bnc
bend naturopathic clinic

Dr. Azure Karli, N.D.
715 nw hill street
bend/oregon/97701
541/389/9750
541/389/2250 fx

New Patient Information Form

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. We do not bill OHP, Medicare, or Supplemental Medicare policies. 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 submitting the charges to your insurance company for reimbursement. A credit card convenience fee of 3% will be applied to all credit card transactions. This fee does not apply to other payment forms such as cash, debit card, or checks. Outstanding invoices over 30 days from receipt will be subject to a $10 or 2% monthly interest charge, whichever is greater.

Missed Appointments: A 24-hour cancellation policy is necessary, so that we may have the opportunity to accommodate other patients. We put aside an entire hour for first time patients and a half hour for returning patients to serve you in the best way possible. Because of this large allotted time for you, we require a credit card to have on file when making your first appointment. Late cancels (less than 24 hours) or no shows for new appointments will incur a $150 fee charged to the credit card on file. A $75 fee will be charged for missed/late cancel follow up appointments.

Late: If you are more than 10 minutes late, your appointment may be rescheduled and a missed appointment fee of $75 or $150 will be charged to your credit card depending on type of appointment.

Phone Calls: As a courtesy, I am happy to answer questions by phone at any time I am 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 most of your general health care needs including physical exams, pap smears, laboratory work, and others. Please note that we do not have a provider on call after hours. If you need a provider to be available 24 hours we suggest having a relationship with a primary care doctor that has on call hours.

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: _____
We only send patient information in an encrypted email. Any general correspondence will likely not be encrypted. Please keep this in mind when emailing us. We generally will respond faster with a phone call.

How did you hear about us: _____

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

Live with:
Spouse / Partner / Parents / Relatives / Friends / Child / 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 care that: _____

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		

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)_____

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?_____ If so, how much?_____

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?____

Women: Date of last menses_____Was it normal for you?_____Any bleeding between cycles?_____ Are you currently sexually active?_____If no, have you ever been?____Type of birth control?_____ 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: ____/____/_____

_____ DOB: ____/____/_____

Print Name Please

Bend Naturopathic Clinic care is covered under many policies by medical insurance providers. Please call the number on the back of your insurance card and ask if your specific policy covers **Naturopathic** care. A few of the insurance companies that often have coverage available are MODA, Blue Cross Blue Shield, Pacific Source, Providence, and First Choice Health.

As a courtesy we will be happy to bill any insurance company on your behalf. Please note that the information available to us by phone and online from your insurance company can at times be misleading or wrong. If there is a dispute with your insurance, we 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, debit card, check or cash at the time of your visit. This allows us to provide a 30% discount for your charges. We will charge a 3% fee if using a credit card. There is no extra fee for using cash, check or debit card. We can then provide you with a superbill that you can submit to your insurance company for reimbursement. *Pre-verification by you or our office does not guarantee payment by your insurance company. If denied you will be responsible for the full amount due.* Please contact us if you have any questions at (541) 389-9750 or by email at info@bendnaturopath.com.

Outstanding invoices over 30 days from receipt will be subject to a $10 or 2% monthly interest charge, whichever is greater. We require a credit card to have on file at the time of making your first appointment. A missed new patient appointment will incur a $150 fee and all other appointments will incur a $75 fee. An extra 3% will not be applied to these charges.

Signature_____Date_____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless.	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much.	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy.	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating.	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	☐ 0	☐ 1	☐ 2	☐ 3
2. Not being able to stop or control worrying.	☐ 0	☐ 1	☐ 2	☐ 3
3. Worrying too much about different things.	☐ 0	☐ 1	☐ 2	☐ 3
4. Trouble relaxing.	☐ 0	☐ 1	☐ 2	☐ 3
5. Being so restless that it's hard to sit still.	☐ 0	☐ 1	☐ 2	☐ 3
6. Becoming easily annoyed or irritable.	☐ 0	☐ 1	☐ 2	☐ 3
7. Feeling afraid as if something awful might happen.	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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