NW HEADACHE AND WELLNESS CENTER

11782 SW BARNES RD BLDG C SUITE 130

PORTLAND OREGON 97225

PHONE: 503-601-0300 / FAX: 503-597-6005

PATIENT INFORMATION

Patient's last name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Sgl ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name)	Birth Date	Age	Sex ☐ M ☐ F

Home Address	City	State	Zip Code

Social Security	Home Phone ( )	Cell Phone ( )	Email

Occupation	Employer	Work Phone No.

How were you referred to our clinic?

☐ Family ☐ Friend ☐ Close to home/work ☐ Dr. _____ ☐ Insurance plan ☐ Other:_____

Attorney Information (if applicable)	Which phone number can we leave messages on?
PREFERRED PHARMACY: **PRIMARY DOCTOR:**	Is there any family member or friend that we have permission to communicate with about your health? **Name:** **Relation:** **Phone:**

INSURANCE INFORMATION

Person Responsible for Bill	Birth Date	Address (if different from above)	Home Phone No.

Occupation	Employer	Employer Address	Employer Phone No.

Primary Insurance Company Name and Phone Number

Subscriber's Name	Subscribers Social Security #	Birth Date	Policy #	Group #	Co-payment $

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Secondary Insurance Company Name and Phone Number (if applicable)	Subscriber's Name	Policy #	Group #

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

EMERGENCY CONTACT INFORMATION

Name of Local friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physicians. I understand that I am financially responsible for any balance. I also authorize NW Headache and Wellness Center or insurance company to release any information required to process my claims.

PATIENT/GUARDIAN SIGNATURE X _____ DATE: _____

NW HEADACHE AND WELLNESS CENTER

11782 SW Barnes Road, Suite 130, Portland, OR 97225

Phone 503-601-0300 / Fax 503-597-6005

CONSENT, RELEASE, AND FINANCIAL AGREEMENT

Medical Consent: The undersigned consent to and authorize any medical treatment, examination or services that may be considered advisable or necessary for the patient in the judgement of Dr. Dale Carter.

Release of Medical Records: NW Headache and Wellness Center may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to NW Headache and Wellness Center or to the patient or to a family member or employer of the patients for all or part of NW Headache and Wellness Center's charges, including but not limited to medical services companies, insurance companies, or workmen's compensation carriers. The undersigned gives consent to release information for the specific purpose of treatment, payment or healthcare operations. All such information would be available after a written request and the approval of NW headache and Wellness Center.

Release of Medical Records: The undersigned authorizes the release of information in the medical record to his/her private physician and to any physician, hospital or agency to which the patient is referred by NW Headache and Wellness Center. The undersigned also authorizes any private physician and any physician, hospital, or agency to which the patient is referred to release NW Headache and Wellness Center information regarding treatment by or at said physician, hospital, or agency.

Insurance: NW Headache and Wellness Center will bill your private health insurance company when supplied with current and accurate insurance coverage information. This office will accept your insurance companies' maximum allowable reimbursement. The patient will be responsible for any deductible, co-insurance, and co-payment amount. If your insurance claim is denied for any reason, you are responsible for payment. The patient is 100% responsible for payment of any non-covered service at the time of service. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to deductibles, co-payments, non-covered charges, and "usual and customary" charges. We reserve the right to not bill your secondary insurance, and we cannot bill third party insurance. NW Headache and Wellness Center does not participate in Medicare, Medicaid, or OHP. You are responsible for the timely payment of your account.

Co-pays, Co-insurance, and Deductibles: All insurance co-payments, co-insurance estimates, and deductibles are due at the time of service, prior to seeing your provider at NW Headache and Wellness Center. Please come to your office visit prepared to pay co-pays, co-insurance, deductibles, and any past due balances.

Self-Pay: If you are a self-pay or uninsured patient, then full payment of services is due at the time of service. Cash payment discount may apply to services rendered by NW Headache and Wellness center. While we will try to accurately estimate the cost of services in advance, the patient agrees in advance to pay for all services and fees NW Headache and Wellness Center feels is necessary for the patient's care.

Motor Vehicle Accident and Work Comp or Third Party Claims: Payment in full is required for services rendered at the time of your initial visit. If return appointments are necessary, the Practice Manager will discuss billing arrangement and/or a monthly plan prior to scheduling. We offer a 20% discount for cash payment. If the medical problem for which you are seeing Dr. Carter involves an attorney, monthly payments by the patient are required. We do not wait for payment until the time of settlement is reached.

Late Cancellations and "No-Shows": Patients who reserve an appointment at NW Headache and Wellness Center and fail to cancel within 24 hours will assess a $100 charge. Patients who do not show for a scheduled appointment will be charged a $100 Missed Appointment Fee. NW Headache and Wellness Center may choose to discontinue care for patients who are chronic late cancel or no-show appointment holders. New patients who do not show for their appointment will not be fined and will not be re-scheduled.

The balance is due 30 days from the first date of billing. If the patient is unable to pay in full, a payment plan may be established. The undersigned understands if this account is assigned to an attorney or collection agency, they will be obligated to pay reasonable associated costs. The undersigned certify that they have read and understand the foregoing and re the patient, or duly authorized by the patient as patient's general agent to execute the above and accept its terms.

_____ I do not wish to release the information to my insurer. I understand my insurance company will not be billed and I will be expected to pay for services personally.

Signature: _____ Date:_____

(Printed Name) _____

"Health Insurance Portability and Accountability Act"
HIPAA Patient Privacy Notice

This notice describes how medical information about you may be used and disclosed, how you can get access to such medical information. This is an update from previous Notices of Privacy Practices that includes new provisions under the Omnibus Rule that took effect on March 26, 2013. Please review carefully.

The Federal Government requires that your Protected Health Information (PHI) stored in your medical record remains private, confidential, and absolutely not available to anyone without your expressed written consent, other than for purposes of Treatment, Payment and Health Care Operations. Our medical record of your care remains the property of NW Headache and Wellness Center. Forms are used for you to authorize, in writing, the release of a copy of your specific medical records to you, another physician, medical practice, or to an insurance company.

Treatment, Payment, and Health Care Operations:

There remains certain instance, where, in the process of delivering quality medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without express written consent of each and every specific incident by you. Some examples include:

- Calling/faxing/electronic communications to your pharmacy for new or renewal prescriptions
- Completing claim forms to obtain payment from your insurance company
- Calling your insurance carrier for eligibility/benefits/billing and reimbursement purposes
- Faxing your insurance carrier with documentation of care and services rendered
- As a specialist, Calling/faxing/e-mailing your Primary Care Physician (PCP) asking to share patient PHI or with results of care or questions regarding your care
- Handling of mail, newsletters, claims, bills, referrals and prior authorizations
- Requesting that the office staff call you to schedule an appointment, acquire a referral, or to inform you about medications or testing that may have been ordered
- Verbal or written correspondence with insurance companies; yours and ours
- Routine inter-office communication between professional staff of this specific practice to effective manage your medical care, and with the administrative staff to coordinate referrals, prior authorizations, send/telephone appointment reminders, file and store medical records, order/receive pharmaceutical drugs on your behalf, submit claims and manage accounts billings, co-payments and other accounts receivable information
- Messages may be left on your home message machine, your work voice mail or your cell phone
- PHI utilized to conduct Quality programs to improve activities or for implementation of compliance programs
- Employee training programs, Accreditation, licensing, certification of activities
- Other Authorizations Required by Law, including: legal proceedings and law enforcement; Workers' Compensation; PHI related to Inmates; Military, National Security and Intelligence Activities; for the Protection of the President; certain approved research purposes; organ and tissue donation; for use by Public Health Activities, coroners, medical examiners and funeral directors; or any other reason such a disclosure would be required by federal, state or local law.
- You may restrict disclosure of any part of your PHI from within this practice to any outside source or recipient, where not allowed by Federal Law, State Law or by Court Order

Your Rights under HIPAA

- You have the right to expect that we will respect and honor your Personal Health Information
- You have the right to inspect and request in writing a copy of your medical record for yourself and/or to be sent to another Physician. If you request a copy of the information, we may charge a fee to cover the cost of producing and mailing the copy.

- You have the right to discuss any and all information contained in your medical record with your Provider of care in a private environment

- You have a right to amend information that we may use to make decisions about you if you believe it is incorrect or incomplete. This request must be in writing and include a reason for the amendment. We may deny your request if the records are complete and accurate, if the records were not created by us, and the records' author is available; if the records are not maintained by us or if the records are otherwise not subject to your access. We will explain our reasons for denial in a written response to you. You have the right to respond in writing to our explanation of denial.
- You have the right to a listing of the disclosures we made of your health care information after April 14, 2003, with exceptions for the purposes of treatment, payment, or health care operations or as directed by law.
- You have the right to complain to the Privacy Officer regarding how your Personal Health Information is guarded, handled, and released (or not released) under the tenants of the law
- You have the right to express concerns about the law and its limitations to the Secretary of the US Government Department of Health and Human Services, or if you believe your privacy rights have been violated
- You have a right not to be retaliated against for filing a complaint
- You have a right to receive notification by a covered entity following a breach of unsecured PHI
- You have the right to opt out of receiving fundraising communications from any health care covered entity.
- Under the HITECH Act, you have the right to restrict disclosures of PHI to your health plan if you pay out-of-pocket in full for a healthcare item or service.
- You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask us not to call you at home, but rather to communicate only by mail.
- Under the Genetic Information Nondiscrimination Act (GINA), your health plan is prohibited from using or disclosing genetic information for underwriting purposes.

Authorization to Release Personal Health Information

- Other uses and disclosures not described in this NPP will be made only with the authorization of the individual.
- You may upon formal written request authorize another individual rights to your Personal Health Information; including but not limited to billing requests
- You may rescind this authorization at any time by providing a formal written request.
- Your authorization is required for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI.
- If you wish to give permission to another to act on your behalf, please request the PHI authorization form from the office staff
- Other uses and disclosures not described in the NPP will be made only with authorization from the individual to whom the PHI relates.

Our Practice Responsibilities

As a covered entity, we have legal duties and privacy practices with respect to Protected Health Information and terms of the Notice of Privacy practice currently in effect. It is our responsibility to guard and maintain personal health information about you and your health in a very private manner. This information will be disclosed within the practice on a "Need to know" basis, and then kept confidential for your assurance that we comply with the Federal Law, State and Local laws on confidentiality of medical information. Your health care information is a personal matter and we are committed to protecting its confidentiality.

Please contact the Practice Manager of NW Headache and Wellness Center at (503) 601-0300 for further information

By signing below, I acknowledge I have read and understand my HIPAA rights and responsibilities.

Printed Name:_____ **Patient Signature:**_____ Date:_____

NW HEADACHE AND WELLNESS CENTER
11782 SW BARNES RD BLDG C SUITE 130
PORTLAND OREGON 97225
Phone: 503-601-0300 | Fax: 503-597-6005

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

PATIENT NAME:_____ DATE:_____
(PLEASE PRINT)
PHONE NUMBER:_____ DATE OF BIRTH:_____

The purpose of the Use/Disclosure is for:
☐ Continuity ☐ Transfer of Care ☐ Persona l ☐ Disability ☐ Insurance ☐ Legal ☐ Other

NEEDED BY DATE: ____/____/____ EXPIRATION DATE (60 DAYS) ____/____/____

(Circle TO or FROM to indicate where you want records sent)

I Authorize records to be released TO/FROM:	**My Records Are to be sent FROM/TO:**
Dale Carter, MD **Facility Name and/or Physician Name/Title Facility**	_____ **Name and/or Physician Name/Title Facility**
11782 SW Barnes Rd, Building C, Suite 130 **Address**	_____ **Address**
Portland, OR 97225 **City, State, Zip Code**	_____ **City, State, Zip Code**
503-601-0300 503-597-6005 **Phone #** **Fax #**	_____ _____ **Phone #** **Fax #**

INFORMATION TO BE RELEASED:

*(PLEASE **INITIAL** EACH LINE THAT APPLIES -no checkmarks please!)*

_____ Progress/OV Notes (most recent visit)

_____ Progress/OV Notes (last 2 years)

_____ Most Recent Lab Reports (within 3 months) & diagnostic/neuro testing

_____ Any CT, MRI/MRA, MRV, EMG, or other

_____ Current List of Medications w/doses

_____ Other:_____

Protected or Sensitive Information:

Additional federal and state laws protect your rights by requiring specific authorization for the release of the following protected health information. I understand and agree that this information will be disclosed if I place my INITIALS in the applicable space next to the type of information:

_____HIV/AIDS information _____Mental Health information

_____Genetics Testing information _____Drug/Alcohol diagnosis, treatment or referral information

PERMISSION TO FAX PROTECTED HEALTH INFORMATION FROM MY MEDICAL RECORD

_____ YES _____ NO My INITIALS give specific consent to fax my information from my medical record. I understand a confidentially statement is included on the fax cover sheet but cannot guarantee the confidential transmitting of my protected health information.

_____ _____
Patient or responsible Party Signature **Date**

NW Headache and Wellness Center, PC

Dale M. Carter, MD

MEDICAL INFORMATION RELEASE FORM

Name: _____ Date of Birth: _____/____/_____

[ ] I authorize the release of information including the diagnosis, records, scheduling; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

NW HEADACHE AND WELLNESS CENTER

MEDICAL HISTORY FORMS

Patient Name: _____ Today's Date: _____

Medication List

List **ALL** medications, including those prescribed by another doctor, and all over-the-counter medications such as Tylenol, Vitamins, herbals, creams, lotions, and drops. This helps us ensure your continuing quality healthcare.

CURRENT Medications (Name, Dosage and Milligrams, Days/Week)	**TRIED/FAILED Medications** (Name, Dosage and Milligrams, Days/Week)

Notes

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Primary Dr. _____ Referring Dr. _____

Occupation: _____

Please list the names of other providers (w/ their specialty) you have seen (including physicians, naturopaths, chiropractors, acupuncturists, counselors, psychiatrists, physical therapists):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WT		**P**	
HT		**R**	
BP		**T**	
Pain:			
Location:			
LMP:			

What is the main reason for your visit today? (Briefly explain specific symptoms, how symptoms started and what happened):

_____

_____

_____

PAST MEDICAL HISTORY:

Do you have, or have you had in the past, any of the following conditions (please circle):

ADD/ADHD	Cancer:_____	High Blood Pressure	Rheumatoid/Osteoarthritis	
Allergies	Depression	High Cholesterol	Seizure Disorder	
Anxiety	Diabetes	Kidney Disease	Sexually Transmitted	
Arnold Chiari Malformation	Fainting	Kidney Stones	Stroke	
Asthma	Heart Attack	Osteoporosis	Thyroid Disease	
Bipolar	Hepatitis	Renal Failure	Tuberculosis	Ulcers

Please list any prior injuries and or accidents and their dates:

_____ _____ _____

_____ _____ _____

SURGICAL HISTORY

Please list any surgeries you have had with the dates they were performed:

_____ _____ _____

_____ _____ _____

Have you ever had a neck CT or MRI performed on you? YES / NO

If so, when and where? _____

_____

_____

Patient Name: _____ Date of Birth:_____

ALLERGIES:

Have you ever had a reaction to any medication? If so, which medication and what happened?

_____

Are you allergic to any food, plants or animals? If yes, please explain:

_____

Are you on a special diet? If yes, please explain:

_____

FAMILY HISTORY:

Are there illnesses such as epilepsy, cancer, diabetes, heart disease, high blood pressure or depression that run in your family? YES NO

Please list ALL family, living or deceased, and all health issues such as ADD/ADHD, Aneurysm, Cancer, Diabetes, Fainting, High Blood Pressure, Mental Illness, Seizures, Stroke, etc. If none, please write none.

Relationship:	Living:	Age:	Significant Health Problems:
Mother	Y N	____	_____
Father	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Paternal Grandmother	Y N	____	_____
Paternal Grandfather	Y N	____	_____
Maternal Grandmother	Y N	____	_____
Maternal Grandfather	Y N	____	_____
Child	Y N	____	_____
Child	Y N	____	_____
_____	Y N	____	_____

Patient Name: _____ Date of Birth: _____

WELLNESS QUESTIONS: Do you…

Currently smoke tobacco? Y N If yes, how much? _____ For how long? _____

Have you smoked in the past? Y N If yes, how much? _____ How Long? _____ Quit date? _____

Do you drink alcohol? Y N If yes, how much? _____ how often per month? _____

Drink caffeinated beverages? Y N If yes, how much? _____

Use recreational "street drugs"? (Including Marijuana, Cocaine, Ecstasy, LSD, Methamphetamine)

Y N If yes, what type? _____ How much? _____

Ever inject drugs? Y N If yes, how much? _____

Do you wear a seatbelt? Y N If yes, how often? _____

Are you sexually active? Y N If yes, with men? Y N with women? Y N both? Y N

Travel outside the US? Y N If yes, where? _____

Where were you born? _____

Describe your sleep quality: Excellent Average Poor

If not excellent, please explain why this may be the case: _____

Do you exercise? Y N If yes, please describe your exercise program and how often you do this:

_____

Do you skip meals? Y N If yes, how often and at what time of day?

Do you pray? Y N Do you meditate? Y N If yes, please describe:

_____

How many glasses of water do you drink each day? _____

How happy are you? Very Moderately Somewhat Very Unhappy

Please explain further: _____

WOMEN: Date of last menses? _____ Birth control method? _____ is your period predictable? If no, how long has it been this way? _____

Number of pregnancies: ____ Number of births: ____ Number of miscarriages: ____ When did this occur?

_____

Patient Name: _____ Date of Birth: _____

REVIEW OF SYMPTOMS:

Please circle any that apply to you or write in any symptoms that are not listed:

General: fever, chills , night sweats , snoring , restless legs , weakness , weight loss , anxiety , anger , fatigue , sadness , poor concentration

Eyes: blurry vision , double vision , irritation , redness , vision loss , excessive tearing , wear glasses or contacts

Ears, Nose, throat: ear pain , ringing or popping in ears , decreased hearing , nasal congestion , wax in ears

Cardiovascular: chest pain , heart disease , fast/slow heart rate , light headedness , palpitations

Respiratory: cough , shortness of breath at rest , excessive phlegm , bloody phlegm , asthma , chest pain with taking a deep breath , pneumonia , wheezing

Gastrointestinal: nausea , vomiting , diarrhea , constipation , change in bowel habits , abdominal pain , blood in stool , blood in vomit , jaundice , gas , bloating , ulcers , hernia , difficulty swallowing , indigestion/heartburn , hemorrhoids

Muscles and Joints: back pain , joint pain , joint swelling , muscle cramps or pain , muscle weakness , arthritis , fractures , dislocations , sprains , cold or blue/white fingers or toes

Neurologic: burning , tingling , seizures , tremors , dizziness , fainting spells , frequent falls , frequent headaches , memory loss , difficulty walking , blurry vision or double vision

Psychological: depression , anxiety , ADD/ADHD , phobias , confusion , bipolar , post-traumatic stress disorder

Endocrine: cold intolerance , heath intolerance , excessive thirst , excessive urination , unusual weight change , excessive hair growth or hair loss

Skin: rash , itching , dryness , redness , flaky scalp , skin cancer , moles

Blood: abnormal bruising or bleeding , anemia , enlarged/swollen glands , recurrent infections

Allergy: postnasal drip . sneezing , itchy eyes , skin , nose or throat , rashes

For Men: painful urination , blood in urine , penile discharge , urinary frequency , urinary hesitancy , abnormal urine stream , waking often to urinate , loss of urine with cough or straining , testicular pain or swelling , difficulty achieving or maintaining erections , pain with ejaculation , premature ejaculation , history of sexually transmitted disease

For Women: cysts on ovaries , endometriosis , heavy cycles , irregular cycles , pain with menses , loss of urine with cough , laughing hard or straining , painful urination , blood in urine , urinary frequency , pain or bleeding with intercourse , history of abnormal pap smear , history of sexually transmitted disease , vaginal discharge , uterine ablation , hysterectomy (partial or full)

Epworth Sleepiness Scale

Patient Name: _____

Date of Birth: _____

Today's Date: _____

This scale is used to determine a person's level of daytime sleepiness.

In the following situations, how likely are you to doze off or fall asleep, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep

1 = slight chance of dozing or sleeping

2 = moderate chance of dozing or sleeping

3 = high chance of dozing or sleeping

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best as you can.

Situation	Chance of dozing or sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a car for an hour	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopping for a few minutes in traffic while driving	
Total Epworth Score	

UNDERSTANDING YOUR SCORE

0-10: Normal range in healthy adults

11-14: Mild sleepiness

15-17: Moderate sleepiness

18 or higher: Severe sleepiness

*If you scored 11 or higher, consider seeing a sleep medicine specialist to diagnose and treat the cause of your sleepiness