NEW PATIENT PACKET

1. Legal Authority to Provide Medical Consent & Information
2. Naturopathic Consent for Treatment
3. Acknowledgement of Receipt of Payment Policy
4. Acknowledgement of Receipt of Notice of Privacy Practices (optional)
5. New Patient Intake Form

Please fill out and sign all forms.

Return via mail or fax to:

Dr. Kate Spangler
PO Box 3293
La Grande, OR 97850

Fax: (888) 972-1716

Forms must be received 48 business hours in advance of your scheduled appointment, or your visit will be cancelled.

For example, if your visit is on a Monday morning, forms must be received by the Thursday morning prior. This ensures that Dr. Kate has adequate time to review your health history and concerns prior to your appointment.

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LEGAL AUTHORITY TO PROVIDE MEDICAL CONSENT & INFORMATION

Patient's full legal name: _____

Patient's date of birth (MM/DD/YYYY): _____/_____/_____

I hereby affirm that I am:

- ☐ The patient
- ☐ The patient's legal guardian
- ☐ A legally authorized medical representative of the patient

IF YOU ANSWERED "PATIENT" ABOVE, SKIP TO SIGNATURE AT THE BOTTOM OF THIS PAGE.

If you are NOT the patient, but are filling out these forms and/or signing on their behalf, please fill out the following:

Your full legal name: _____

Your date of birth (MM/DD/YYYY): _____/_____/_____

Relationship to patient: _____

Legal authorization to make medical decisions for patient:

- ☐ Legal guardian
- ☐ Other (Specify): _____

Signature: _____ Date: _____

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NATUROPATHIC CONSENT FOR TREATMENT

By signing below, I hereby authorize Dr. Kate LLC and its staff to conduct any of the methods, procedures and therapeutic approaches outlined on page 2 of this document. I authorize Dr. Kate LLC to examine, use, store, and dispose of all tissue, fluids, or specimens removed from my body. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

With this knowledge, I voluntarily consent to the treatments outlined below, and acknowledge that no guarantees have been made to me by Dr. Kate LLC or staff regarding the likelihood of success or outcomes of any examination, test, diagnosis, treatment, or therapy performed at or by Dr. Kate LLC.

I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment with Dr. Kate LLC. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my legal medical representative, or as otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Signature: _____ Date: _____

Dr. Kate LLC is a naturopathic medical practice that utilizes various medical treatment modalities to aid in the assessment, diagnosis, management, and treatment of patients' health conditions. Dr. Katherine Spangler is licensed as a Naturopathic Physician in the State of Oregon and has completed graduate level medical training and national board certification.

The following is a list of techniques that may be utilized in naturopathic medical care:

1. **General Diagnostic Procedures:** including but not limited to venipuncture, blood and urine laboratory analysis, imaging procedures, general physical exams, neurological and musculoskeletal assessments, and genital and/or digital rectal examinations.

2. **Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions**

3. **Botanical Medicines; Dietary Supplements; Nutraceuticals:** including but not limited to the use and prescription of various therapeutic substances derived from plant, mineral, and/or animal materials. Such substances may be prescribed in the form of teas, pills, powders,

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tinctures (alcohol-containing), glycerites, topical creams, pastes, plasters, washes, vaginal or rectal suppositories, homeopathic preparations, and/or other forms.

4. **Dietary Advice and Therapeutic Nutrition:** includes the use of foods, dietary modifications, and/or nutritional supplements for assessment, management, and/or treatment of a specific medical condition, or to improve overall health and wellbeing — may include intramuscular vitamin injections.

5. **Soft Tissue and Osseous Manipulation:** soft tissue manipulation includes the use of massage, neuro-muscular techniques, muscle energy stretching, Kinesio-Tape applications, and visceral and/or fascial manipulation. Osseous manipulation includes manipulations of the extremities and spine including traction, high-velocity low-amplitude manipulations, functional indirect manipulation, and craniosacral therapy.

6. **Electromagnetic and Thermal Therapies:** includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared or ultraviolet therapies, and hydrotherapy.

7. **Pharmaceutical Medications:** includes all substances for which Naturopathic Physicians licensed in the State of Oregon have prescriptive rights, as outlined in Oregon Administrative Rules, Chapter 850, Division 60.

Potential Risks: While not common, harm can occur from any therapy. Such complications may include but are not limited to: Pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat therapies, frictional therapies, electromagnetic stimulation, and/or hydrotherapies; loss of consciousness or deep tissue injury from needle insertions or needle breakage; allergic reactions or other intolerances to prescribed herbs, supplements, or medications; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms. In addition, the patient must inform the practitioner if the patient has a severe bleeding disorder, life threatening allergies, or pacemaker prior to treatment.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used may present a risk to the pregnancy.

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ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I hereby acknowledge that Dr. Kate LLC has provided me with an opportunity to review its Financial Policy Document. The Document provides in detail information regarding payment policies, acceptable forms of payment, fees for missed appointments or late cancellations, late and nonpayment policies, and other pertinent payment information.

I understand that payment is due in full at the time of service, and that I am solely responsible for all payment and fees due to Dr. Kate LLC.

I understand that Dr. Kate LLC's current Financial Policy Document is available for my review at any time on the Website, www.drkate.net/office-policies. I understand that if I have questions or complaints regarding payments or bills, I may contact:

Dr. Kate Spangler (541) 962-5235

I understand that Dr. Kate LLC reserves the right to change the terms of its Financial Policy at any time. If changes to the policy occur, the Financial Policy Document available on the Website will be updated accordingly, and will continue to be available for review at any time.

Signature: _____ Date: _____

The following are select highlights of Dr. Kate LLC's Financial Policy. To review the Financial Policy Document in full, please see www.drkate.net/office-policies.

Payment

- **Payment is due in full at the time of service**, unless other arrangements have been made in advance with the approval of Dr. Kate LLC.
- **Dr. Kate LLC does NOT accept or bill insurance. The patient (or legal guardian) is responsible for payment in full.**
    - Dr. Kate LLC will provide a superbill on request for the patient to bill their insurance provider. This is optional, and is the responsibility of the patient. **Dr. Kate LLC makes no guarantees of any insurance reimbursement to the patient, this will vary based on policy. The patient is still solely responsible for all payment and fees due to Dr. Kate LLC.**
- Dr. Kate LLC accepts the following forms of payment:
    - All major debit and credit cards including Visa, MasterCard, Discover, and American Express
    - Personal checks
    - Cash; exact change only

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Missed appointments and late cancellations

- **A $50 fee will be charged for all missed appointments and appointments cancelled less than 24 hours in advance.** If the appointment is on a Monday (or a Tuesday following a weekend on which Monday is a nationally recognized holiday), cancellations must be made by 5 pm on the Friday prior to the appointment.
- All charges are the responsibility of the patient, and will be billed directly to the patient.
- Patients may be discharged from this practice if:
    - They have 2 or more missed appointments or late cancellations within a 6 month period.
    - They have 3 or more **consecutive** missed appointments or late cancellations over any period of time.
    - In such a scenario, Dr. Kate LLC's Patient Termination Policy will be followed. Please see www.drkate.net/office-policies for the full Patient Termination Policy.

Dishonored ("Bounced") Check Policy

- **If Dr. Kate LLC receives a returned check from our bank for a payment by or on behalf of a patient, an invoice will be created for the original amount of the check plus a $25 bank fee per check, or 5% of each check amount, whichever is greater. The payment for said invoice will be due within 10 days of the invoice date, and may not be paid via personal check.**
- Dr. Kate LLC reserves the right to re-submit the original dishonored check for payment, to pursue collection of statutory damages in accordance with ORS 30.701 if the outstanding debt is not paid by the date indicated, and/or to decline provision of further medical treatment to any patient who owes a debt on their account (unless urgent and directly related to a former treatment prescribed or administered by Dr. Kate LLC, for which qualified replacement professional care cannot be found. See Patient Termination Policy for more details).
- **If a patient writes two or more bad checks over any period of time to Dr. Kate LLC, Dr. Kate LLC reserves the right to require payment in full prior to any future visits, and/or to demand future payments from that patient in non-check forms only, and/or to discontinue care with that patient, in accordance with the Patient Termination Policy.** Please see www.drkate.net/office-policies for the full Patient Termination Policy.

Laboratory and imaging orders

- **Dr. Kate LLC does NOT guarantee coverage by the patient's insurance of any testing procedures. The patient is responsible for knowing the coverage and limitations of their insurance policy. If cost may be an issue, patients should contact their insurance company to verify their benefits prior to receiving testing.**

Additional charges

- In addition to the cost of the visit, Dr. Kate LLC may recommend supplements, body work, or other services or products that are associated with an additional fee. The patient will be notified of this verbally prior to any financial transaction, and has the right to decline any and all recommendations for additional purchases made by Dr. Kate LLC.
- **Supplements ordered by Dr. Kate LLC on behalf of a patient will be shipped to their home following the visit, however payment will be due in full at the time of the visit.**
- An itemized receipt for each visit and transaction will be made available to the patient on the Patient Portal (accessible via www.drkate.net/patient-portal) within 72 hours of the encounter.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that Dr. Kate LLC has provided me with an opportunity to review its Notice of Privacy Practices Document. The Document provides in detail the uses and disclosures of my Protected Health Information (PHI) by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my PHI.

I understand that Dr. Kate LLC's current Notice of Privacy Practices Document is available for my review at any time on the Website, www.drkate.net/office-policies. I understand that I am entitled to receive a copy of this Document upon request. I understand that if I have questions or complaints regarding my PHI, I may contact:

Dr. Kate Spangler (541) 962-5235

I understand that Dr. Kate LLC reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI resident at, or controlled by, this practice. If changes to the policy occur, the Notice of Privacy Practices Document available on the Website will be updated accordingly, and will continue to be available for review at any time. I understand that I am entitled to receive updates and/or copies of the Document upon request if Dr. Kate LLC amends or changes its Notice of Privacy Practices.

Signature: _____ Date: _____

THIS SECTION IS TO BE COMPLETED BY STAFF ONLY, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgement

☐ Other (specify): _____

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NEW PATIENT INTAKE FORM

How did you hear about us (please be specific): _____

Main health concern(s) that you would like to address:

_____

_____

Goals & expectations for first visit:

_____

_____

What is your level of commitment to making lifestyle changes to improve your health?
_____% committed

General Information

Last name: _____ First name: _____ MI: ____

Preferred name: _____

Other names that records may be kept under:

_____

Social security number: _____-____-_____

Date of birth (MM/DD/YYYY): _____/_____/_____

Gender: ☐ Female ☐ Male

Street address (incl. city, state, zip):

_____

_____

Billing address (incl. city, state, zip): ☐ Same as above

_____

_____

Communication and Information Sharing Preferences

Phone number: (_____) _____-_____

I authorize Dr. Kate to leave voice messages, that may include my protected health information or appointment times, at this number: ☐ Yes ☐ No

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Email: _____

I consent to receive email notices regarding my care with Dr. Kate: ☐ Yes ☐ No

(Note: *no details about your health status or treatment, aside from appointment times and supplement recommendations, will be shared in your email inbox if you check "yes" above.* ***You must check "yes" if you are filling out electronic intake forms, or would like access to the Patient Portal****, where you can view/print treatment plans, visit summaries, lab results, receipts, superbills, and more.*)

I would like to receive updates and offers from Dr. Kate via email: ☐ Yes ☐ No

Emergency contact

Name: _____

Address (incl. city, state, zip):

_____

Phone number: (_____) _____-_____

Relationship: _____

Authorization to share health information with others

It is NOT NECESSARY to fill out the following two questions. If you would like Dr. Kate to be able to discuss your health care freely with someone else in your life, please list that person below. By doing so, you agree and consent, per Dr. Kate's Privacy Policy, that Dr. Kate LLC may share your protected health information with the named individual, until such time as your consent is revoked in writing.

1) Full name, phone number, and relationship:

_____

_____

2) Full name, phone number, and relationship:

_____

_____

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Social History

Occupational status:

☐ Employed full time ☐ Retired

☐ Employed part time ☐ Disability ☐ Other (specify): _____

If employed, what do you do? _____

Marital status:

☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Please list names, ages, and relationship to you for all persons currently residing in your home:

_____

_____

Foundations of Health

Rate your average daily energy levels on a scale from 1-10 (10 is most energy): _____

What behaviors or lifestyle habits do you engage in regularly that you believe support health?

_____

_____

_____

What behaviors or lifestyle habits do you engage in regularly that you believe are unhealthy?

_____

_____

_____

What obstacles do you see that may prevent you from making healthy changes in your life?

_____

_____

_____

Rate your average daily stress level on a scale from 1-10 (10 is most stress): _____

What do you do to manage your stress?

_____

_____

_____

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Who or what in your life will be sincerely and consistently supportive of you as you begin to make healthier lifestyle choices?

What do you love to do, and how often do you do these things?

How would your life change for the better if you were healthier? What things would you be able to do that you can't do now?

How many ounces of water do you drink per day, on average? _____

Do you have any dietary restrictions (please list)? If yes, why do you avoid these foods?

How much exercise do you get, and what kind? (Any sustained movement counts)

[CONTINUE TO NEXT PAGE]

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Family History

Please indicate if any closely related family members have had, or currently have, any of the following conditions, and specify what type of disease they had, if applicable.

	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF
Addiction*								
Autoimmune condition*								
Cancer*†								
Diabetes								
Heart disease*†								
High blood pressure								
Parkinson's/Alzheimer's								
Stroke†								
Thyroid disease*								

MGM=Maternal grandmother; MGF=Maternal grandfather; PGM=Paternal grandmother; PGF=Paternal grandfather

* Please specify type of disease

† Please specify if they passed away from this, and at what age

Any other relevant family history that you would like to mention:

_____

_____

Personal medical history

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

If yes, who? _____

Please list all other providers involved in your care (include names and specialties):

_____

_____

List all current health conditions that have been diagnosed by a medical professional:

_____

_____

Have you had blood tests or imaging performed in the past year? ☐ Yes ☐ No

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List any abnormal lab values or imaging results you have had in the past year.

_____

_____

_____

What are your most important health problems? List in order of importance:

_____

_____

_____

Have you been treated for this problem before? ☐ Yes ☐ No

What treatments have you tried?

_____

_____

_____

_____

List any major accidents, illnesses, or injuries, and the year they occurred.

_____

_____

_____

_____

List any hospitalizations or major surgeries and the year they occurred.

_____

_____

_____

_____

Allergies

List any life-threatening allergies you have (anaphylactic reactions to drugs, foods, or other substances):

_____

List any non-life-threatening allergies you have (to drugs, foods, or other substances):

_____

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Current Medications and Supplements

Please list the following for each PHARMACEUTICAL MEDICATION you are taking - over the counter and prescription:

Medication name	Dosage (# mg, mcg, IU, etc.)	Timing/Frequency (1x/day, 2x/day, etc.)	Reason for taking:

Please list the following for each SUPPLEMENT you are taking:

Supplement name and brand	Dosage (# mg, mcg, IU, etc.)	Timing/Frequency (1x/day, 2x/day, etc.)	Reason for taking:

I hereby certify that the above statements are true and correct to the best of my knowledge and that I have represented myself accurately. By signing below, I agree to be legally bound by this signature.

Printed name: _____

Signature: _____

Today's date (MM/DD/YYYY): _____/_____/_____

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