Southern Oregon
Wellness Clinic

2921 Doctors Park Drive, Medford, OR 97504 Phone (541) 973-2551 Fax (541) 973-2835

CONDITIONS OF SERVICES RENDERED

FINANCIAL AGREEMENT: I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Southern Oregon Wellness Clinic in accordance with the regular rates and terms. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, whether I sign as agent or as patient, direct payment to Southern Oregon Wellness Clinic of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient services at a rate not to exceed Southern Oregon Wellness Clinic's actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

HEALTH PLAN OBLIGATIONS: Southern Oregon Wellness Clinic maintains a list of health plans with which it contracts. Southern Oregon Wellness Clinic has no contract, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Southern Oregon Wellness Clinic if he/she belongs to a plan, which does not appear on the above- mentioned list.

RELEASE OF INFORMATION: I authorize Southern Oregon Wellness Clinic to release any information necessary to provide medical treatment to me, allow Southern Oregon Wellness Clinic to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Southern Oregon Wellness Clinic is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Southern Oregon Wellness Clinic. The undersigned certifies that he/she had read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE: _____ PRINT NAME: _____

SIGNATURE: _____ (PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than patient, indicate relationship: _____

** ATTENTION PATIENTS **

Scheduled appointments that are not cancelled 24 hours in advance will incur an annoyance fee of:

$25.00

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2921 Doctors Park Dr, Medford OR, 97504 (P) 541-973-2272 (F) 541-973-2835

PATIENT ACKNOWLEDGEMENT FORM

Receipt of Joint Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of Southern Oregon Wellness Clinic *Notice of Privacy Practices*. Southern Oregon Wellness Clinic is permitted to use or disclose my health information to carry out treatment, payment or health care operations. Health information means any and all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Southern Oregon Wellness Clinic's Notice of Privacy Practices explains the types of uses or disclosures that Southern Oregon Wellness Clinic may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Office Manager at the telephone number listed below. I further understand Southern Oregon Wellness Clinic may change the terms of the Notice of Privacy Practices from time to time, and that I may contact the Office Manager to obtain a revised version of the notice at any time.

Patient's Printed Name: _____Patient's DOB: _____

Signature of Patient: _____ Date: _____

Signature other than patient: _____ Date: _____

If signed by other than patient, indicate relationship: _____

You may contact our office regarding your privacy by calling 541-973-2551

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Patient Registration Form

Please Print

Patient name _____ Date of birth _____

Mailing address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ SSN# _____-_____-_____

Is it okay to leave medical information on your voicemail if we are unable to reach you? Yes_____ No_____

Male _____ Female _____ Single _____ Married _____ Divorced _____ Widowed _____

Employer _____ Phone _____

Spouse's name _____ Date of birth _____

Spouse's SSN# _____-_____-_____ Phone _____

Spouse's Employer _____ Phone _____

Emergency Contact (a person not living at the same address)

Name _____ Relationship _____ Phone _____

Medical Insurance Information

Primary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Secondary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Name: _____

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Medical History

- Arthritis
- Allergies
- Asthma
- Alcoholism
- Alzheimer's Disease
- Autoimmune Disease
- Blood Pressure Problems
- Cancer
- Chronic Fatigue Syndrome
- Carpal Tunnel Syndrome
- Eating Disorder
- Colitis
- Dental Problems
- Depression
- Diabetes
- Decreased Sex Drive
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental Sensitive
- Fibromyalgia
- Food intolerance
- Gastro Esophageal reflux disease
- Genetic Disorder
- Gout
- Heart Disease
- Inflammatory bowel syndrome
- Kidney or Bladder disease
- Learning Disability

[] Liver Disease
[] Thyroid Problems
[] Mental Illness
[] Migraine Headaches
[] Neurological Disease
[] Sinus Problems
[] Stroke
[] Obesity
[] Osteoporosis
[] Pneumonia
[] Sexually Transmitted Disease
[] Skin Problems
[] Tuberculosis
[] Ulcer
[] Urinary Tract Infection
[] Varicose Veins
[] Other_____

Would you like:

[] Have More Energy
[] Be Stronger
[] Have more endurance
[] Increased your sex drive
[] Lose weight
[] Gain Weight
[] Improve your complexion
[] Be less moody
[] Be less depressed
[] Feel more motivated
[] Think more clearly\ focused
[] Improve Memory
[] Not dependent on medication
[] Do better in school
[] Be pain free
[] Sleep better
[] Have healthier Hygiene
[] Talk about stress control
[] Talk about school problems
[] Learn about Wellness Program

Do you feel safe at Home: [] Yes [] No

Do you feel safe at school: [] Yes [] No

Problems with grades: [] Yes [] No

Problems involving other peers at school: [] Yes [] No

Are you in a unsafe relationship: [] Yes [] No

In the last 2 weeks have you experienced any feelings of hopelessness and being down throughout the day?

[] Yes [] No

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Name: _____

Allergies: Are you allergic to any of the following? (Circle all that apply) NONE Aspirin Penicillin Codeine Metal Latex Local Anesthetics

Other:

_____

If yes, explain the reaction: _____ Anaphylaxis: Yes/ No

Social History:

Family / Household member (everyone who lives in your household)

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Did you EVER or do you smoke cigarettes or use other tobacco products? (Please Circle) Yes No

Type: _____ Age Started: _____ Age Quit:_____ Packs per day_____

Do you use Marijuana, Cocaine, or non-prescribed narcotics? (Please circle) Yes No

If so, please describe: _____

How many cups of coffee, tea or carbonated drinks do you drink daily? _____

How many beer, mixed drinks, or glasses of wine do you have weekly? _____

Family History:

Please check all that apply ONLY if you're Mother, Father, Brother/Sister or Grandparents have any of the following: (If it is Grandparents, please indicate M for Mother's side or P for Father's side of family.

[] Alcoholism _____ [] Cancer _____ [] Suicide _____

[] Allergies _____ [] High Cholesterol _____

[] Diabetes _____ [] Thyroid issues_____

[] Tuberculosis_____ [] Major medical problems_____

[] Heart Disease_____ [] High Blood Pressure _____

[] Stroke _____ [] Depression/ Anxiety / Bipolar _____

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Surgeries: (Write down the name and year of Surgeries)

Women Only:

Dates of Last Period _____

Current Method of Contraception _____

Pregnancies_____ Miscarriages_____

Live Births_____ Terminations_____

Age of Menopause _____

Date of Last:

Pap test: _____ Mammogram_____

Dexa Scan_____ Colonoscopy (50+) _____

Men Only:

Do you Perform Monthly Testicular Self-Exams (TSE)?

Yes _____ No_____

Date of Last PSA Test: _____

Date of last Colonoscopy (50+) _____

Name:_____

Name: _____

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UNIVERSAL MEDICATION LIST

List all medications you are currently taking:

List prescriptions and over the counter medications (example: aspirin, antacids) and herbals (examples: ginseng, gingko).

Include medications taken as needed (example: nitroglycerin)

Date	Name of Medication	Dose	Notes: Reason for taking	Date STOPPED

Date _____ Signature _____