Mammogram		
PAP		
Lab Tests		

IMMUNIZATIONS

Please circle any immunizations you have had:

Polio: Y / N

Diphtheria: Y / N

Measles: Y / N

Pertussis: Y / N

Tetanus: Y / N

Other: Y / N Detail: _____

ALLERGIES

Please list any allergies including food, drug or other:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

MEDICATIONS, VITAMINS & SUPPLEMENTS

Please list any medications, supplements or vitamins you are currently taking:

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

CHILDHOOD ILLNESSES

Please circle any child illnesses to your knowledge:

Scarlet Fever: Y / N	Measles: Y / N	Other: _____
Mumps: Y / N	Rheumatic Fever: Y / N	_____
Diphtheria: Y / N	German Measles: Y / N	_____

FAMILY HISTORY

Please check/fill out the applicable boxes for your family member history:

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Good Health						
Poor Health						
Cancer						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hay Fever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age at Death						
Cause of Death						

Habits

How many ounces of water do you drink daily? _____
How many alcoholic beverages do you drink weekly? _____
Alcoholic beverage = 1 oz. liquor, 12oz beer, 6oz wine
How many ounces of coffee do you drink daily? _____ Caffeinated beverages (not including coffee) _____
Please write down a couple examples of what you ingest for each meal:
Breakfast _____
Snack (if any) _____
Lunch _____
Snack (if any) _____
Dinner _____
Dessert(if any) _____
How much exercise do you get in a week? What type? _____

How many hours do you get of sleep per night on average? _____
Do you wake up and feel rested? _____
Do you use recreational drugs? _____
How many hours do you read daily? _____
How many hours do you watch TV daily? _____
Have you ever been treated for alcohol or drug dependence? _____
Do you smoke / use tobacco? _____ If so, how much? _____

Review of Symptoms

Weight _____ Height _____ Weight one year ago _____ Maximum weight _____

Please answer Y or N, if needed please add brief detail / description:

Fatigue _____
Skin Issues _____
Headache or Head injury _____
Vision Issues _____
Ear / Hearing Issues _____
Allergies (other than listed above) _____
Throat / swallowing issues _____
Respiratory issues _____
Asthma _____
Cardiovascular disease _____
Urinary issues _____
Musculoskeletal issues _____
Neurologic problems (i.e. seizures, numbness) _____
Emotional issues _____
Thyroid dysfunction _____
Adrenal dysfunction _____
Anemia _____
Gastrointestinal issues _____
-How many bowel movements do you have per day / week? _____
-Any blood in the stool? If yes, hemorrhoids? _____
-Excessive hunger or thirst? _____
Any history of venereal disease? If yes, which ones? _____
Any sexual concerns? _____
Are you currently sexually active? _____ If no, have you ever been? _____ Type of birth control? _____

Women: Date of last menses _____ Was it normal for you? _____ Any bleeding between cycles? _____
Number of pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
Do you do self breast exams? _____ Any changes to your breast tissue you are concerned about? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. **IMPORTANT NOTICE:** This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

- 1) How we may use and share health data about you:
 - a) Treatment- To give you medical treatment or other types of health services.
 - b) Payment- To bill you or a third party for payment for services provided to you.
 - c) Health Care Operations- For our own operations such as quality control, compliance, monitoring, auditing or other.

- 2) Disclosures where we do not have to give you a chance to agree or object:
 - a) To you
 - b) As required by Federal or State Law
 - c) If child abuse or neglect is suspected
 - d) Public health risks
 - e) Lawsuits and disputes
 - f) Law enforcement
 - g) Coroners, medical examiners and funeral directors
 - h) Organ or tissue donation facilities if you are an organ donor
 - i) To avert a threat to an individual or public health safety

- 3) Disclosure where we have to give you a chance to agree or object:
 - a) Patient directories- You can decide what health data, if any, you want to be listed in patient directories.
 - b) Persons involved in your care or payment of your care – we may share your health data with a family member, a close, friend or other persons that you name as being involved in your health care.

- 4) Other uses of health data. Other uses not covered by this notice or the laws that apply to us will be made only with your consent.

- 5) You have the following rights related to the health data we keep about you:
 - a) Right to inspect your health record and to receive a copy of your health record upon request. You may be charges copying fees.
 - b) Right to amend information in your health record you believe in inaccurate or incomplete,
 - c) Right to know to whom we have disclosed your health information.
 - d) Right to ask for limits on the health information data we give out about you.
 - e) Right to receive communication from us about your health information in alternative ways.
 - f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

X _____

Date: ____/____/____

Print Name Please

DOB: ____/____/____

Bend Naturopathic Clinic care is covered under many policies by medical insurance providers. Some insurance companies that cover services at BNC well are First Choice Health, EBMS, PacificSource, BCBS and MODA. Please call the number on the back of your insurance card and ask if your specific policy covers **Naturopathic** care. If your insurance company is one that Dr. Karli is not contracted with, you may want to ask about your “out of network” coverage. Often there is still some coverage available this way. Often in these instances a deductible has to be met.

As a courtesy we are happy to bill any insurance company on your behalf. If there is a dispute with your insurance, you will get more positive outcomes if you have called the company yourself to determine your coverage. Most calls are recorded and they will have record of benefits told to you.

If coverage is uncertain, we suggest paying for your services with a Visa, MasterCard, check or cash at the time of your visit. This allows us to provide a 30% discount for your office visit charges. We can then provide you with a superbill that you can submit to your insurance company for reimbursement. Please contact us if you have any questions at (541) 389-9750 or by email at info@bendnaturopath.com.

Signature _____ Date _____