Alive & Well Healing Arts
Dr. Daivati Bharadvaj, Naturopathic Physician
1675 SW Marlow Ave #307, Portland OR 97225 503-484-8647 Fax: 503-530-8174

Patient Health History Questionnaire

Name: _____ Date: _____
Address: _____
City: _____ _____State: _____ Zip Code: _____
Phone (home, cell, work): _____ _____
Do we have your permission to leave confidential messages on your voicemail?:_____
E-mail: _____ _____Age: _____ Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____
Relationship of emergency contact person to you _____
If the patient is a minor (under the age of 18), please provide the name(s) and signature(s) of parent(s)/legal guardian(s):
_____
Name of Insurance Company _____ Policy ID #_____Group #_____
Occupation & employer: _____ _____
Employer's address _____Hours per week: _____
Live with: □ Spouse □ Partner □ Parents □ Children □ Friends □ Alone □ Other (pets, etc) _____
How did you hear about our clinic? _____
Who can we thank for referring you to us (name and phone number if applicable)?
_____
When was your last visit to a clinic or hospital? Why? _____
_____
What are your most important health concerns currently? _____
_____
_____
To what extent do these health issues interfere with your daily activities (work, sleep, eating, physical movement, etc)?
_____
Are there others in your family with the same or similar conditions? _____
What are your long-term health goals (physically, mentally, emotionally, spiritually)? _____
_____
_____
What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please circle):
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
What behaviors or lifestyle habits do you currently engage in regularly that you believe support and strengthen your health?
_____
_____
_____
What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?
_____
_____
_____
What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to therapy and guidance provided here? _____
_____
What do you believe to be the root cause(s) of your health condition(s)? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify having caused or aggravated your health problems?
_____
_____
Have you previously sought other forms of healthcare for your health problems (MD, DO, acupuncture, chiropractic, naturopathy, homeopathy, massage, etc)? _____
What hospitalization or surgeries have you had? When and why? _____
_____
_____
Do you have allergies to drugs, food, airborne (dust, mold, pollen), or other allergens? What happens when you have a reaction?_____

Family history:

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

alcoholism allergies anemia arthritis asthma cancer cataracts
diabetes epilepsy gallbladder disease glaucoma goiter hayfever/hives
heart disease high blood pressure HIV/AIDS kidney disease liver disease mental illness
stroke tuberculosis

Father's health status, age, (or cause/age of death):_____

Mother's health status, age, (or cause/age of death):_____

Siblings health status, age(s): _____

Childhood Health:

Please circle if you have/had any of the following conditions as a child/adolescent:

chicken pox diphtheria measles mumps pertussis rubella polio

Please list any vaccinations/immunizations you have had: _____

_____

Past medical history: Please circle any of the following conditions you have had **in the past**:

Appendicitis alcoholism arthritis anemia malaria epilepsy cancer
Tuberculosis diabetes heart disease high cholesterol mental illness pleurisy
Pneumonia sexually transmitted infections goiter low back pain rheumatic fever
Influenza mononucleiosis chronic viral infections chronic pain or fatigue eczema
Hepatitis others _____

Review of systems: Please circle any of the following issues or conditions that you **currently have**:

headaches/migraines head injury TMJ/jaw pain ringing in the ears dizziness earaches
ear infections impaired hearing goiter swollen lymph nodes or glands neck pain/stiffness
blurred visioneye strain cataracts glaucoma color-blindness prescriptive lenses
nasal congestion hayfever or allergies sinus infections loss of smell frequent colds
sore throats dental cavities vocal hoarseness gum disease coldsores
asthma cough shortness of breath coughing up blood or sputum difficulty breathing
chest pain heart palpitations blood clots murmur fainting high/low blood pressure
skin rashes itching acne hair loss eczema hives night sweats
joint pains muscle spasms arthritis muscle weakness sciatica fractures
diarrhea constipation ulcers jaundice heartburn gas/bloating hemorrhoids appetite changes
urinary incontinence kidney stones painful urination frequent urination discharge
anemia cold hands/feet easy bruising varicose veins intolerance to temperature extremes
seizures memory loss numbness/tingling anxiety depression mood swings
hernias prostate issues sexual difficulties breast tenderness or lumps menstrual pain PMS

MEDICATION/SUPPLEMENT LIST

Please list any current medications (prescriptive or over-the-counter), supplements, herbs, vitamins, birth control pills etc

Pharmacy name, phone number _____ *Drug allergies?* _____

Start date End date Medication name Dosage Frequency Adverse effects

Consent for Treatment

Naturopathic medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information. Any treatment or advice provided to me as a patient of Alive & Well Healing Arts, PC is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider. I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider. No physician, instructor, employee, or anyone else under the direction or control of Alive & Well Healing Arts, PC is recommending that I refrain from seeking or following the advice of another licensed health care provider. The treatment and therapies provided or recommended by this clinic may be different from those usually offered by another licensed health care provider. I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

_____

Signature of Patient Date

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: • Patient medical records
• Medical images • Live two-way audio and video • Output data from medical devices and sound and video files

Security Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits
• Improved access to medical care by enabling a patient to remain at a remote site
• More efficient medical evaluation and management
• Obtaining expertise of a distant specialist
• Maintaining patient safety during a pandemic or declared state/federal emergency

Possible Risks
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:
• In rare cases, information transmitted may not be sufficient (ie. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
• Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
• In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
• In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment. In the event that my telemedicine session is disrupted or distorted by technical failures, I would like to be contacted via telephone at: _____

By signing this form, I understand the following:
1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information according to the patient medical records policies set by the clinic.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
5. I understand that my telemedicine appointment may involve electronic communication of my personal medical information to other medical practitioners if a referral is warranted.
6. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have had with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured.
8. I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations.
9. I understand that there is a chance that my insurance (Cigna, American Specialty Health, or Healthnet) may not cover for our telemedicine (virtual) office visit, and I take full responsibility for any fees or balances due for our visit if my insurance does not offer coverage. If my telemedicine visits with you are denied coverage, I will discuss with you about time of service discounts or other reduced payment options, and set up a payment to you directly in a timely manner.
10. I understand that I need to be physically in Oregon during the entire duration of my telemedicine visit, and I will not be driving or performing any task that could jeopardize my safety during the visit.

By signing this form, I certify:
• That I have read or had this form read and/or had this form explained to me
• That I fully understand its contents, including the risks and benefits of telemedicine
• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
• I hereby authorize Dr. Daivati Bharadvaj and Alive & Well Healing Arts and medical staff to use telemedicine in the course of my diagnosis and treatment.

Patient Name: _____Signature: _____Date: _____

Alive & Well Healing Arts, PC ~ Daivati Bharadvaj, ND Naturopathic Physician
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Financial Policies

Health Insurance: I understand that if I have insurance which covers naturopathic medicine, my provider(s) can offer to bill services to my insurance company for reimbursement as a courtesy extended to me. I understand that it is my responsibility to **confirm my coverage** by calling my health insurance customer service representative **before my first appointment.** Except in the case of in-network coverage, I agree to accept full responsibility for all amounts not paid for by my insurance company and agree to pay the treating provider(s) for all services provided to me which the insurance company denies due to their usual and customary policy or for other reasons. I agree to pay the copay plus any costs for supplements, pharmacy, medicinary items, laboratory fees not covered by my insurance plan in full at the time of the visit. Payments for office visits, procedures, medicinary items, etc can be made using cash, check, Visa, or Mastercard.

Private Pay: If not covered by insurance**,** I agree to pay for any fees for services, costs of supplements and medicines, cost of laboratory tests, or other fees out of pocket **at the time of the visit**. It is my responsibility to ask about fees for services before or during my first appointment. I understand that the terms of this office are to pay the balance within 30 days of the most recent statement. Balances not paid within 30 days may be charged a rebilling fee. If a balance is not paid within 90 days, and my account is not sent to a collection agency, I understand that I am responsible for any additional collection and/or attorney fees related to my delinquency, and I hereby authorize my provider(s) to release information necessary to secure payment. Discounts and/or payment extension plans are only offered on an individual basis, based on financial need, and it is my responsibility to request any discounts. Payments for office visits, procedures, medicinary items, etc can be made using cash, check, Visa, or Mastercard.

Cancellation policy: **It is my responsibility to provide 24 hours notice by phone to cancel or change appointments, unless I have an emergency. I understand that I am responsible for paying the full amount for the missed appointment. This cancellation fee cannot be billed to my insurance, and is entirely my responsibility.**

Medicinary/pharmacy items: I understand that it is my full responsibility to pay for any medicines or pharmacy items that I choose to purchase at the time of the visit or at the time of pick up. I understand that items purchased **cannot be returned or refunded** unless the item is expired or defective. If I have an adverse reaction to, or simply cannot tolerate, a particular medicine recommended or prescribed to me, it is my responsibility to notify my provider(s) as soon as possible, so that the treatment can be re-evaluated.

Minors (patients under the age of 18): The minor patient's parent(s) or legal guardian(s) is/are fully responsible for payments of fees for services, costs of supplements and medicines, cost of laboratory tests, or other fees out of pocket at the time of the visit. All minors must be accompanied by their parent(s) or legal guardian(s) during the full office visit or appointment, unless otherwise agreed upon by the provider(s), the patient(s), and their parents/guardians.

I have read, and agree to, the above financial policies.

Patient Signature (or signature of parent or legal guardian)

_____Today's Date _____

Printed Name _____ Date of Birth _____

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HIPAA PATIENT CONSENT FORM

Effective September 1st, 2003

I, _____, consent to the use or disclosure of my protected health information by Daivati Bharadvaj, ND, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Alive & Well Healing Arts PC dba Daivati Bharadvaj, ND. I understand that diagnosis or treatment of me by Daivati Bharadvaj, ND, may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the health care operations of the practice. Daivati Bharadvaj, ND is not required to agree to the restrictions that I may request, however, if Daivati Bharadvaj, ND agrees to a restriction that I request, that restriction is binding.

"Protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Daivati Bharadvaj, ND's Notice of Privacy Practices prior to signing this document. Daivati Bharadvaj, ND's Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Alive & Well Healing Arts PC dba Daivati Bharadvaj, ND. The Notice of Privacy Practices also describes my rights and the duties of Daivati Bharadvaj, ND with respect to my protected health information.

Alive & Well Healing Arts PC dba Daivati Bharadvaj, ND reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the HIPAA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my time of my next appointment.

Daivati Bharadvaj, ND reserves the right to leave a message on the patient's home answering machine/recorder or private cell phone. As the patient, I consent to this right.

I understand that if I, the patient, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

_____ _____

Signature of Patient or Personal Representative Name of Patient/Personal Representative

_____ _____

Description of Personal Representative Date