cToday's date: ☐

PLEASE COMPLETE AND SIGN

New Patient ☐ Updated info:

ACCOUNT# PATIENT INFORMATION FCOF RCOF

Last name: First name: Middle Initial: Marital status: Single ☐ Mar ☐ Partner ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? Social Security no.: Birth date: Age: Sex: ☐ M ☐ F

Street address (Mailing address for statements) City: State: Zip:

Email address: Evening phone no: ( )

Prefer to receive messages or coupons: Day# ☐ Evening# ☐ Email ☐ None ☐

Employer Daytime phone no.: ( )

Chose clinic because/referred to clinic by: ☐ Location ☐ Family ☐ Friend ☐ Insurance plan ☐ Physician ☐ Seminar or event ☐ Dex Yellow Pages ☐Verizon Super pages ☐ Redirect guide ☐ Other

NAME OF PERSON WHO REFERRED YOU (if applicable):

We may require a credit card on file to receive discounted rates. Please include:

Credit card type: *Credit card number:* *Expiration:*

3-digit verification code:

PRIVATE HEALTH INSURANCE INFORMATION

(**Please give your insurance card to the receptionist**.)

Name of primary insurance: Address: City: State: ZIP Code:

Name of secondary insurance:

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-pay/insurance:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IF YOU HAVE A SECONDARY INSURANCE YOU WOULD LIKE US TO BILL PLEASE NOTIFY THE RECEPTIONIST.

MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INSURANCE INFORMATION

☐Work comp ☐ MVA (Please give your insurance card to the receptionist.)

Name of insurance plan: Address: City: State: ZIP Code:

Claim representative's name: Phone no.: ( ) Attorney's name: Phone no.: ( )

Date of injury: Claim number: Injured body part:

Employer at time of injury name:

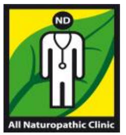
IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Phone no.: ( )

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance per the credit policies of the All Naturopathic Clinic. I also authorize the All Naturopathic Clinic or insurance company to release any information required to process my claims.

Patient or Guardian signature: Date:



Are you currently under the care of a medical professional? Yes No

If yes, please list the name of the facility and physician:

____

Date of last physical/annual exam_____________ **Date of last blood test** ________________________

Any ongoing diagnoses or abnormal lab values?

____

What are your most important health concerns?

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

Any past hospitalizations, serious illness and/or injuries?

____

____

Review of Systems:

Please list any symptoms you are currently experiencing in the following areas

Severity of current complaint(s) (0-best, 10-worst):

	Symptoms	Severity		Symptoms	Severity
Head:			Blood/Peripheral Vascular:		
Ears:			Gastrointestinal:		
Eyes:			Genito-Urinary:		
Nose:			Endocrine:		
Throat:			Neurological:		
Respiratory:			Musculo-Skeletal		
Mood/Psych:			Skin:		
Cardiovascular:			Other:		

Last menstrual period (♀): ________________________________

Social History:

Please circle those that apply: Single Married Significant Other

Do you have any children? Yes No Year(s) of their births? ______________________________

Occupation: ____

Prescriptions currently taking	Dosage	Supplements currently taking	Dosage

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola Alcohol Recreational drugs

Average Daily Diet:

Morning: ____

Afternoon: ____

Evening: ____

Snacks:______________________________Beverages:______________________________

Do you exercise regularly □ Yes □ No

If yes, what type? ____________________________________

How long? ________________ How often? ______________________________

Any known allergies? Drugs: ________________________

Inhalants: ____________________________ Food:__________________________

Family History: Please check the "yes" box next to each condition that **applies to you or a family member**. Note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	Yes	Relationship	Dates Resolved Past(P)Current (C)		Yes	Relationship	Dates Resolved Past(P)Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression/ Anxiety				Stroke			
Diabetes				Tuberculosis			
Eczema				Auto Immune Disease			
Epilepsy				Thyroid Disorder			

Dr. Kacy Borba, ND, LAc, LMT
917.258.1853
kacyborba@gmail.com

Informed Consent and Request for Naturopathic Medical Care, Classical Chinese Medicine Treatment and Acupuncture

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As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Kacy Borba, ND, LAc, LMT, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, ________________________, hereby request and consent to examination and treatment with Naturopathic Medicine, Classical Chinese Medicine (CCM), and Acupuncture with Dr. Kacy Borba, ND, LAc, LMT and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called *allied health care provider*.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Kacy Borba, ND, LAc, LMT, and/ or with the *allied health care provider* providing backup:
(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:
▪Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and Neurological assessments)
▪Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory
▪evaluation of blood, urine, stool and saliva)
▪Soft tissue and osseous manipulation (including therapeutic and deep tissue massage, shiatsu, neuro muscular technique, naturopathic/osseous manipulation of the spine and extremities, massage to relieve muscular discomfort associated with pregnancy, muscle energy technique and cranio-sacral therapy)
▪Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
▪Trigger point injection therapy with vitamin substances
▪Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, And animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
▪Homeopathic remedies (highly diluted quantities of naturally occurring substances)
▪Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
▪Counseling (including but not limited to visualization for improved lifestyle strategies)
▪Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

The scope of practice of acupuncture is outlined below. I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Tuina (ancient Chinese massage)
- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.
Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.
Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.
Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Dr. Kacy Borba, ND, LAc, LMT, of these conditions.

Please **INITIAL** the following:
________I understand that Dr. Kacy Borba ND, LAc, LMT is not licensed to prescribe any controlled substances.
________ I understand that Dr. Kacy Borba, ND, LAc, LMT, will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.
________I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.
_______ I understand that Dr. Kacy Borba, ND, LAc, LMT is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Kacy Borba, ND, LAc, LMT, and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request Dr. Kacy Borba, ND, LAc, LMT to explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

Terms of Admission

Financial Terms: I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than me, is not authorized to receive my medical information unless expressly authorized by me in writing.

Notice of Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. The All Naturopathic Clinic is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully.

Cancellations and No Show: Please notify us if you are unable to make your appointment or make any changes within 24 hours of your appointment to avoid a late fee of **$20.**

X ______________________________________ ____________________

Patient Signature Date

X ______________________________________ ____________________

Guardian/Representative's Signature Date

X ______________________________________ ____________________

Relationship to Patient/Representative Authority Date