asha Integrative Wellness

Confidential Patient Information

Today's Date _____

Personal Information

Preferred Name _____

Legal Name (if different than above) _____

Age Date of Birth Pronoun? He/Him She/Her They/Them Other:____

Home address City State Zip

Home phone # Email

Occupation Employer

Emergency Contact: Phone # Relationship:

Person responsible for this account Relationship to patient

Phone # Address (if different from above)

Insurance Information

Type of policy: ( ) Health Insurance ( ) Auto ( ) Worker's Comp

Name on Medical Records Sex on Medical Record? Female Male

Name of insured Relationship to patient

Insurance company name Insurance Phone #

MEMBER ID# GROUP or CLAIM #

Policy Holder's Name Date of Birth

The NOTICE OF PRIVACY PRACTICES is attached to your clipboard. If you don't see it, please ask the front desk for a copy of it so that you may read it before you sign this page.
I have read the notice of privacy practices. I have read and understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

_____ _____
(Patient / Guardian Signature) (Date Signed)

_____ _____
(Print Name) (Patient Name – if signing as a parent or legal guardian)

Office Policy Regarding Fees and Payments

1. Private Pay – Full payment is expected at time of each visit. We accept cash, check or MC/Visa/AMEX. If payment is not received at the time of your visit, you will not be eligible for a TOS fee. Labs, supplies and supplements are excluded from this fee. No insurance will be billed if this option is selected.

2. Insurance - For patients who have private health plans covering our services: We require your co-payment at the time of service, per your insurance policy. Insurance coverage is **NOT** a guarantee of payment and you are fully responsible for any fee your insurance does not cover, and for checking your benefits and confirming coverage for all services.

3. Personal Injury/Car Accidents –As a courtesy, we will bill and collect from your car insurance company, however if your insurance company does not pay your balance in full, you are responsible for any unpaid portion and you can recover any monies paid at the time of settlement.

Continued →

4. Worker's Compensation – If you have been injured on the job, you are required by law to report to your employer first and open a claim. The first provider you see following your injury will be considered your 'primary provider' for this case. *If we are not your primary provider on the case, it will require a referral from that provider.* If a denial occurs, you will be fully responsible for the balance of your account.

FINANCIAL POLICY – I understand that all billing and accrued balances are ultimately my responsibility and that I will pay these amounts in a timely fashion. There will be a charge for returned checks. Appointment cancellations require advanced notice. Voicemail is available 24 hours a day, 7 days a week and I will be charged the full cost of a visit for any missed appointment without 24-hour notice. If I arrive late I may be asked to reschedule.

Client/Patient NAME_____ **Date of Birth**_____

Client/Patient signature_____ ***Date***_____

Informed consent for routine/referral clinic services

(excludes counseling, psychotherapy, naturopathy) *Please initial and date the following consents for services planned/received.*

_____**CONSENT TO ROUTINE MASSAGE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Lyn Hughey, Camille Hook, Ambert Dunsmore, Jarrod Morrow, Marco Madian, Jaimie Oller, Seda Elizabeth Bedsole or any licensed massage therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the massage therapist named above. I understand and am informed that, in the practice of massage therapy there are some risks to treatment, including but not limited to sore muscles and joints, increased risk of emboli from varicose veins, and increased blood pressure from hypertension. I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of the procedure which the massage therapist feels at the time, and based upon the facts then known, is in my best interest. I understand that no guarantee has been made to me as to the result or cures that may be obtained from treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE ACUPUNCTURE SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Adrianna Locke LAc , Toshio Omura-Long LAc., and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above. I understand and am informed that, as in the practice of medicine, in the practice of acupuncture, there are some risks including but not limited to bruising, bleeding, blistering, pneumothorax, or fainting. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from examination or treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

_____**CONSENT TO ROUTINE PHYSICAL THERAPY SERVICES:** I consent to the services to be rendered during this visit on an outpatient basis by Shawn Cooney, Greg MacKnight & PDX Bodyworks Physical Therapy, or any licensed physical therapists who now or in the future treat me while employed by, working or associated with or serving as back-up for the physical therapist named above. I understand and am informed that, in the practice of physical therapy there are some risks to treatment, including but not limited to sore muscles and joints, increased risk of emboli from varicose veins, and increased blood pressure from hypertension. I do not expect the physical therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the physical therapist to exercise judgment during the course of the procedure which they feel at the time, based upon the facts then known, and is in my best interests. I understand that no guarantee has been made to me as to the result or cures that may be obtained from treatment in this clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I may seek treatment.

All practitioners of Asha Integrative Wellness are affiliated with each other to combine their skills in the treatment of patient maladies. All Practitioners are legally independent health care practices. They are not affiliated to each other by tax identification or liability. Asha Wellness Center / Levy Chiropractic LLC is not responsible for the business practices or treatments by any affiliated practitioners. All Affiliated business are not responsible for the business practices or treatments by any affiliated practitioners.

CONSENT TO TREATMENT – I, OR MY REPRESENTATIVE, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

_____

Signature of Patient Date

FOR MINOR PATIENT/ PATIENT UNDER GUARDIANSHIP

Patient is _____ years of age OR unable to sign because: _____

_____ _____ _____

Parent/ Guardian Signature Date Relationship to patient