



Welcome to Bear Creek Naturopathic Clinic!

Thank you for choosing Bear Creek Naturopathic Clinic. We are committed to assisting you in your path toward health by offering the highest quality of healthcare services.

To begin the process, it is important that you fill out the In-Take forms that are included with this letter. Please be as complete as possible and take your time considering each area and in answering the questions fully. The information you provide on your first visit will aid the doctor in diagnosing and designing a personalized treatment plan for you. Our goal is to help your body regain its balance and harmony as soon as possible. We also wish to keep you fully informed of our clinic fees and payment policies. Feel free to speak with the front desk at any time with questions or concerns. We look forward to working with you.

New Patient Appointments-

Our new patient appointments can be 1.5-2 hours in length, as our physicians take extra care in assessing your unique case, health, lifestyle, history, and individual concerns. Please come prepared for this consult length, and bring a snack and/or water bottle for yourself if needed.

Preparing For Your First Appointment-

Please bring these completed forms with you to your new patient appointment. We ask that you arrive 15 minutes early to allow for proper processing of your paperwork. Remember to bring your insurance card, even if we will not be billing your insurance. We do keep insurance cards on file for other purposes such as laboratory testing, prescriptions authorizations, etc.

We strongly encourage you call your insurance company and complete the entire form "Checking Insurance Benefits".

Please bring any lab test results you may have, or other significant testing from the last two years. It may be brought to your appointment or faxed in advance from other providers.

Cancellations

Should you need to reschedule, we require 48 hour notice **via phone**. You may leave a message on our voicemail if it is outside of business hours. We do not accept emailed cancellations at this time.

*Please note, we are unable to bill for any patient who has Medicare or a Medicare Advantage plans. All charges including consults and laboratory testing will be due directly to our clinic by these patients on the day of service.

Bear Creek Naturopathic Clinic

Office Policies

OFFICE VISITS, LABS, AND PAYMENTS

Self-Pay and Payment Options:

Payment for office visits and procedures are due on the day of service, unless we are billing your insurance company. Special payment plan arrangements can be made *in advance* of your appointment. We accept cash, check, and most credit cards. We currently do not offer a Care Credit option.

Statements and Account Balances:

Please pay off your account balance as soon as possible. Electronic billing statements will be emailed to all patients with an email address on file. Hard copy statements will be mailed after the first month. Unpaid balances may incur a monthly \$15 fee. Delinquent accounts outstanding longer than 90 days after insurance payments post, will be considered for collections referral. Returned checks will incur a \$35 fee. We reserve the right to make changes to our fees and late payment charges without advanced notice.

Insurance Patients:

All charges incurred at our office are your responsibility, regardless of insurance coverage. We recommend that you speak with your insurance company to verify coverage and limitations before your scheduled appointment. It is your responsibility to follow up with your insurance company regarding payment concerns.

Medicare, Medicare Advantage:

We are unable to bill for any patient who has Medicare or a Medicare Advantage plan. All charges (consults, labs, etc.) will be “self-pay” and due directly by such patient on the day of service.

Billing Your Own Insurance:

Please let us know if you will be billing your own insurance, so that we may provide you with all the necessary information, including superbills, CPT, and diagnosis codes (ICD10).

Cancellations:

If you are unable to keep your return patient appointment, please notify us at least 24 hours before your scheduled time, or you may be charged a \$75 fee. 48 hour notice is required for cancellation or rescheduling of any new patient initial appointment, or you may lose your \$100 prepayment. Less than 24 hour notice of cancellation for any laboratory service may incur a charge of \$30. IV CANCELLATIONS with less than 24 hour notice will incur a fee up to the charge of your scheduled IV. Please make all cancellations by phone, even outside of our business hours, as email cancellations will not be accepted.

Phone, Email, and Teleconferencing:

In some cases a phone consult may be arranged, and are billed at the same rate as office visits. *Phone/virtual consult are not billable to insurance.* Email messages that require more than simple yes or no answers may incur charges, and are not billable to insurance.

Laboratory Fees:

Many of our laboratory tests are made payable to our clinic on the day of service. Some laboratory companies require direct payment to the lab in the form of credit card or check. We do our best to keep up-to-date prices on each individual tests and take home kits. In the case where labs have increased prices without our knowledge, we will bill you to collect the additional balance. Some tests charge an additional add-on or reflex fee, which may be billed to you *after results are processed*. You will be billed an additional fee in this case. We strive to keep our laboratory prices under the suggested retail price.

Medical Records:

The law requires that requests for medical records *must be in writing*, even when released to self. Please allow 2-3 weeks for medical records release processing. There is a fee for this service for patients requesting greater than 10 pages. Upon request, copies of lab results are available to patients following each lab review.

Patient Behavior:

We value the safety and respect of all staff, patients, and providers. Threatening and/or aggressive behavior, or sexual advances, will not be tolerated. Any person exhibiting such behavior(s) will immediately be dismissed from the practice.

Privacy Policy:

Our clinic is dedicated to maintain the privacy of your protected health information. Our privacy policy is available in the reception area for you to read at any time.

MEDICINARY**Purchase of Items:**

All natural medicines and products *must be paid for at the time of purchase*. We do not bill insurance for these items. We do our best to keep the doctors' most commonly used items in stock. We cannot always predict what will be purchased each given week by all patients. As a result of fluctuations in purchases, there may be times when the item you use will be out of stock. Please be aware of the timing of your refills, and plan to order items with enough advanced notice as possible. We would appreciate at least *one week notice* of any refills you may need.

Return of Items:

Unopened items in original condition may be returned within 30 *days of purchase*. Refunds cannot be given for injectables, refrigerated products, or custom made items such as tinctures, homeopathics, salves, and powders. Returns will not be given when more than 3 of the same items are purchased together, as this greatly affects our inventory numbers.

Shipping:

We will ship items to you *after payment has been made*, either with a credit card over the phone, or by check. If you opt to mail a check for payment of items, we will hold your order until your check is received. We do charge a small handling fee in addition to the regular shipping postage. Please allow 2-3 business days *after receipt of payment* for your shipment to go out. All items ship out 3 day priority via USPS. Overnight shipping is NOT available. Please plan ahead for holidays and weekends. Please keep us informed of any changes to your shipping address. We cannot be responsible for items that fail to reach you.

Policy and Payment Agreement

I have received and agree to Bear Creek Naturopathic office policies and payment terms.

I understand that I am responsible for payment for services and products rendered by Bear Creek Naturopathic Clinic at time of service, unless prior arrangements have been made.

I agree to pay for all products and services regardless of insurance coverage.

I authorize the release of any medical records necessary for processing of insurance claims. I understand that these policies may be updated at any time, and I agree to check BCNC website for updated information.

Patient Name (Please Print)

Patient Date of Birth (DOB)

Patient/Responsible Party Signature

Date

Print Responsible Party Name (if not patient)_____

Bear Creek Naturopathic Clinic

Email Consent Form

HIPAA stands for the Health Insurance Portability and Accountability Act, and was passed by the U.S. government in 1996 to establish privacy and security protections for health information.

Many email services do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may potentially be able to access your email account and read it without your permission.

Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. This information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Please initial your choice for email communication:

_____ ALLOW UNENCRYPTED EMAIL: I understand the risks of unencrypted email and do hereby give permission to Bear Creek Naturopathic Clinic to send me personal health information via unencrypted email to the email address on file, including but not limited to appointment reminders, receipts, billing statements, email responses to treatment questions, etc.

OR

_____ DO NOT ALLOW UNENCRYPTED EMAIL: I do not wish to receive personal health information via email. Bear Creek Naturopathic Clinic will not keep your email address active. You will not receive emailed appointment reminders, statements, or receive emailed responses from our office.

Patient Name: _____

Date: _____

Patient/Responsible Party Signature: _____

Name of Responsible Party if different from Patient: _____



Acknowledgment of Review/Receipt of Privacy Notice

As required by the Privacy Regulations, I hereby acknowledge that I have reviewed a current copy of **Bear Creek Naturopathic Clinic, LLC** "NOTICE OF PRIVACY PRACTICES."

As required by the Privacy Regulations, an employee from the Bear Creek Naturopathic Clinic, LLC has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that the Bear Creek Naturopathic Clinic, LLC has included a provision that it reserves the right to change the terms of this notice and to make the notice provisions effective for all protected health information that it maintains.

By way of signature, I provide Bear Creek Naturopathic Clinic, LLC with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

Patients Name (print)

Patient's Signature

Date

Signed form received by (Staff Member Use)

Date

Good faith effort to obtain receipt: (Describe) _____



Authorization to Release Confidential Health Information

There is a medical records preparation fee of \$25 for records over 10 pages.

This form authorizes release of medical records to ONLY the Patient or their Responsible Party such as a legal guardian/parent. It does NOT allow for a release to any other entity. Please fill out highlighted areas so we may provide your test results to YOU, when requested by you.

Patient Name _____ Date of Birth _____
Address _____ Phone _____
Responsible Party Name _____ Relationship to Patient _____

(Check all permissions that apply. Release will be in person, or via USPS mail if no permission noted below.)

_____**(check)** Permission to send via email (non-encrypted) to Email: _____
_____**(check)** Permission to Fax# _____ - _____ - _____
_____**(check/Default)** Permission to send by mail.

For the Purpose of: ☐ Concurrent Care ☐ Transfer of Care (Permanent) ☒ Other

I authorize the release of healthcare information:

☒ From:

Send/Provide Information:

☒ To: **Self / Patient / Responsible Party**

Practice/Provider: **BEAR CREEK NATUROPATHIC CLINIC**

Address: **2612 E. BARNETT RD.**

City: **MEDFORD, OR 97504**

Phone: **541-770-5563**

Fax: **541-772-3028**

I specifically authorize the release of the following medical records, to the Patient/Responsible Party, upon request, if such records exist:

☒ Laboratory reports ☒ Clinician office chart notes Other _____
☒ Pathology reports ☒ Diagnostic imaging reports _____

If the information to be disclosed contains any information related to HIV/AIDS, mental health diagnoses or medication management, genetic testing, drug/alcohol diagnosis, treatment or referral information additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed by signing below.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. Provider has up to 30 days to release medical records according to Oregon law and the Health Information Privacy Protection Act.

This authorization may be revoked in writing at any time. If you revoke this 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 coverage.

Unless revoked earlier, **this consent will expire 365 days from the date of signing** or shall remain in effect for the period reasonably needed to complete the request. A copy of this request is acceptable in lieu of the original.

Patient/Responsible Party Signature _____ Date _____



CORY TICHAUER, ND & ASSOCIATES
2612 E. BARNETT ROAD, MEDFORD, OR 97504
PH 541.770.5563 FX 541.772.3028
WWW.BEARCREEKCLINIC.COM

Date _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held **absolutely** confidential.

Name _____		Sex	M	F	Age _____
Address _____		Birthdate _____			
City _____	State _____	Zip _____	Home Phone () _____		
Social Security Number _____		Work Phone () _____			
Email Address _____					
Parent/Guardian _____		Phone _____			
Marital Status	M	S	D	W	Spouse/Partner Name _____ Phone _____
Employment Position/Vocation _____		How Long _____			
In Emergency Notify _____		Phone _____			
Primary Insurance Carrier _____					
Policy or Group Number _____					
Insured's Name _____					
Date symptoms first noticed _____		Work Related		Y	N
Is your condition accident related		Y	N	Where _____	
How did you hear about our clinic? _____					

Main Concern(s)
What are the main concerns you would like us to help you with? _____

How Long ago did these problems begin (be specific)? _____

Have you been given a diagnosis? If so, what? _____

To what extent do these problems interfere with your daily activities? _____

What other types of treatment have you tried? _____

Past Medical History

Significant Illnesses: (Please circle)	Cancer	Diabetes	Colitis	High Blood Pressure
Heart disease	Rheumatic fever	Thyroid disease	Seizures	Venereal disease
Hayfever	Asthma	Depression	Migraines	Fatigue
Hepatitis	Anemia	Jaundice	Stroke	Malaria
Alcoholism	Other _____	Pneumonia	T.B.	Hypoglycemia
Surgeries or hospitalizations _____				
Significant trauma: (auto accidents, falls, etc.) _____				
Allergies: (drugs, chemicals, foods, treatments) _____				

Medicines: Taken within the last two months: (include vitamins, over-the counter drugs, herbs, etc.) _____

Family Medical History: (please circle)

Cancer Diabetes High Blood Pressure Stroke Heart disease Seizures Kidney Stones
 Allergies Arthritis Colitis Ulcers Substance Abuse Thyroid disease Scoliosis
 Mental Disorders Epilepsy Alcoholism Violent Temper Nervous Breakdown Asthma
 Skin Disease Other _____

LIFESTYLE

Do you have a regular exercise program? Yes No Please describe: _____

Are you or have you even been on a restricted diet? What Kind? _____

Habits: (please circle and indicate amount per Day, Week or Month)

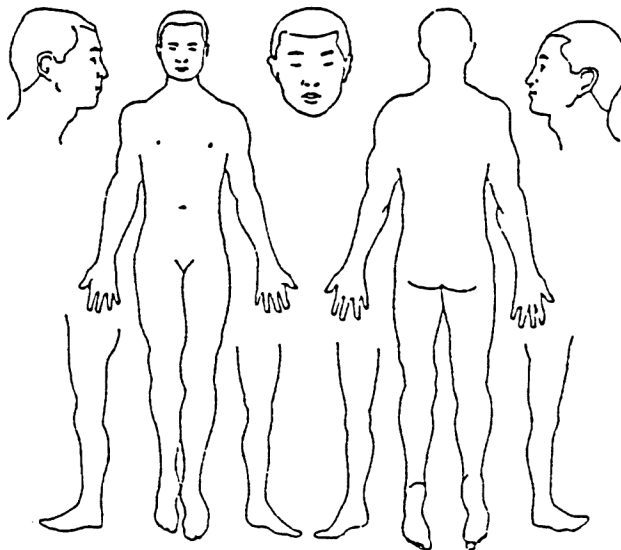
Cigarettes _____ Other Tobacco _____ Coffee _____ Tea _____ Sodas _____ Salt _____ Antacids _____
 Alcohol _____ Candy _____ Sleeping pills _____ Sedatives _____ Aspirin _____ Diet Pills _____
 Birth Control Pills _____ Laxatives _____ Other _____
 Average hours of sleep per night _____. Awake refreshed _____ or tired _____ ?

Weight: Current _____ Most (when) _____ Least (when) _____

Describe a few typical meals:

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
1.						
2.						

Indicate Painful or Distressed Areas on Drawings below:



Please Check if you have had (in the last three months)

GENERAL:

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Frequent colds or flus |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> (What time of day?) _____ | <input type="checkbox"/> Lack of thirst |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Strong thirst (hot or cold) | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |

SKIN AND HAIR:

- | | | |
|--|---|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Oily Skin or Hair |
| <input type="checkbox"/> Dry Skin or Hair | <input type="checkbox"/> Recent Changes of Moles or Warts | |
| <input type="checkbox"/> Change in Hair or Skin Texture or Color <input type="checkbox"/> Skin Cancer Location _____ | | |
| Any other Hair or Skin Problems? _____ | | |

HEAD, EYES, EARS, NOSE AND THROAT:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Corrective Lenses | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Grinding of Teeth |
| <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Jaw Clicks |
| <input type="checkbox"/> Sores on Lips or Tongue | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Hoarse Voice |
| <input type="checkbox"/> Prolonged Cough | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Change in Voice |

Headaches (Where and When?) _____

Any other head or neck problems? _____

CARDIOVASCULAR:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Blood Cholesterol | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Feet Swelling |
| <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> High Blood Triglycerides | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Murmur |

Any other heart or blood vessel problems? _____

RESPIRATORY:

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pain With Deep Breath | Last T.B. Test _____ |
| <input type="checkbox"/> Sputum (Color) _____ | <input type="checkbox"/> Bronchitis | Last Chest X-Ray _____ |
| <input type="checkbox"/> Coughing Blood | | |

Other Lung Problems? _____

GASTROINTESTINAL:

- | | | |
|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heartburn or Indigestion |
| <input type="checkbox"/> Excessive Belching | <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Stomach Pains |
| | | <input type="checkbox"/> Rectal Pain |
| | | <input type="checkbox"/> Hemorrhoids |

Any other intestinal or stomach problems? _____

GENITOURINARY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Impotency |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Get up at night to urinate | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Change in Urine Stream | <input type="checkbox"/> Abnormal Discharge? | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Prostate Problems | Color _____ | |

PREGNANCY AND GYNECOLOGY:

- | | | |
|--|--|---|
| <input type="checkbox"/> Number of Pregnancies | <input type="checkbox"/> Heavy/Light Flow | <input type="checkbox"/> Vaginal Burning or Itching |
| <input type="checkbox"/> Number of Live Births | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Bleeding Between Periods |
| <input type="checkbox"/> Miscarriages/Abortions | <input type="checkbox"/> Painful Menses | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Presently/Possibly Pregnant | <input type="checkbox"/> Cycles Irregular | <input type="checkbox"/> Breast Pain |
| <input type="checkbox"/> Age at First Menses | | |

Have you used birth control pills? Y N How Long? _____

Have you had frequent vaginal or urinary tract infections? Y N

Last gynecological exam and PAP _____

Any other gynecological considerations? _____

MUSCULOSKELETAL:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot/Ankle Pains |
| <input type="checkbox"/> Hand/Wrist Pains | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Peculiar Sensations | <input type="checkbox"/> Scoliosis | |

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL:

- | | | |
|---|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Irritable | <input type="checkbox"/> Prolonged Grief |
| <input type="checkbox"/> Nervousness or Anxiety | <input type="checkbox"/> Poor Libido | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Disturbing Dreams | <input type="checkbox"/> Boredom | <input type="checkbox"/> Severe Frustration |
| <input type="checkbox"/> Easily Susceptible to Stress | <input type="checkbox"/> Loss of Balance | |

Have you ever been treated for emotional problems? Y N

Have you ever considered or attempted suicide? Y N

Any other neurological or psychological problems? _____

Thank you for the time and care you took in completing this form.