



# Salem Naturopathic Clinic, P.C.

1305 Broadway Street NE • Salem, OR 97301 • ph. 503 364-1441 • fax 503 364-9924

## Workers' Compensation Intake Form

### Patient Information:

Today's Date: \_\_/\_\_/\_\_\_\_

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_

*(Current patients of Salem Naturopathic Clinic may skip ahead to Insurance Claim Information unless there have been changes to the following demographic information)*

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone- (Cell): \_\_\_\_\_ (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

Email: \_\_\_\_\_

Would you like to receive appointment reminders by text and/or email? Text: \_\_\_ Email: \_\_\_ No Reminders: \_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relation to You: \_\_\_\_\_ May we discuss billing and/or treatment with this person? Yes: \_\_\_ No: \_\_\_

Name of Primary Care Provider: \_\_\_\_\_

May we update your Primary Care Provider regarding your treatment in our office? Yes: \_\_\_ No: \_\_\_

Whom may we thank for your referral today? \_\_\_\_\_

### Insurance Claim Information:

Date of Accident: \_\_/\_\_/\_\_\_\_

Time of Accident: \_\_\_\_\_ AM: \_\_\_ PM: \_\_\_

In which state did the accident occur? \_\_\_\_\_

Your Employer's Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Insurance Company Phone #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Claim Adjuster's Name: \_\_\_\_\_

Claim Adjuster's Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Have you retained an attorney? Yes: \_\_\_ No: \_\_\_

Attorney's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have you been seen by another naturopathic physician, chiropractor or physician assistant for this injury?

No: \_\_\_ Yes: \_\_\_ ; If Yes, Date(s) of those visits: \_\_\_\_\_

*(In Oregon, Workers' Compensation patients can be seen by a naturopathic physician, chiropractor and/or a physician's assistant for only 60 consecutive days or 18 visits. After this, you may be personally financially responsible.)*

### Accident History:

Please describe the accident in your own words:

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### Home Care Remedies Since Injury:

Rest: \_\_\_\_\_ Details: \_\_\_\_\_

Ice/Heat: \_\_\_\_\_ Details: \_\_\_\_\_



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Exercise: \_\_\_\_\_ Details: \_\_\_\_\_  
Medication: \_\_\_\_\_ Details: \_\_\_\_\_  
Other: \_\_\_\_\_ Details: \_\_\_\_\_

**Did you experience a flash of light or a feeling of explosion in your head?** Yes: \_\_\_ No: \_\_\_  
**Immediately after the accident, did you become:** Confused: \_\_\_ Disoriented: \_\_\_ Dizzy: \_\_\_ Light Headed: \_\_\_  
Nauseous: \_\_\_ Blurred Vision: \_\_\_ Ears Ringing: \_\_\_ Other: \_\_\_\_\_

**How long did the symptom(s) last?** \_\_\_\_\_

**Did you lose consciousness?** Yes: \_\_\_ No: \_\_\_ **Was your head injured?** Yes: \_\_\_ No: \_\_\_

**What was the position of your head at the time of the accident?** \_\_\_\_\_

**Immediately after the accident, did you experience:**

Headache: \_\_\_ Neck Pain: \_\_\_ Low Back Pain: \_\_\_ Other: \_\_\_\_\_

**Did you go to a hospital after the accident?** No: \_\_\_ Yes: \_\_\_ If yes, name? \_\_\_\_\_

**How did you get to the hospital?** \_\_\_\_\_

**Treatment received at the hospital:** \_\_\_\_\_

**Were any of the following tests performed at the hospital?** X-Ray: \_\_\_ MRI: \_\_\_ CT Scan: \_\_\_ Lab Work: \_\_\_

**Have you had any of the following symptoms since your injury?**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Hip Pain (R/L)      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Concentration Difficulty    |
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Leg Pain (R/L)      | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Memory Difficulty           |
| <input type="checkbox"/> Neck Stiffness       | <input type="checkbox"/> Knee Pain (R/L)     | <input type="checkbox"/> Depression             | <input type="checkbox"/> Intolerance to Cold         |
| <input type="checkbox"/> Mid-back Pain        | <input type="checkbox"/> Ankle Pain (R/L)    | <input type="checkbox"/> Lights Bother Eyes     | <input type="checkbox"/> Sexual Dysfunction          |
| <input type="checkbox"/> Low-back Pain        | <input type="checkbox"/> Foot Pain (R/L)     | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Personality Changes         |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Shoulder Pain (R/L) | <input type="checkbox"/> Difficulty Swallowing  | <input type="checkbox"/> Pins and Needles in Arm     |
| <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Arm Pain (R/L)      | <input type="checkbox"/> Intolerance to Alcohol | <input type="checkbox"/> Pins and Needles in Leg     |
| <input type="checkbox"/> Jaw Clicking         | <input type="checkbox"/> Elbow Pain (R/L)    | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Personality Changes         |
| <input type="checkbox"/> Ears Ring            | <input type="checkbox"/> Wrist Pain (R/L)    | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Relationship Difficulty     |
| <input type="checkbox"/> Restlessness         | <input type="checkbox"/> Hand Pain (R/L)     | <input type="checkbox"/> Irritable              | <input type="checkbox"/> No longer care about things |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Difficulty Thinking    | <input type="checkbox"/> Heavy Head                  |
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Forget ATM/Phone #s | <input type="checkbox"/> Writing Problems       | <input type="checkbox"/> Chest Pain                  |
| <input type="checkbox"/> Fluid in Ears        | <input type="checkbox"/> Loss of Attention   | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Blurred Vision              |
| <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Cold Hands/Feet     | <input type="checkbox"/> Sciatica               | <input type="checkbox"/> Reading Problems            |
| <input type="checkbox"/> Regional Swelling    | <input type="checkbox"/> Uncoordinated       | <input type="checkbox"/> Loss of Balance        | <input type="checkbox"/> Urinary Difficulties        |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Loss of Smell       | <input type="checkbox"/> Loss of Taste          | <input type="checkbox"/> Constipation                |
| <input type="checkbox"/> Emotional Difficulty | <input type="checkbox"/> Intolerance to Heat | <input type="checkbox"/> Upset Stomach          | <input type="checkbox"/> (Other: _____)              |

**When did the symptoms first appear?** \_\_\_\_\_

**Which of the symptoms were present and active within one year prior to the accident?**

**Have you ever received a concussion prior to the accident?** Yes: \_\_\_ No: \_\_\_

**Any previous work accidents?** No: \_\_\_ Yes: \_\_\_ If yes please, when/describe: \_\_\_\_\_

**Please list any medication or supplements you are currently taking (please include dosage):**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

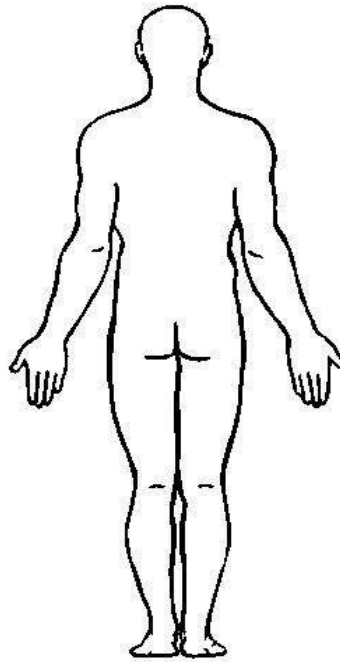
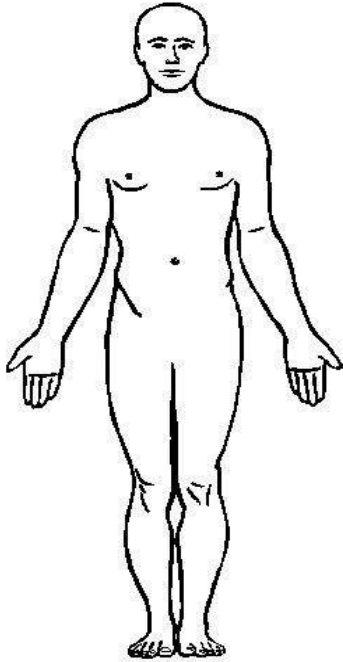
**Please indicate on the body diagram where you are experiencing symptoms:**

X= Sore N= Numbness B= Burning S= Sharp Pain T= Tingling D= Dull Ache



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**Please describe anything else you would like to discuss:**

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**I hereby attest that the above information is true and correct to the best of my knowledge.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name & Legal Guardian (if applicable)

\_\_\_\_\_  
Relationship to Patient

## Financial Policy



## Salem Naturopathic Clinic, P.C.

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Thank you for choosing us as your healthcare provider. We are committed to providing you with quality care. We are sure you understand that payment for this service is your responsibility. This policy outlines your financial responsibilities related to payment for professional services. Please read it and ask us any questions you may have. When completed, please sign in the space provided. A copy will be provided to you upon request.

**Insurance.** We can bill most insurance plans, however are not a contracted Medicare provider and we may not be in-network with your insurance company. We will bill your primary insurance and, if applicable, a secondary insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We will obtain a copy of your photo I.D. and valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges. If you do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may not be covered. You must pay for these services in full at the time of visit or after your insurance has denied them.
4. **Claims submission.** We will submit your claims to assist with payment. Please be aware that your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Claim Payment.** If your insurance company does not pay within a reasonable time period of 90 days, you may be billed. If we later receive payment from your insurer, we will refund any overpayment to you.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Failure to provide new insurance information at the time of your appointment may result in payment responsibility to fall to you.

**Non-Insurance/Self-Pay.** If you do not have insurance or have insurance that does not provide payment for our services, you will be considered a self-pay patient and payment in full is expected at each visit.

**Lab Services.** We can obtain and process a specimen here in our office and send it to our third-party laboratory for analysis for your convenience. If you wish to go elsewhere, we can provide you with a lab order to take to a lab better covered by your insurance or more convenient for you.

**Supplements.** Many supplements are available for purchase at Salem Naturopathic Clinic. We do not bill insurance for supplements. Payment for supplements must be made in full at the time of purchase.



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**Non-Sufficient Funds.** If you present a check for payment to Salem Naturopathic Clinic and it is not honored by your bank, a \$25 Non-Sufficient Funds charge will be added to your account per occurrence.

**Medical Record Copies.** Salem Naturopathic Clinic charges \$25 per request to copy your medical records for you. (This fee does not apply to records requests from other providers). You must complete a Medical Records Request Form and pay the copying fee prior to our releasing records to you.

**Cancellation and Missed Appointment Policy.** As a courtesy, we request that you provide us with 24 hours notice if you must cancel or reschedule an appointment. After the second consecutive cancelled or rescheduled appointment with less than 24 hours notice, a \$50 late cancellation fee will be added to your account. Payment of the late cancellation fee must be made prior to scheduling your next visit. After a third missed appointment without advanced notice, you may be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment or providing at least 24 hours notice in the event you must cancel or reschedule.

**Nonpayment.** If you are a self-pay patient and your account is over 90 days past due OR if you are billing insurance and your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing service. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice. In addition, if your bill is dismissed by a court as part of your bankruptcy, you and your immediate family members will be discharged from this practice. If you are dismissed from this practice, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician(s) will only be able to treat you on an emergency basis.

*Thank you for understanding our Payment Policy. Please let us know if you have any questions.*

**I have read and understand the Payment Policy and agree to abide by its guidelines:**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name & Legal Guardian (if applicable)

\_\_\_\_\_  
Relationship to Patient



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### Workers' Compensation Financial Policy

This Workers' Compensation Financial Policy outlines financial terms and conditions specifically related to payment for the treatment of your work-related injury. All other terms and conditions of our general Financial Policy, which you also signed, will apply.

- We will file your Workers' Compensation claim with your employer's Workers' Compensation insurance carrier. You must provide us with the information needed in order to file the claim by completing the attached Intake Form and an 801 Form.
- Please be aware that under Workers' Compensation Insurance in Oregon, you can be treated by any naturopathic physician, chiropractor and/or physician's assistant for 60 consecutive days from the first visit or 18 visits. If you have already seen another naturopathic physician, chiropractor and/or physician's assistant, those prior visits count towards the 60 day/18 visit limit. If you have exhausted the 60 day/18 visit limit we cannot bill further services to your Workers' Compensation Insurance.
- You should verify that your employer's Workers' Compensation Insurance carrier will allow you to be treated by us (SAIF, CCMSI and Sedgewick, for example, may not).
- In the event that your claims are denied by your employer's Workers' Compensation insurance carrier, any balance on your account becomes due in full within 30 days.
- In the event that your claims are denied by your employer's Workers' Compensation carrier, we **may** be able to file your claim with your personal health insurance carrier. Though we may attempt to bill your personal health insurance carrier, there is no guarantee that they will pay the claim.
- We will not accept an attorney's 'letter of protection' for claims being disputed or in litigation. Payment will be collected at time of service in these cases.
- Missed appointment fees cannot be billed to your employer's Workers' Compensation insurance carrier. You will be personally responsible for paying these fees. Please see general Financial Policy for full details.

*Regardless of the outcome of your Workers' Compensation claim against an insurance company or litigation you might pursue related to your Workers' Compensation claim, you are ultimately personally responsible for payment of any services provided by Salem Naturopathic Clinic, PC. Please see our general Financial Policy for payment terms.*

**I have read and understand the Workers' Compensation Financial Policy and agree to abide by its guidelines:**

\_\_\_\_\_  
Patient name (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient



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### Workers' Compensation Financial Policy (Cont.)

*In the event that my Workers' Compensation claim is denied or my benefits exhausted, my preference would be the following (please select one):*

<input type="checkbox"/>	I would like Salem Naturopathic Clinic to attempt to bill my personal health insurance for this claim. My insurance information is:  Insurance Carrier: _____  Policy Number: _____ Group Number: _____  Mailing Address for Claims: _____  Name of Insured: _____ Date of Birth of Insured: _____  Relationship to Insured: _____
<input type="checkbox"/>	I would <b>NOT</b> like Salem Naturopathic Clinic to attempt to bill my personal health insurance for this claim.
<input type="checkbox"/>	I would like to decide this later. I will contact Salem Naturopathic Clinic prior to my claim being denied.



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I have been given the opportunity to read and review a copy of Salem Naturopathic Clinic, P.C. 's Privacy Practices. I have had all questions regarding these procedures answered to my satisfaction. These policies are in accordance with the most current HIPAA guidelines in my State.

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Guardian (if applicable)





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### Informed Consent to Naturopathic Medical Care

I hereby request and consent to the performance of evaluation and management services as well as other procedures by my doctor at the Salem Naturopathic Clinic, PC. I understand that I have the right to ask questions and discuss to my satisfaction with Dr. \_\_\_\_\_ the nature and purpose of naturopathic medical evaluation and treatment and other procedures which my naturopathic physician may administer.

I understand and am informed that:

1. Naturopathic Medicine is the science, philosophy and art of identifying and treating diseases, dysfunctions, disorders and imbalances of normal human physiologic function. There has been no promise implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic.
2. As with any practice of medicine, it is not an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.
3. I understand that my physician may administer manual therapy using his/her hands. I understand that my physician may use manipulation of joints, tendons, muscles and connective tissue in the body to restore motion / mobility. He or she will use his hands or a mechanical device upon my body to adjust a joint which may cause an audible "pop" or "click."
4. It is not reasonable to expect my physician to be able to anticipate, or explain, all possible risks and complications of a given procedure on any particular visit and I wish to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest.
5. An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. I agree to communicate any such information to my physician in a timely manner so that changes in my treatment plan, if any, can be made.
6. As with any healthcare procedure, there are certain complications which may arise during any given medical procedure. Those complications from manipulation include sprains/strains, dislocations, fractures, disc injuries, or cerebral-vascular accidents. Complications from injections may include pain at site of injection/infusion, allergy to injectant resulting in anaphylaxis, which may be fatal; light-headedness and weakness after injection. These complications are extremely rare occurrences.
7. There may be significant medical differences of opinion/controversies regarding some of the therapies offered at Salem Naturopathic Clinic. Some therapies may not be approved by the Food and Drug Administration (FDA) or may not be approved to treat your symptoms ('off-label use'). The diagnosis and treatment received at Salem Naturopathic Clinic may be considered non-conventional, complementary or alternative.

I have read the above consent, or had it read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided and consent to naturopathic medical evaluation, treatment and management on that basis.

Signed by:

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient's Name & Legal Guardian (if applicable)

\_\_\_\_\_  
Date