



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: _____

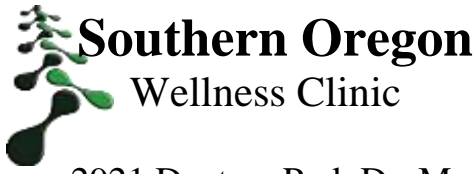
SIGNATURE: _____ (PATIENT/PARENT/CONSERVATOR/GUARDIAN)

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



Southern Oregon
Wellness Clinic

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



Southern Oregon Wellness Clinic

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(P) 541-973-2251 (F) 541-973-2835

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 _____

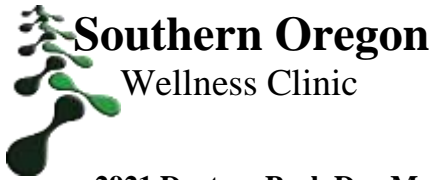
Insured name _____ Date of birth _____

Secondary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Name: _____



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Medical History

Would you like:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Have More Energy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Be Stronger |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Have more endurance |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Increased your sex drive |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Lose weight |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Gain Weight |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Improve your complexion |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Obesity | <input type="checkbox"/> Be less moody |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Be less depressed |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Feel more motivated |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Think more clearly\ focused |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Improve Memory |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Not dependent on medication |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Do better in school |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Be pain free |
| <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Sleep better |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other_____ | <input type="checkbox"/> Have healthier Hygiene |
| <input type="checkbox"/> Emphysema | | <input type="checkbox"/> Talk about stress control |
| <input type="checkbox"/> Eyes, ears, nose, throat problems | | <input type="checkbox"/> Talk about school problems |
| <input type="checkbox"/> Environmental Sensitive | | <input type="checkbox"/> Learn about Wellness Program |
| <input type="checkbox"/> Fibromyalgia | Do you feel safe at Home: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Food intolerance | Do you feel safe at school: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Gastro Esophageal reflux disease | Problems with grades: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Genetic Disorder | Problems involving other peers at school: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Gout | Are you in a unsafe relationship: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Heart Disease | In the last 2 weeks have you experienced any feelings of | |
| <input type="checkbox"/> Inflammatory bowel syndrome | hopelessness and being down throughout the day? | |
| <input type="checkbox"/> Kidney or Bladder disease | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Learning Disability | | |



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 _____

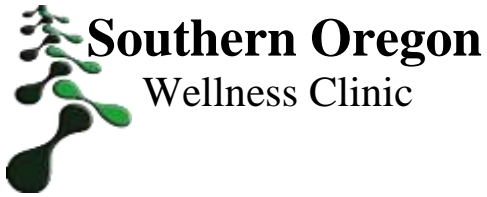
Allergies _____ High Cholesterol _____

Diabetes _____ Thyroid issues _____

Tuberculosis _____ Major medical problems _____

Heart Disease _____ High Blood Pressure _____

Stroke _____ Depression/ Anxiety / Bipolar _____



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

Women Only:

Men Only:

Dates of Last Period _____

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

Current Method of Contraception _____

Yes _____ No _____

Pregnancies _____ Miscarriages _____

Date of Last PSA Test: _____

Live Births _____ Terminations _____

Date of last Colonoscopy (50+) _____

Age of Menopause _____

Date of Last:

Pap test: _____ Mammogram _____

Dexa Scan _____ Colonoscopy (50+) _____

Name: _____

Name: _____



UNIVERSAL MEDICATION LIST

List all medications you are currently taking:

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

Include medications taken as needed (example: nitroglycerin)

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

Date _____

Signature _____