The Benchmark Clinic
2456 NW Northrup, Suite 1A Portland OR 97210
www.BenchmarkClinic.com **Phone: 503-223-7067** Fax: 503-223-9639

Welcome

Thank you for trusting The Benchmark Clinic with your health care. We look forward to working with you to enhance your health and well-being.

Our office is open Monday through Friday. We value your time, and realize that office visits may be an interruption in an otherwise very busy schedule for you. For this reason, we've taken steps to assure that your time in the clinic is as focused and efficient as possible. Please note the following:

Enclosed you will find a **Patient Information Form, Health History Questionnaire and Consent Forms.** This information is our first introduction to you and your history. Your detailed and thoughtful responses will help us use our time in the clinic more effectively. **Please bring these completed forms with you to your first visit or to expedite things even more, you may drop it off 2-3 days in advance of your visit.**

We will gladly assist you with your insurance billing. **Please provide us with a copy of your insurance card and a completed, "How do I Check My Insurance Benefits" form prior to your first visit.** Please review our consent and payment policy forms for more detailed information regarding your insurance.

Please note that we offer discounted fees for patients who pay at the time of service.

Please bring the following documents with you to your office visit:

1. Completed Health History Questionnaire – signature required
2. Privacy Practices – signature required
3. Clinic Policies – signature required
4. Consent Forms – signature required
5. Authorization/Permission to Speak with Spouse, etc.
   Complete this form only if you wish to allow us to discuss your care with someone else
6. Release of Medical Records – *please complete this form if you wish to have your previous medical records sent to us*.
7. **Check Insurance Benefits Form – this is very important if you would like us to bill insurance for your visit.**
8. Insurance card
9. Copies of any recent lab-work

We appreciate your assistance in making our time together more efficient, and look forward to meeting you soon.

This page is for your information. Please retain for your records.

NOTICE OF PRIVACY PRACTICES
Patient Copy

Benchmark Clinic maintains strict requirements for protection of your private information. The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires covered entities to keep patient information confidential and provides the means for you to understand and control how your health information is used. By law, your medical records information can be used for three purposes, as follows:

1. Treatment-we can use your current record to carry out your medical treatment in-house. Example: discussing your information with a referral physician.
2. Payment-allows the release of information for different financial transactions. Examples: sending office notes to insurance payers so that they will process benefits to you, or other billing activities.
3. Healthcare Operations-allows us to conduct quality assessments and improve our health-care activities and customer service. Also allows us to call you by name in the reception room and to disclose your protected health information, as necessary, to contact you for appointment reminders, treatment alternatives or other health-related information that would be of interest to you.

Benchmark Clinic may use or disclose your protected health information as follows without your authorization as required by law: Public health issues, communicable diseases, health oversight, abuse or neglect situations; FDA requirements; legal proceedings, law enforcement, coroners, funeral directors and organ donation; research; criminal activity; military activity and national security; Worker's Compensation and inmates.

All other disclosures will require your written authorization before the information will be released. You may revoke such authorization in writing and no further releases will be made without obtaining new written authorization allowing Benchmark Clinic to again release your personal health information. We will not disclose your private health information to family members, other relatives, close personal friends, or any other person unless specifically authorized by you, in writing.

You have the right to access your medical records information at any time. A written request to see your records must be submitted to Benchmark Clinic. You may obtain information of any disclosures of your protected health information. All communications from our office will be confidential and protected from disclosure to the best of our ability. Please advise the resident physician or the staff of Benchmark Clinic if you feel your rights have been violated. There will be no retaliation for registering such a complaint.

Your signature below acknowledges that you have read this Notice of Privacy Practices. We will be happy to provide you with a copy upon request.

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PATIENT INFORMATION:

Current date: ____

Legal Name: ______________________________ **Date of birth:** ______________

Age: _______ Preferred name: ______________________________

Gender: Biological ___Female ___Male ___ Transgender **Identity:** ___Female ___Male ___Transsexual

Mailing address: ____

City/State/Zip: ____

____

Contact information - please circle preferred method of contact:

E-mail: ______________________________ Cell phone: ______________

Home: ______________ Work: ______________ Other: ______________

Emergency contact person: ______________________ Relationship: __________

Phone number of emergency contact: ______________________________

What is your occupation? ______________________________

Employer: ____

Do you have health insurance? ___ Yes ___ No **Employer** or **private** based plan? Please circle one.

If you would like us to bill insurance for you, please mail or fax a copy of your insurance card (see fax # above) & follow the instructions on page 14. It is your responsibility to verify your benefits prior to your first visit. If benefits have not been verified, you will be asked to pay for your visit at the time of service until insurance verification can be completed.

Insurance company: ______________________ Member ID # ______________

Policy #: ______________________________ Group #: ______________

Are you the **primary insured** or a **dependent** on this plan? Please circle one.

Name of the primary insured on this plan if other than yourself: ______________________

Date of birth of primary insured if other than you: ______________

Do you have a primary care provider? ___ Yes ___ No

Name of primary care provider: ______________________________

Practice name and location: ______________________________

Please list any other doctors you have seen in the past 2 years:

Name ______________ Clinic ______________ Reason ______________
Name ______________ Clinic ______________ Reason ______________
Name ______________ Clinic ______________ Reason ______________

Please let us know where you heard about our clinic:

Web search: __Google __ Yahoo __Newspaper Other website or ad: ______________________

Were you referred to us? ___Yes ___No If so, by whom? Dr. ______________________

Name: ______________________ ____ Family ___ Friend ___ Other

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HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient, physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and mark anything you don't understand with a question mark.

ALLERGIES:
MEDICATION: ____ REACTION: ________________________________
MEDICATION: ____ REACTION: ________________________________
MEDICATION: ____ REACTION: ________________________________
SENSITIVITIES (FOOD/ENVIRONMENT/PETS) ____

CURRENT MEDICATIONS: Prescriptions and over the counter medications. (If more than 4, please attach a list)
Name ___________________________ Dose _____________________________ Reason __________________________
Name ___________________________ Dose _____________________________ Reason __________________________
Name ___________________________ Dose _____________________________ Reason __________________________
Name ___________________________ Dose _____________________________ Reason __________________________

SUPPLEMENTS, HERBS AND TEAS, VITAMINS, HOMEOPATHIC AND OTHER REMEDIES (If more than 4, please attach a list):
Name ________________________ Brand _____________ Dose ___________________ Reason ____________________
Name ________________________ Brand _____________ Dose ___________________ Reason ____________________
Name ________________________ Brand _____________ Dose ___________________ Reason ____________________
Name ________________________ Brand _____________ Dose ___________________ Reason ____________________

Please check any natural methods that you regularly employ to manage stress:
____ Exercise ____ Meditation ____ Herbs or herbal teas ____ Massage ____ Chiropractic ____ Acupuncture
Do you see a professional practitioner for these services? ____ Yes ____ No If so, please list: ___________________________

What is the reason for your visit today?
____ To establish care primary care for prevention and wellness ____ Acute illness ____ Chronic illness
If ill, what is the nature of your current illness? ____
What is your primary complaint (symptom) related to this illness? ____
How does this condition affect you? ____
Pain: If this is a concern today, please note location: ____
Pain severity today: Please circle: 1 2 3 4 5 6 7 8 9 10
Pain severity on average in daily life: Please circle: 1 2 3 4 5 6 7 8 9 10
Do you have other important health concerns? Please list in order of importance:
1. ____ 3. ____
2. ____ 4. ____

PAST VACCINES/CONTAGIOUS ILLNESSES	Illness	Vaccine	Please circle or check all that apply
All regular U.S. childhood vaccines		(___)	
Adult vaccines:			
Varicella/Chicken Pox/**Shingles**	___	___	
MMR: Measles/Mumps/Rubella	___	___	
HPV: Human papilloma virus	___	___	
Pneumonia/Meningitis	___	___	
Hepatitis A/B	___	___	Have you been tested for Hepatitis C? ___ Yes ___ No
Strep throat	___	How many times? _____	
Rheumatic Fever/Scarlet Fever	___	At what age? _______	

Influenza vaccine annually? ___ Yes ___ No Last time? ____________ Single dose/ preservative free? ___Yes ___No ___ ?

FAMILY HISTORY	Mother	Father
Living – note age and health. G=Good P=Poor	____________________	__________________
Deceased – age at death and cause	____________________	__________________
Alcoholism	______	______
Asthma	______	______
Alzheimers	______	______
Cancer	______	______
Dementia	______	______
Diabetes	______	______
Heart Disease	______	______
High blood pressure	______	______
Mental Illness	______	______
Stroke	______	______

HOSPITALIZATIONS/SURGERIES

Reason or procedure ___________________ Date______ Reason or procedure _________________Date _______

Reason or procedure ___________________ Date______ Reason or procedure _________________Date _______

____

____

X-RAYS, IMAGING AND SPECIAL STUDIES (Circle: EKG, MRI, CT scan, PET scan, Ultrasound, EECG)

Study	Date	Region	Reason	Outcome
Circle: EKG Echo ECG	________________________	_________________	_______________	____________
Circle: X-Ray MRI CT	________________________	_________________	_______________	____________
Circle: PET Ultrasound	________________________	_________________	_______________	____________
Mammogram	________________________			____________
DEXA	________________________			____________

GENERAL: Height ________in/cm Weight _________ lbs/kg Max weight: ________ lbs/kg. When? _____________

Weight one yr ago: ________ lbs/kg Personal ideal weight: _________lbs/kg

Do you want help losing weight? ___Yes ___No If so, how much weight? ____________ lbs/kg

Do you cook at home? ___Yes ___No How often do you eat out? ____ x week or ___ x month

How is your energy? (Rate 0 - 10) _______________________________________ Is this a change? ___Yes ___No

What time is your energy best? ________________________What time is your energy the worst? _____________________

How is your appetite? _____________________________________ Is this a change? ___Yes ___No

How is your mood? _____________________________________ Is this a change? ___Yes ___No

How is your sleep? _____________________________________ Is this a change? ___Yes ___No

#_______ hours of sleep per night. Do you awaken rested? ___Yes ___No Is this a change? ___Yes ___No

Do you have a supportive relationship? ___Yes ___ No

Who? Spouse – Partner – Parent – Sibling – Child – Friend – Other

Are you sexually active? ___Yes ___No **If so, with** ___one partner ___multiple partners ___men ___women __both

Please note the following six questions are confidential, protected health information.

1. Do you have any history of abuse? ___Yes ___No ___Childhood ___ Adult ___ Past ___ Current

2. Have you ever suffered a major trauma? ___Yes ___No ___ Physical ___ Emotional

3. Have you ever had psychological counseling? ___Yes ___No

4. Are you currently seeing a counselor? ___Yes ___No If so, who are you seeing? ___________________________

5. Would you like a referral for counseling? ___Yes ___No

6. Do you have other confidential concerns? ___Yes ___No Please explain below briefly if you care to:

____

____

LIFESTYLE

Do you enjoy your work? ___Yes ___No Do you take vacations? ___Yes ___No

Do you exercise? ___Yes ___No If so, what kind of exercise? _________________________

How often? _________ x per week For how long? _____________ min/hours

How much time do you spend outdoors every day? _____# of hours per day

Watch television _____# of hours per day

Read _____# of hours per day

Computer work _____# of hours per day

Computer games _____# of hours per day

Do you drink alcohol currently/past? ___Yes ___No _____ Daily _____ x week ____ x mo ____ Occasional

Wine: Red/White __Beer __ Liquor Do you have concerns about alcohol? ___Yes ___No

Do you use cannabis? ___Yes ___No If so, for what purpose? ___Pain ___Recreation ___ Other___________

If so, in what form? ___Smoke ___ Vapor ___Edible How often? ___Daily ___ x per week ___ x per mo ___occasional

Do you use other recreational drugs currently / past? (Circle) ___Yes ___No Drug of choice __________________________

Have you ever been in or referred to an Alcohol or Drug Rehabilitation program? ___Yes ___No

Tobacco use (current): ___Yes ___No __________packs/day _______ yrs Want help quitting? ___Yes ___No

Tobacco use (past): ___Yes ___No __________packs/day _______ yrs When did you quit? ______________

DIET: ___Omnivorous ___ Pescatarian ___ Vegetarian ___ Vegan ___ Dairy free ___ Gluten free

Please check those foods you eat: __ Meat __ Fish __Eggs __Cheese __Yogurt __Milk __All of these

Please indicate your **average** daily meal choices:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Water: _______ ounces Coffee ___ cups Tea (Herb/Green/Black) ___ cups Soda ___ cup

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Review of systems:

Please check C for Current or P for past regarding any of the following symptoms you may have experienced.

ENDOCRINE	C	P	**PERIPHERAL VASCULAR/IMMUNE**	C	P
Fatigue			Spider veins		
Hair loss			Varicose veins		
Thyroid problems / goiter			Easy bruising or bleeding (Circle)		
High blood sugar			Swollen ankles or feet (Circle)		
Diabetes			Blood clots		
Excessive thirst			Swollen glands		
Excessive hunger			Cancer		
Crave sweets			Slow wound healing		
Night sweats			Autoimmune disease		
Exercise intolerance			If AI disease, what type?		

GASTROINTESTINAL	C	P	**HEAD-EYES-EARS-NOSE-THROAT**	C	P
Diarrhea/Constipation (Circle)			Migraines		
Gas			TMJ problems/clicking noises/grinding (Circle)		
Heartburn			Dental implants, braces or appliances		
Belching			Cold sores on lips – Mouth ulcers (Circle)		
Nausea			Eye pain		
Pain or cramps			Blurry vision		
Trouble swallowing			Double vision		
Vomiting frequently Vomiting blood (Circle)			Tearing/dry eyes		
Stomach ulcer			Spots/floaters in vision		
Liver disease / hepatitis (Circle)			Cataracts		
Gallstones			Glasses/Contact Lenses		
Change in appetite			Impaired hearing/Hearing aids		
Hemorrhoids			Earaches/infections		
Black tarry stool or red blood in stool (Circle)			Ringing in ears		
Treated with antibiotics multiple times			Stuffiness/sinus problems		
Daily bowel movements			Nosebleeds Loss of smell (Circle)		
If so, how many stools per day?			Seasonal allergies		
Problems digesting Fats - Protein - Carbohydrates (Circle)			Frequent sore throat/hoarseness		
HEART	C	P	**NEUROLOGIC**	C	P
Heart disease			Muscle weakness		
Chest pain			Numbness – Location?		
Murmur			Tingling – Location?		
Fainting			Seizures		
Heart attack / stroke (Circle)			Paralysis		
Palpitations / flutters (Circle)			Lightheaded		
High blood pressure			Dizziness		
Low blood pressure			Loss of balance		
Other:			Loss of vision		
SLEEP					
Diagnosed with sleep apnea			Use a CPAP/BiPAP machine		
Do you snore?			Does your snoring bother others?		
Has anyone ever noticed that you stop breathing for short intervals at night?				Y	N
Have you been offered a dental appliance for sleep apnea?				Y	N
LUNGS	C	P	**SKIN-NAILS**	C	P
Cough			Acne		
Asthma			Boils		
Shortness of breath			Rashes		

Pneumonia			Hives		
Pleurisy			Eczema		
Bronchitis			Psoriasis		
Emphysema			Lumps		
Spitting up blood			Itching		
Exposure to second hand smoke or other toxins			Brittle nails		
MUSCULOSKELETAL	C	P	**URINARY**	C	P
Arthritis			Painful or frequent urination (Circle)		
Muscle pain or cramps (Circle)			Frequent urinary tract infections		
Sciatica or lumbar pain (Circle)			Blood in urine		
Degenerated discs – cervical – thoracic - lumbar			Inability to hold urine		
Joint pain Swollen joints (Circle)			Kidney stones		
If so, where?			Kidney disease		

MENTAL/EMOTIONAL	C	P	**FEMALE BREASTS**	C	P
ADHD Autism (Circle)			Breast pain, lumps/discharge		
Depression			Regular breast self-exam		
Anxiety Panic Attacks (Circle)			History of fibrocystic disease		
Mood swings			History of breast cancer		
Eating disorder			**FEMALE REPRODUCTIVE**	C	P
Sleep disorder			Pelvic pain/cramping		
Feeling hopeless			Vaginal pain/itching		
Suicidal thoughts			Endometriosis		
Attempted suicide			Excessive flow/clotting Fibroids (Circle)		
Have you ever received treatment for these?			Cervical dysplasia-abnormal PAP		
MALE REPRODUCTIVE	C	P	Condyloma (genital warts)		
Prostate disease BPH Cancer (Circle)			Chlamydia/Gonorrhea/Syphilis		
Elevated PSA on test (Prostate Specific Antigen)			Ovarian cysts		
Testicular pain/masses			Is your cycle regular?	Y	N
Low sex drive/impotence			Postmenopausal		
Erectile dysfunction			Age of first menses		
Herpes – genital Discharge/Sores (Circle)			Number pregnancies: Live births:		
Condyloma (genital warts)			Number miscarriages: Abortions:		
Chlamydia/Gonorrhea/Syphilis			Duration between cycles		
Current birth control method			Current birth control method		

Do you have other concerns regarding your health that you would like to discuss? Please explain or note any attached lists here.
____
____

Patient Signature (or responsible party) ____

Date: ______________________________ Relationship to patient: _________________________________

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Clinic Copy

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Benchmark Clinic may use or disclose your protected health information as follows without your authorization as required by law: Public health issues, communicable diseases, health oversight, abuse or neglect situations; FDA requirements; legal proceedings, law enforcement, coroners, funeral directors and organ donation; research; criminal activity; military activity and national security; Worker's Compensation and inmates.

All other disclosures will require your written authorization before the information will be released. You may revoke such authorization in writing and no further releases will be made without obtaining new written authorization allowing Benchmark Clinic to again release your personal health information. We will not disclose your private health information to family members, other relatives, close personal friends, or any other person unless specifically authorized by you, in writing.

You have the right to access your medical records information at any time. A written request to see your records must be submitted to Benchmark Clinic. You may obtain information of any disclosures of your protected health information. All communications from our office will be confidential and protected from disclosure to the best of our ability. Please advise the resident physician or the staff of Benchmark Clinic if you feel your rights have been violated. There will be no retaliation for registering such a complaint.

Your signature below acknowledges that you have read this Notice of Privacy Practices. We will be happy to provide you with a copy upon request.

Patient Signature (or responsible party) ____

Date: ___________________________________ Relationship to patient: ____________________________

PROTECTED HEALTH INFORMATION

I consent to the use or disclosure of my protected health information by Benchmark Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Benchmark Clinic. I understand that diagnosis or treatment of me

by my physician or acupuncturist at Benchmark Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Benchmark Clinic is not required to agree to the restrictions that I may request. However, if Benchmark Clinic agrees to a restriction that I request, the restriction is binding on Benchmark Clinic and my physician at Benchmark Clinic.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician at The Benchmark Clinic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Benchmark Clinic's Notice of Privacy Practices prior to signing this document. Benchmark Clinic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Benchmark Clinic. This Notice of Privacy Practices also describes my rights and Benchmark Clinic's duties with respect to my protected health information.

The Benchmark Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Signature (or responsible party) ____

Date: ______________________________ Relationship to patient: ________________________

CONSENT TO TREATMENT

PLEASE READ CAREFULLY BEFORE SIGNING.

Naturopathic, chiropractic, acupuncture and Chinese medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee of a specific cure or result.

Print Name: ____

Patient Signature (or responsible party) ____

Date: ______________________________ Relationship to patient: ________________________

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CLINIC POLICIES

PLEASE READ CAREFULLY AND INITIAL BY EACH POLICY.

___________ **Payment Agreement**
When you make an appointment, that time is reserved exclusively for you. Because of this individualized service, we require at least a 24 hour notice if you need to re-schedule your appointment. You will be charged a $50.00 missed appointment fee if you miss a scheduled appointment or fail to cancel at least 24 hours in advance. If you miss your first appointment without giving 24-hours prior notice, you will be asked to put down a deposit of $50 to reschedule; this deposit will apply towards your first visit. Thank you for being considerate to us and to others waiting for appointments.

If you have a phone consultation with the doctor, the charge is the same as for an office visit, with payment due at time of service. Some insurance plans do not cover phone consults. If we are not billing insurance, then you are responsible for your balance at the time of your visit. We do offer a discount to patients paying at the time of service.

Payment for medicines, services, co-pays and any uninsured labs or procedures are due at the time of service. We accept cash, check, credit and debit cards. We use a professional insurance billing service which will bill your insurance company only for covered services. You are responsible for any and all charges your insurance company does not cover including labs, copays, deductibles, in-office treatments, medicinary items, etc. If it is necessary to bill you for a balance, the billing fee is $15. This fee is waived if you pay in less than 15 days. Accounts over 30 days past due accrue 18% interest fees. Return check fee is $35.

_________ **Insurance Agreement**
If you would like us to bill your insurance, then you are responsible for determining the extent of your coverage prior to your first appointment**. The Benchmark Clinic provides a "How to check your benefits" form,** which guides patients through calling their insurance company to determine their coverage. **Please fill this form out completely.** You are responsible for your co-pay or co-insurance at the time of service. If your insurance has a deductible, you must pay the full amount at the time of service until the deductible is met. We will provide you with the paperwork to submit for credit towards this deductible if you wish. Your insurance might pay only a portion of the charge for your treatment; you are responsible to pay for any balance on your account. If we are billing insurance for you, our billing service will bill you for the remainder once we have received the payment and explanation of benefits from your insurance.

_________ **Product Returns**
We maintain an extensive Medicinary so you can purchase high quality supplements conveniently. **Please give us a 7-day notice on refills, or sign up for our automatic refill service**. Medicinary items (except fish oil) are returnable within one month of purchase if they are sealed in the original packaging. Custom and special orders must be paid for when ordering and are non-refundable.

_________ **Perfumes**
The Benchmark Clinic is a Fragrance Free Zone. Many of our patients have severe sensitivities to scented products, especially hair products. Please do not wear perfumes, colognes, hair spray/gel or other scented products to the clinic. Thank you for your cooperation.

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PERMISSION TO SPEAK WITH SPOUSE/PARTNER/PARENT/CHILD/OTHER AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

COMPLETE THIS FORM ***ONLY*** *IF YOU WISH TO ALLOW US TO DISCUSS YOUR CARE WITH SOMEONE ELSE*

Patient Name: ____Date of birth: ______________________

I authorize the Benchmark Clinic to discuss my health information with the following individual(s):
Please list name and relationship:
____
____

If the information to be disclosed contain of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the applicable space. I further understand and agree that if I do not authorize release of this information, that my medical records will be reviewed before release and this information, if it exists, will be blacked out of the record or pages removed prior to release.**

_______ HIV/AIDS information **Initial here if you want this information, if it exists, to be discussed:**
_______ Mental Health information **Initial here if you want this information, if it exists, to be discussed:**
_______ Genetic testing information **Initial here if you want this information, if it exists, to be discussed:**
_______ Drug/alcohol diagnosis, treatment **Initial here if you want this information, if it exists, to be discussed:**

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information, without specific authorization. I understand that federal and state law affects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance. The revocation will not affect any information that was already disclosed.

To revoke this authorization, please send a written statement to Ellen Sauter, ND (contact person) at The Benchmark Clinic and state that you are revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires:
____
(Insert applicable date or event)

Patient Signature (or responsible party) ____

Date: _______________________________ Relationship to patient: _________________________

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RELEASE OF MEDICAL RECORDS
AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

COMPLETE THIS FORM IF YOU WISH TO HAVE PREVIOUS MEDICAL RECORDS SENT TO US FOR REVIEW

Patient Name: ____ Date of Birth: __________________

Purpose of Release Request: Doctor Consultation/Referral. This request is being made by the patient.

Type of medical information to be released:

____ Physician notes and records, operative reports, (limited to two years - other protected records excluded).
____ Lab results, Imaging reports [X-ray, MRI, CT, Echo, Ultrasound, Electrocardiogram (ECG/EKG)]

I authorize the information designated above to be released from the following specific record holders:

A: Name of facility or physician: _____________________________________ Fax: ______________________
Phone: _____________________________________ Location: ____________________________________

B: Name of facility or physician: _____________________________________ Fax: ______________________
Phone: _____________________________________ Location: ____________________________________

C: Name of facility or physician: _____________________________________ Fax: ______________________
Phone: _____________________________________ Location: ____________________________________

D: Name of facility or physician: _____________________________________ Fax: ______________________
Phone: _____________________________________ Location: ____________________________________

If the information to be disclosed contain of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the applicable space. I further understand and agree that if I do not authorize release of this information, that my medical records will be reviewed before release and this information, if it exists, will be blacked out of the record or pages removed prior to release.**

Initial here if you want this information, if it exists, to be released: _______ HIV/AIDS information
Initial here if you want this information, if it exists, to be released: _______ Mental Health information
Initial here if you want this information, if it exists, to be released: _______ Genetic testing information
Initial here if you want this information, if it exists, to be released: _______ Drug/alcohol diagnosis, treatment/referral information

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. I also understand that federal or state law prohibits re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, vocational rehabilitation records or referral information, without specific authorization. I understand that federal and state law affects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I authorize the information designated above to be released to:
Benchmark Clinic, 2456 NW Northrup #1A, Portland OR 97210 Phone: 503-223-7067 Fax 503-223-9639

Expiration of Authorization to Release: This authorization is valid for one year from date of signing or until ____ /____/____ unless revoked by the patient orally or in writing. I understand that if I am requesting information from The Benchmark Clinic that I can revoke this authorization by contacting the HIPAA Privacy Officer (Ellen Sauter, ND) at 2456 NW Northrup #1A, Portland OR 97210, 503-223-7067 except when the action has already occurred as instructed in this authorization.

Disclosure & Authorizations Signature: I understand that I do not have to sign this authorization and that I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. My refusal to sign this authorization will not affect my ability to receive health care services. I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure by others without the knowledge of The Benchmark Clinic and without my consent.

Patient Signature (or responsible party) ____

The Benchmark Clinic
2456 NW Northrup, Suite 1A Portland OR 97210
www.BenchmarkClinic.com **Phone: 503-223-7067** Fax: 503-223-9639

Date: ________________________________ Relationship to patient: __________________________________

How Do I Check My Insurance Benefits?

Patient Name ____DOB: (Date of birth) ________________
Name of primary insured: ____DOB primary insured: _______________
Insurance ________________________________ Member ID# ____________________________ Group # _________________
Phone number of insurance company benefits department____
We will happily assist you with filing an insurance claim for reimbursement, and in some cases, we are able to bill the insurance company directly for your visit; however, **it is the patient's responsibility** to be aware of her/his coverage and co-pay, as well as any deductible and maximums. To determine your benefits, ***call the number*** listed on your insurance card and ask the representative:

1. When did my coverage begin and when is it valid thru? Beginning Date of Coverage ___________________________
   Ending Date of Coverage ___________________________
2. Does my insurance plan follow a Fiscal or Calendar year schedule? (Circle one) Fiscal Calendar
3. **Do I need a referral from my primary care physician for naturopathic or alternative care? Yes No**
4. Is the practitioner I want to see at The Benchmark Clinic either **In-Network or a Preferred Provider** with my insurance?
   Name of provider _________________ **Yes No**
5. Will my insurance pay the clinic or my chosen provider directly? **Yes No**
6. What will my insurance pay an Out of Network provider? ____ % Is this amount subject to deductible? **Yes No**
7. **<u>Benefits for Naturopathic care:</u>**

Are office visits to a naturopathic doctor covered in accordance with the new health care law?
If so, is there a co-payment or coinsurance? Yes No
If so, what is the co-payment or coinsurance amount? _______________
Are office visits subject to any deductible?
Is naturopathic care covered as "Complementary or Alternative" medicine? Yes No
% Covered: __________ Co-payment amount: ___________ Co-Insurance payment: ____________
Is there a yearly maximum benefit for naturopathic care? Yes No
If so, what is this amount? ____________
Is there any waiver of deductible for naturopathic care? Yes No

8. **Is there a third party administrator for naturopathic benefits? If so, please check below:**
   Examples: ASHN - American Specialty Health Network _____
   CHP – Complementary Health Plans (Kaiser) _____
9. **<u>Benefits for acupuncture:</u>**

Is acupuncture a covered benefit on this plan?
If so, is there a co-payment or coinsurance? Yes No
If so, what is the co-payment or coinsurance amount? _______________
Are acupuncture visits subject to any deductible?
Is acupuncture covered as "Complementary or Alternative" medicine? Yes No
% Covered: __________ Co-payment amount: ___________ Co-Insurance payment: ____________
Is there a yearly maximum benefit for acupuncture/complementary care? **Yes No**
If so, what is this amount? ____________
Is there any waiver of deductible for acupuncture? Yes No

10. **Is there a third party administrator for acupuncture benefits? If so, please check below:**
    Examples: ASHN - American Specialty Health Network _____
    (Some plans through Aetna, Anthem, CIGNA, Health Net, Providence)
    CHP – Complementary Health Plans (Kaiser self-referred plans) ______
    Other ____
11. **Name of the representative** I spoke with ____ **Date**__________
12. **Referral or file number** given by company representative to document the call and information. ____________

Please bring this form and your insurance cared with you to your appointment and ask your insurance company to fax a confirmation of benefits to our office at 503-223-9639, or if possible, print out your online benefits page. If you have trouble getting the information you need, please feel free to call the clinic for assistance.

*Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information, they may not honor the benefits that were quoted.