A WellSpring of Natural Health, PC

Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Injury-Related Case

___ Mitchell Bebel Stargrove, ND, LAc ___ Lori Beth Stargrove, ND ___ Sara Snyder, LAc

Name (Patient) _____ Date of first visit _____

Address _____

City _____ State _____ Zip code _____

Telephone # (home) _____ (work / cell) _____

Email address _____

Gender identity: _____ Age _____ Date of Birth _____

Relationship status: Married ___ Separated ___ Divorced ___ Widowed ___ Single ___ Partnership ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___ Community ___

Occupation _____ Hours per week _____ Retired _____

Employer _____

Work address _____

Who referred you to WellSpring? _____

Next of kin or other to reach in an emergency _____

Relationship _____ Phone _____

Address _____

****** **MOTOR VEHICLE ACCIDENTS / WORKERS COMPENSATION CASES** ******

Claim # _____ Date of Accident / Loss _____

Claim Representative _____ Phone # _____

Name and Address of Company representing your claim: _____

_____

[WC] Employer at the time of injury _____

Other providers who have treated this injury _____

A WellSpring of Natural Health, P.C.
4720 SW Watson Avenue, Beaverton, OR 97005
P: 503.526.0397 F: 503.643.4633 wellspringofhealth.com

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Motor Vehicle Accident (MVA) History

INSTRUCTIONS: Please answer the following questions as specifically and completely as possible. The more information you give us, the better we can understand the details of your accident. Feel free to continue on the back of this page if you need more room.

Date of MVA: _____ Time of accident _____a.m. / p.m.

Type of vehicle you were in: _____

Were you the: ___ driver ___ passenger ?

Were you wearing a seatbelt? ___ yes, lap belt only
___ yes, shoulder harness and lap belt
___ no seat belt

Were there any other passengers? Yes ____ No ____ If yes, how many? _____

Who? _____

Where were they sitting? _____

Street you were driving on: _____

Direction traveling (N, S, E, W, etc.) _____

Lane you were in (right, left, middle): _____

Approximate speed: _____

Please describe the activity at impact (slowing down, turning right, stopped, etc.) _____

_____

_____

_____

_____

_____

_____

Were you anticipating the impending impact? Yes ____ No ____

If yes, how did you react? _____

Position of your head at impact (looking up/down, etc.) _____

Position of arms/hands at impact (on steering wheel, gear shift, etc.) _____

_____

_____

_____

Visibility at time of accident: Dark/Night ___ Daylight ___ Dusk ___ Foggy ___

Weather (rain, clear, snow, etc.): _____

_____

Condition of pavement (wet, icy, etc.): _____

_____

Other vehicles involved in accident (include year, make, model): _____

_____

Direction it was traveling (N, S, E, W, etc.) _____

Please describe the collision: _____

_____

_____

_____

Where did your car end up? _____

_____

_____

Was there a second impact? Yes ____ No ____ Please describe: _____

_____

_____

_____

Did any part of you suffer impact inside the vehicle? Yes ____ No ____ Please describe: _____

_____

_____

Did you have any immediate symptoms? Yes ____ No ____ Please describe: _____

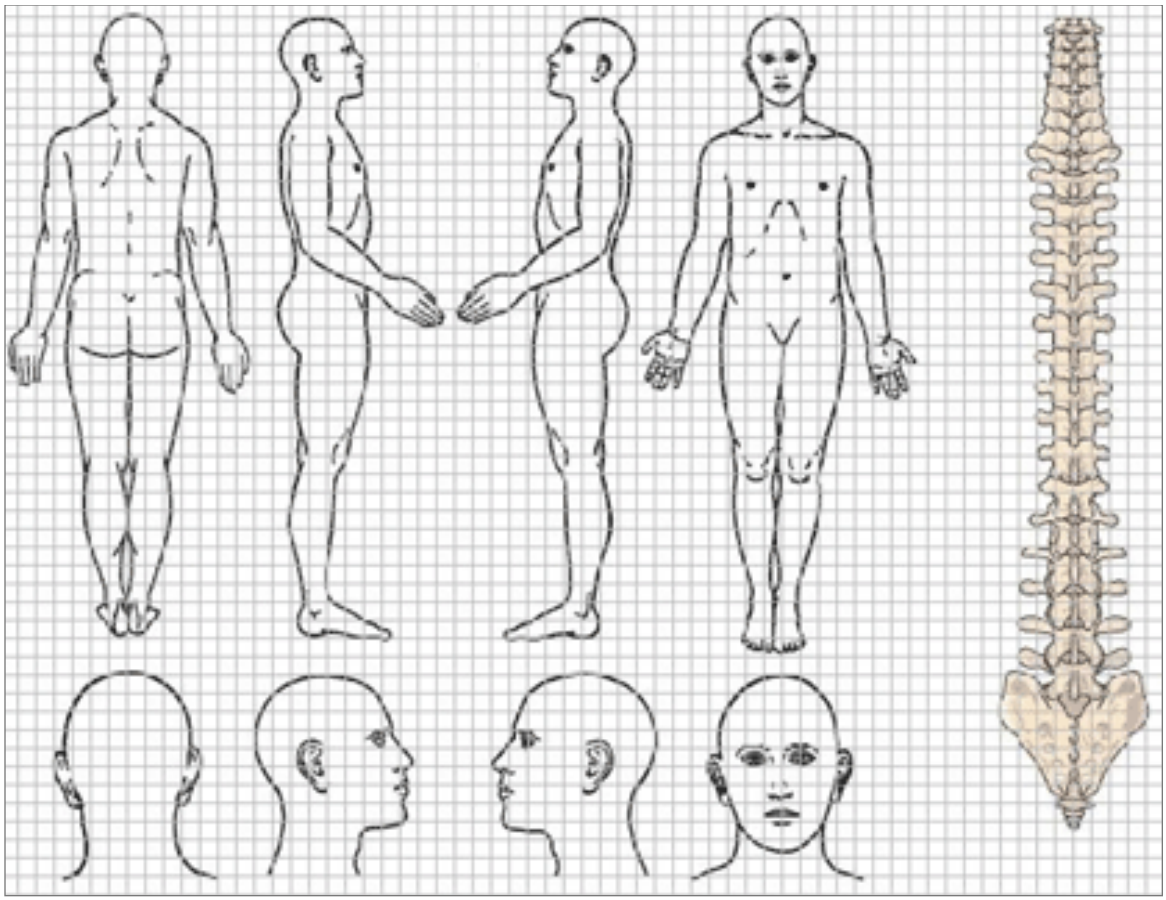
_____

_____

Please use these drawings to indicate the areas and quality of your symptoms:

SS = Cramps/Spasms /// = Stabbing Sensations X = Burning Sensation

OOO = Stiffness VVV = Pins and Needles ## = Dull Aching N = Numbness



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Health History Questionnaire

Safe, effective and individualized medical treatment and health care requires your clinician to understand you as a whole person in your real life context. Please complete this questionnaire as thoroughly as possible. Print all information, and mark anything you don't understand with a question mark.

Are you currently receiving medical treatment? Yes ____ No ____

If yes, where and from whom? _____

_____

_____

If no, when and where did you last receive medical treatment or health care?_____

_____

_____

What was the reason? Did your condition resolve or is it ongoing? _____

_____

_____

What are your injury-related medical concerns? List in order of importance.

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

How has this injury affected your life? _____

_____

_____

_____

_____

_____

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Family and Personal Medical History

☐ Check if adopted

	MOTHER			FATHER			
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Siblings
Age (if living)							
Health (**R**obust, **C**ompromised, **M**ixed)							
Age at death (if deceased)							

Check (√) those applicable

Cancer							
Diabetes /hypoglycemia							
Heart disease							
High blood pressure							
Stroke							
Epilepsy							
Depression/anxiety							
Asthma/hayfever/hives							
Obesity							
Kidney disease							
Tuberculosis							

Hospitalization and Surgery

What hospitalizations or surgeries have you had (when)?

For the Following, Please Circle:

Y = Yes **N** = No

Childhood Illnesses

Scarlet fever	Y N	Chicken pox	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

Immunizations

Diphtheria/Tetanus/Pertussis (DTaP)	Y N	Hepatitis A	Y N
Tetanus (alone)	Y N	Hepatitis B	Y N

X-Rays, Imaging and Special Studies

X-rays, CAT scans, or other imaging or lab studies:

MRI	Y N	Electrocardiogram/EKG	Y N
CT/CAT scan	Y N	Electroencephalogram? EEG	Y N

Family History

Have you used or been prescribed any of the following?

Pain relievers	Y N	Anti-inflammatories	Y N	Anxiety medication	Y N
Steroid	Y N	Sleeping aid	Y N	Antidepressant	Y N

Please list any prescription medications, over-the-counter medications, nutrients, herbs or other supplements you are *currently* taking.

Medicines (Drug, vitamin, nutrient, herb, etc.)	How much? How often?	Prescribed by?	Since when?	Take regularly? Y/N

General History

Weight _____ lb.. Height _____ ABO Blood Type _____

What time of the day is your energy the highest? _____ Lowest? _____

Review of Systems

For the Following, Please Circle:

Y = Condition you have now **N** = Never **P** = Previous condition

Relationships

Adoption	Y N	Divorce (Parental)	Y N
Birth trauma	Y N	Sexual abuse	Y N
Familial alcoholism/addiction	Y N	Violence in family of origin	Y N

Emotional

Treated for emotional problems	Y P N	Depression	Y P N
Mood swings	Y P N	Anxiety or nervousness	Y P N
Considered/attempted suicide	Y P N	Tension	Y P N

Hormones/Endocrine

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Hypoglycemia	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N	Seasonal depression	Y P N
Adrenal stress	Y P N	Night sweats	Y P N

Brain/Neurologic

Seizures	Y P N	Paralysis	Y P N
Muscle weakness	Y P N	Numbness or tingling	Y P N
Loss of memory	Y P N	Easily stressed	Y P N
Vertigo or dizziness	Y P N	Loss of balance	Y P N
Hypersensitivity	Y P N	Concussion	Y P N

Skin/Hair

Rashes	Y P N	Eczema, hives	Y P N
Acne, Boils	Y P N	Itching	Y P N
Color Change	Y P N	Perpetual hair loss or thinning	Y P N
Lumps	Y P N	Use hair dye	Y P N

Head

Headaches	Y P N	Head injury	Y P N
Migraines	Y P N	Jaw/TMJ problems	Y P N

Eyes

Spots in vision	Y P N	Eye pain/strain	Y P N
Impaired or blurry vision	Y P N	Glasses or contacts	Y P N
Tearing or dryness	Y P N	Glaucoma	Y P N
Color blindness	Y P N	Macular degeneration	Y P N
Double vision	Y P N	Cataracts	Y P N

Ears/Hearing

Impaired hearing	Y P N	Ringing/tinnitus	Y P N
Earaches	Y P N	Dizziness	Y P N

Nose and Sinuses

Hayfever	Y P N	Nose Bleeds	Y P N
Stuffiness	Y P N	Frequent colds	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

Musculoskeletal

Neck pain or stiffness	Y P N	Bursitis	Y P N
Mid-back pain or stiffness	Y P N	Arthritis	Y P N
Low back/hip pain or stiffness	Y P N	Fibromyalgia	Y P N
Sciatica	Y P N	Broken bones	Y P N
Foot/ankle pain or stiffness	Y P N	Muscle spasms or cramps	Y P N
Knee pain or stiffness	Y P N	Tendonitis	Y P N

Mouth and Throat

Frequent sore throat	Y P N	Copious saliva	Y P N
Teeth grinding	Y P N	Sore tongue/lips	Y P N
Gum problems	Y P N	Hoarseness	Y P N
Dental cavities	Y P N	Jaw clicking	Y P N

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

Respiratory

Cough	Y P N	Chronic phlegm	Y P N
Croup	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N
Pneumonia	Y P N	Pleurisy	Y P N
Emphysema	Y P N	Difficulty breathing	Y P N
Pain on breathing	Y P N	Shortness of breath	Y P N
Spitting up blood	Y P N	Shortness of breath on exertion	Y P N
Tuberculosis	Y P N	Shortness of breath at night	Y P N

Cardiovascular/Heart

Heart disease	Y P N	Angina	Y P N
High/low blood pressure	Y P N	Murmurs	Y P N
Blood clots	Y P N	Fainting	Y P N
Phlebitis	Y P N	Palpations/Fluttering	Y P N
Rheumatic Fever	Y P N	Chest pain	Y P N
Swelling in ankles	Y P N	Cold hands and/or feet	Y P N

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y P N	Anemia	Y P N
Deep leg pain?	Y P N	Cold hands/feet	Y P N
Varicose veins?	Y P N	Thrombophlebitis	Y P N

Immune/Lymphatic

Vaccinations	Y P N	Chronically swollen glands	Y P N
Chronic Fatigue Syndrome	Y P N	Chronic infections	Y P N
Reactions to vaccinations	Y P N	Slow wound healing	Y P N

Gastrointestinal/Digestive

Trouble swallowing	Y P N	Heartburn/Reflux/GERD	Y P N
Change in thirst	Y P N	Hiatal hernia	Y P N
Nausea	Y P N	Vomiting	Y P N
Ulcer	Y P N	Bowel movements How often? _____	
Blood in stool	Y P N	Is this a change? _____	
Black stools	Y P N	Urgency?	Y P N
Belching or passing gas	Y P N	Constipation	Y P N
Abdominal pain or cramps	Y P N	Diarrhea/Loose stools	Y P N
Jaundice	Y P N	Gall bladder problems	Y P N
Liver disease	Y P N	Hemorrhoids	Y P N
Gluten intolerance	Y P N	Changes in digestive health since injury?	Y P N

Urinary

Pain on urination	Y P N	Increased frequency	Y P N
Frequency at night	Y P N	Incontinence	Y P N
Frequent infections	Y P N	Kidney stones	Y P N

Male Sexual/Reproduction

Hernias	Y P N	Sexual orientation: _____	
Testicular pain	Y P N	Impotence	Y P N
Testicular masses	Y P N	Prostate disease	Y P N
Are you sexually active?	Y P N	Reduced libido	Y P N

Female Sexual/Reproduction/Breasts

Age of first menses _____		Sexual orientation: _____	
Date of last menses _____		Pain during intercourse	Y P N
Length of menstrual cycle _____ days		Are cycles regular?	Y P N
Duration of menses _____ days		Bleeding between periods?	Y P N
Painful menses	Y P N	Clotting	Y P N
Heavy or excessive flow	Y P N	Discharge	Y P N
PMS	Y P N	Birth control	Y P N
If yes, what are your symptoms _____		What type? _____	
_____		Number of pregnancies _____	
Difficulty conceiving	Y P N	Number of live births _____	
Breast pain/tenderness/lumps	Y P N	Menopausal symptoms	Y P N

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Habits and Life Situation

Main interests and hobbies?_____

Do you exercise? Yes ____ No ____ If yes, what kind?_____

_____ How often? _____

Eat three meals a day?	Y N	Drink cola or other soft drinks?	Y N
Do you eat out often?	Y N	Sleep well?	Y N
Do you go on diets often?	Y N	Average 6-8 hrs. sleep?	Y N
Cook meals at home?	Y N	Awaken rested?	Y N
Drink coffee?	Y N	Spend time outside?	Y N

How do the injuries related to this accident affect you?_____

_____

_____

_____

_____

What do you feel needs to happen for you to get better?_____

_____

_____

Is there any information about your health or life situation you would like to add?

_____

_____

_____

_____

_____

Welcome to WellSpring! We are glad to serve you.

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Patient-Clinician Relationship Acknowledgement

The undersigned patient ("Patient") understands and agrees that Patient is retaining the services of a **clinician** ("Clinician") at A WellSpring of Natural Health, P.C. ("WellSpring") **as an independent health care and medical practitioner**.

Patient recognizes, understands and agrees that the **Clinician they are working with is a sole practitioner** and is not a partner or otherwise affiliated with any other Clinician who may be providing similar services at WellSpring.

Patient further recognizes, understands and agrees that the clinician they are seeing is solely responsible for and shall provide all professional services to Patient and that Patient is relying solely on the skill of the Clinician they have engaged for the professional services rendered at WellSpring. The Patient is free to receive medical treatment and health care services from any other clinicians(s) of their choice. This agreement is not intended to restrict the Patient from receiving medical treatment or healthcare services from other clinicians at this clinic or anywhere else.

Patient further recognizes that their Clinician may prescribe medication(s), which may be purchased from a seller of the patient's choice.

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name _____ Date _____

Signature (or Signature of Parent/Legal Guardian) _____

Print Your Clinician's name (here at WellSpring) _____

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Informed Consent for Treatment

I, _____, hereby request and consent to receive naturopathic, acupuncture and/or Chinese medical treatment and health care by the licensed acupuncturist and/or licensed naturopathic physician ("Clinician") at A WellSpring of Natural Health, P.C. ("WellSpring") who now or in the future may treat me while working at or associated with WellSpring. Further, such consent and request applies equally to any other licensed acupuncturist and/or licensed naturopathic physician serving as for medical care back-up or in *locum tenens* for health care practitioner(s) at WellSpring, whether signatories to this form or not. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have also read and understand the attached "Notice of Patient Privacy", which discusses my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Examples of Diagnostic Procedures, Health Care and Medical Treatment:

- Customary diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.
- Traditional naturopathic, Chinese and other natural medicine systems of diagnosis and pattern evaluation, such as pulse and abdominal palpation, tongue and facial appearance, muscular armoring and tension dynamics, gait and postural observation.
- Lab tests and procedures: including referral for x-ray, MRI, or other diagnostic imaging.
- Minor office procedures: e.g., dressing a wound, ear cleaning, incision repair, laceration repair, wart removal, skin biopsy, etc.
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrients.
- Botanical therapies: substances may be prescribed as teas, infusions, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- Homeopathic medicine: the use of diluted quantities of naturally-occurring substances to gently stimulate the body's healing responses, given orally, topically, or by injection.
- Prescription of pharmaceuticals or bio-identical hormones.
- Counseling: life choices, psychological processes, self-actualization, creative expression, health promotion including recommendations for exercise, sleep, contraception, and stress reduction.
- Naturopathic manipulative therapies: specific manipulation of muscles, joints (including cranial bones), or soft tissue.
- Tui na massage, cupping, moxibustion, heating or bleeding of acupuncture points.
- Acupuncture and trigger point needling, including injections such as bee venom therapy, prolotherapy, homeopathic injections.

I have had the opportunity to discuss with my Clinician at WellSpring the nature and purpose of health practices, acupuncture, naturopathic therapies and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic medicine and acupuncture and other practices of Chinese medicine, pose some level of risk. Within the general clinical setting, the possible adverse outcomes of these practices by a naturopathic physician and/or acupuncturist range from minor to potentially fatal.

The health care and medical treatment we provide may or may not be directed at a specific disease or disorder. It may be preventive in nature, designed to improve overall health and well-being, restore your body's innate self-healing processes, and support you in living consciously and creatively. We will always strive to provide full disclosure of all information relevant to your clinical care. I understand that in providing treatments my Clinician is relying on the information that I am providing to them about myself, my health, and my response to therapies and my own behavior. I agree that the information I provide will be true and accurate and that I will disclose to the physician everything needed for treatment.

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The herbs, homeopathic medicines and nutrients (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic and/or Chinese medicines. It is extremely important that the prescribed recommendations be followed when taking herbs, homeopathic medicines and nutritional agents because they may induce adverse effects when taken in excessive amounts or inappropriate situations. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and nutrients may be inappropriate during pregnancy, and I will immediately notify those providing my clinical care at WellSpring if I become aware that I may be or am pregnant.

I will immediately inform the Clinician at WellSpring if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), bruising or burns (associated with acupuncture, injections, cupping or moxibustion), or any unanticipated or unpleasant effects associated with treatment or the herbs or other therapies prescribed by the Clinician at WellSpring. I understand that while this document describes the most common risks of treatment, other adverse effects and risks may occur. In order to properly treat my medical condition and support my health, the Clinician at WellSpring must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, it is important to seek treatment immediately from an emergency care facility or call 911.

With this knowledge, I voluntarily consent to the above procedures and that I realize that no guarantees have been given to me by my Clinician or the staff of A WellSpring of Natural Health, P.C. regarding cure or improvement of my health and medical condition(s).

I have read, or have had read to me, and understand the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name _____ Date _____

Signature (or Signature of Parent/Legal Guardian) _____

Print Your Clinician's name (here at WellSpring) _____

Economics and Billing

Dear New Patient:

Welcome to our clinic. We, the clinicians at A WellSpring of Natural Health, P.C. ("WellSpring") look forward to providing for your health needs and goals. We encourage your questions and participation in all aspects of your health care and medical treatment.

You understand that you are retaining the services of only the clinician named below. You recognize, understand and agree that your clinician is a sole practitioner and is not a partner or otherwise affiliated with any other healthcare practitioner who may be providing similar services at WellSpring or elsewhere. You further recognize, understand and agree that your clinician is solely responsible for and shall provide all professional services to you and that you are relying solely on your clinician's skill for the professional services rendered at WellSpring.

You are important to us. We wish to keep you informed of our policies regarding your payment responsibilities. We feel that it is essential that we share a clear understanding of our economic relationship so as to enhance and not interfere with our therapeutic relationship. We recognize and appreciate that health care can involve a significant financial commitment. That is exactly why we want you to know that our primary goal of the healthcare providers at WellSpring is to provide you with safe, effective and affordable healthcare.

As the patient of your healthcare provider, you are responsible for the total charges incurred from each clinic visit. **Charges related to your Motor Vehicle Accident or Work-related Injury will be submitted to your respective insurance company(-ies) as designated and authorized by you. are to be paid at the time of the visit unless specific arrangements have been made prior to the office visit**. We accept VISA, MasterCard, checks and cash for any services provided not directly related to your covered injury . There will be a charge of $30.00 each for any returned check(s). If your insurance company does not pay the outstanding balance within 60 days of the treatment date, you may be required to pay the full amount along with any new charges incurred. If immediate full payment will present major difficulties for you, please ask about our procedures to assess your financial abilities and formulate a payment plan with you.

You are encouraged to maintain an active dialogue with your insurance company for injury-related medical treatment we provide. **The terms of your insurance policy and its riders may or may not completely cover the care you receive at WellSpring.** We are willing to assist you in billing your insurance company when naturopathic and/or acupuncture care is covered. We provide initial billing to your insurance company, for each visit as a courtesy at no additional charge. If it becomes necessary to re-bill your insurance company for any outstanding balance, a $10.00 per re-billing fee may be charged. Be aware that any account over 60 days past due will accrue interest at 1.5% monthly (18% per annum). Please remember, that **you have the primary relationship with your insurance company and are responsible for the total amount owing if your insurance carrier determines that it will not pay for services that have been provided.**

The terms of the Affordable Care Act requires that acupuncture or naturopathic medical services be covered in accordance with licensing of providers and their respective scope of practice as defined by the State of Oregon. Specifically, Section 2706 – the provider non-discrimination provision of the Public Health Service Act as amended by the Affordable Care Act mandates that insurance coverage prohibits insurance companies from discriminating against naturopathic physicians or licensed acupuncturists (or any other provider for that matter) when the clinician is treating the same conditions or performing the same services that the insurer would otherwise cover.

Patients will be billed a $60 fee for any missed appointment or cancellation of an appointment with less than one full business day (i.e., 24 hours) advance notice. This charge will not be submitted to your insurance company. Any emergencies warranting special consideration will be respected as a reasonable exceptions.

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Furthermore, arriving for an appointment late by 15 minutes or more may qualify as a missed appointment and a $60 fee may apply.

Your clinician may prescribe nutrients, herbal preparations and/or other medications, which may be purchased either at this location or elsewhere. Such products are available at this site from a separate business; payment for all medicinary items is not related to your clinical or economic relationship with WellSpring. Most insurance policies do not cover or reimburse for the nutrient and herbal products that your Clinician prescribes, but certain medical savings accounts or employee benefit plans may reimburse for prescribed medicines. In such cases, WellSpring will provide you with an appropriate Letter of Medical Necessity for submission.

If you have any questions concerning any of these policies, or need to formulate a payment plan, please feel free to contact our staff *before* your office visit. If you accept these terms of relationship, please sign the bottom of this form and hand it in at the front desk.

I have read and understand the above-stated policies of A WellSpring of Natural Health, P.C. and will comply with them in all respects. If my insurance company requires a release of my medical records, I hereby give my permission by signing this form.

☑ _____

READ, UNDERSTOOD AND AGREED

PATIENT

_____ _____

Printed Name Date

_____

Signature (or Signature of Parent/Legal Guardian)

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Irrevocable Clinician's Lien and Assignment of Right to Recovery

I do hereby authorize _____ (hereinafter "clinician") to furnish my attorney with a full report of my examination, diagnosis, treatment, prognosis, etc, of myself in regards to the accident, injury or illness which occurred on or about _____, and for which I have or will receive treatment at A WellSpring of Health, P.C.

In consideration for not having to immediately pay a debt owed and in consideration for receiving future care from the clinician, I hereby assign and convey to the clinician a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain incident which occurred on or about _____ _____ to the full extent of the cost of the treatment provided or to be provided me by the clinician.

I hereby authorize and direct my attorney to hold in trust, and to pay directly to the clinician such sums as may be due and owing for naturopathic, acupuncture and other professional services rendered me by reason of my accident, injury or illness which are due the clinician, and to withhold such sums from any settlement, judgment, or recovery as may be necessary to adequately protect the clinician. I hereby further give a lien on my case to the clinician against any and all proceeds of any settlement, judgment, or recovery as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to the clinician for all medical bills incurred for services rendered me and that this agreement is made solely for the clinician's additional protection and in consideration of the clinician waiting for payment. I further understand that such payment is not contingent on any settlement or judgment by which I may eventually recover. *I am personally responsible for my bills, regardless of the outcome of any legal claim or case.*

I fully understand that if my attorney does not protect the clinician's interest, the clinician may require my to make payments on a current basis.

I have read and fully understand this document, and I am voluntarily signing this document. I am directing my attorney to protect the clinician's interest at the time of settlement, and I am assigning and conveying certain legal rights over to the clinician. I also know that I may not revoke this agreement at any time. I further agree that a printed or digital version of this document shall be as effective as the original.

☑ _____

READ, UNDERSTOOD AND AGREED

PATIENT

_____ _____

Printed Name Date

_____

Signature (or Signature of Parent/Legal Guardian)

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Missed Appointment Policy

Scheduling an appointment with a clinician at WellSpring represents a bond of trust and good faith between you as a patient, your clinician and the clinic as a whole. It implies that we will be here to serve you and that you will be present and on time for your appointment. We schedule appointments in increments of time that balance your individual needs and the typical time requirements for effective health care and medical treatment. We do our best to stay on schedule in a comfortable and caring environment. While always respectful of your time, we do encounter situations where patients require more than the scheduled time. We ask for your understanding and patience on these occasions. You will appreciate our efforts at balancing timeliness and attentiveness some day when you need extra time and attention.

Contact the clinic as soon as possible to reschedule if you will be unable to be at your appointment in a timely manner. For rescheduling or canceling appointments, we require a 24-hour notice, or one full business day in the case of weekends and holidays. If you are not able to reach us during clinic hours you may leave a message in the front desk mailbox of our voicemail system; a message left outside of normal business hours will be considered as received at the opening time of the next business day. A cancellation without adequate notice will be considered a missed appointment. Likewise, if you are more than 15 minutes late for your scheduled time, the appointment will be considered as "missed" and will have to be rescheduled.

Both missed appointments and late cancellations are subject to a $60 fee.

We appreciate your understanding of this policy. Our goal is to nourish a professional relationship based upon trust, confidence and mutual respect, which will enhance the quality of your health care and medical treatment. Please talk to the office staff if you need clarification of this policy.

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name _____ Date _____

Signature (or Signature of Parent/Legal Guardian) _____

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Notice of Patient Privacy (Short Form)

Health Insurance Portability and Accountability Act (HIPPA)

Effective Date: April 14, 2003 Updated: June 21, 2015

A WellSpring of Natural Health, Inc. (WellSpring) is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and WellSpring's responsibilities with respect to your Protected Health Information.

WellSpring may use or disclose your PHI for the purpose of diagnosing or providing medical treatment, obtaining payment for health care bills or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected medical and health care information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask at the front desk and we will provide you with a copy. This document is also available in the Forms section of the wellspringofhealth.com website.

We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

You may contact our Privacy Officer, Clinic Director Dr. Lori Stargrove at 503.526.0397 if you have any questions, concerns or complaints or seek further information about the complaint process.

By signing this form you are acknowledging that you have been provided information regarding our privacy practices pertaining to your "Protected Health Information."

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name _____ Date _____

Signature (or Signature of Parent/Legal Guardian) _____

A WELLSPRING OF NATURAL HEALTH, PC
Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Directions to WellSpring ~ 4720 SW Watson Avenue, Beaverton

From South I- 5 or Tigard:

Take Interstate-5 to Hwy 217. Follow Hwy 217 North heading toward Beaverton. Take the **Allen Street Exit**. Turn left at the first stoplight, which is Allen Street. Go forward to the **third stoplight**, which is **Hall Boulevard**. Turn right onto Hall going North. After the stoplight at 5th Avenue, turn **left onto Third Avenue**. Go forward just short of **two blocks**. Our parking lot and building are located on the **right-hand side**. The clinic is on the Northeast corner of 3rd and Watson at 4720 SW Watson Avenue.

From Downtown Portland:

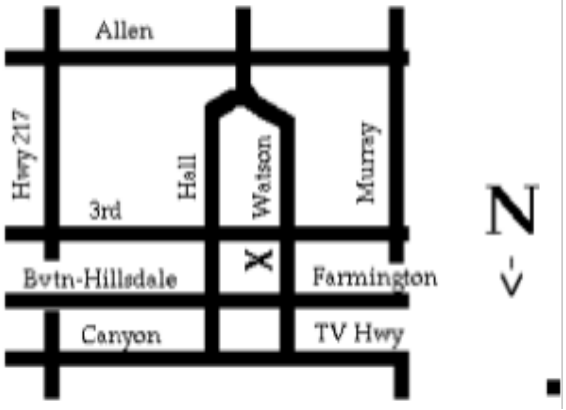
Take **Highway 26 West** to Highway 217 South. Follow Hwy 217 and take the **Beaverton-Canyon Road Exit** (Highways 8 and 10). Turn right at the **second stoplight**, which is **Beaverton-Hillsdale Highway**, and then becomes **Farmington Road** as you cross the railroad tracks. Go forward to the **fourth stoplight**, which is **Watson Avenue** (two blocks past Hall Blvd.). Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner, nearest you, of 3rd and Watson at 4720 SW Watson Avenue.

From SW Portland:

Take **Beaverton-Hillsdale Highway** west. After you pass underneath **Hwy 217**, go straight up to the **fifth stoplight**, which is **Watson Avenue**. Turn left onto Watson. The clinic is located **three blocks down** on the left-hand side. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.

From Hillsboro or Aloha:

Take **Farmington Road** to downtown Beaverton. Turn right onto **Watson Avenue**. (If you have come to Hall Boulevard, you have gone two blocks too far.) The clinic is located **three blocks down on the left**-hand corner. We are on the left-hand (NE) corner of **3rd and Watson** at 4720 SW Watson Avenue.



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Communication Guidelines

These are some guidelines that can make our communication more effective:

1. When you call, give the receptionist a message including a detailed description of your concerns and/or questions and a few times during which you will be available to talk on the phone. This initial information will enable your clinician to make a preliminary determination about whether your needs can be adequately addressed on the phone or whether you need to come into the office.
2. If the doctor has not returned your call in what you feel is a reasonable amount of time, you may call again. Our ability to respond will be delayed in the event that you do not answer the phone when an attempt is made to call vou. Our working together will best facilitate your needs being addressed in a timely manner.
3. Timing is important. If you or your child is sick, call early in the workday. Likewise, avoid waiting until late in the week to contact us with an acute need.
4. Accurately prescribing medication over the phone is inherently difficult and compromised. If your medical condition has changed significantly since a recent visit or a new condition has emerged we can only provide responsible, effective and ethical medical care by understanding the unique presentation of your symptoms and your experience of your condition. The person-centered health care offered at WellSpring is best delivered in person and we will work to accommodate your needs in a timely manner. Telephone, electronic or other indirect communication can not provide us with the opportunity to serve you as well as seeing you in person.
5. Children and illnesses do not always follow the rhythms of the clinic schedule. Your clinician is available in the beyond clinic hours if you feel that you have a medical condition requiring urgent decision-making and/or treatment; the WellSpring voicemail system (press #2) will contact your clinician and transmit the detailed message you leave. You will be called as soon as possible. In the event of a medical emergency, call 911 or go to the nearest urgent care facility or emergency room.
6. The WellSpring website provides a contact form for communicating with our staff and practitioners. These submissions will be reviewed and responded to but are not a timely or reliable means of communications with your clinician regarding your health care and medical treatment. In general, we at WellSpring prefer to communicate directly on the phone or in person and do not use electronic communications such as email or the WellSpring website for discussing your health care or medical treatment. Such forms of electronic messages are useful and appropriate for matters involving clinic hours and policies, insurance verification, and other matters of general business. The staff email (*care@wellspringofhealth.com*) and WellSpring website contact forms are available to more appropriately serve these functions. The clinicians at WellSpring do not use email for discussing your case or receiving documents. Email and online form submissions do not meet the confidentiality and security standards required by HIPAA and other relevant regulations and thus are not appropriate for transmitting personal information such your birthdate, social security number, passwords, etc.

Thank you!
The Clinicians and Staff of A WellSpring of Natural Health, P.C.