



Reba Akin ND
Lisa Shaver ND LAc
Laura Torgerson ND

Dear _____,

Thank you for choosing Everyday Wellness Clinic, LLC for your healthcare needs. Our goal is to help you solve your health problems and promote a healthy lifestyle, naturally. **Please read this letter carefully and sign and date at the bottom.** Fill out the enclosed materials and return them to the clinic as soon as possible. This will provide us with a comprehensive picture of your health status and a greater ability to address the health issues which concern you most.

At your first visit we will listen carefully to your health concerns, review your medical history and answer your questions about how naturopathic care can address your health problems. Together we develop an individualized strategy for you to reach your specific health goals.

Payment is due at time of service. We currently accept cash, check and Visa or MasterCard. We do accept insurance. **It is your responsibility to call your insurance company to verify your coverage.** Please complete the included Insurance Benefits Verification form in its entirety and return it with your intake form. If you have not verified your coverage before your visit, our office will be unable to bill insurance, and you will be charged for your visit. *You are responsible for any services and labs not covered by your insurance plan.* Please call if you have questions.

Appointment cancellation policy: We require **two** working days' notice for a changed or cancelled appointment. A \$50.00 cancellation fee will apply for a missed appointment.

The clinic is located on the corner of SW 11th and Yamhill, in the Professional Building which is directly north of the Central Library. Our facility has stair access to our lobby.

There is a convenient SmartPark on SW 10th and Yamhill for which we validate parking (we do not validate for any other lot). There is also on-street parking. The MAX stops one block away at 10th & Morrison (heading west) or 10th & Yamhill (heading east). The street car stops at 10th & Yamhill (heading north) or 11th & Taylor (heading south). In order to encourage the use of public transportation, we will exchange a new TriMet ticket for a used one.

We look forward to seeing you. If you have not completed your health questionnaire, please arrive at least 30 minutes early to fill out your forms.

Please sign and date below confirming that you have read and understood the content of this letter in its entirety.

Signature _____ Date _____

Appointment: Day _____ Time _____

Sincerely,

Drs. Akin, Shaver and Torgerson

Everyday Wellness Clinic, LLC, 1033 SW Yamhill St., Ste. 300 Portland, OR 97205
p 503.222.1315 f 503.222.1317 info@bewelleveryday.com



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Lisa Shaver ND LAc
Laura Torgerson ND

CONFIDENTIAL CONTACT FORM

Full Legal Name: _____ / _____ / _____
Last Name First Name Middle Initial

Preferred Name: _____ Age _____ Date of Birth _____ S.S. # _____

Address: _____ / _____ / _____ / _____
Street #/PO Box City State Zip code

Telephone: (H) _____ (W) _____ (M) _____

E-mail Address: _____ Gender: Female _____ Male _____

Occupation: _____ (circle) Full Time / Part Time / Student /Retired

Emergency Contact: _____ / _____
Name Relationship

Emergency Contact Number: (H) _____ (W) _____ (M) _____

COMMUNICATION

What is the best way to communicate with you between office visits? E-mail / Home ph. / Work ph. / Cell ph.

Is there any place you do NOT want us to leave a message? _____

May our practitioner(s) discuss your private medical information with you via e-mail*? **Yes No**

May we send you educational/promotional materials such as newsletters via e-mail? **Yes No**

NOTE: Please be aware that email is not a secure communication and that discussion of your medical care will become part of your medical record.

Certain laboratories that the clinic may use participate in anonymous or coded genetic research with samples submitted by this clinic. Please indicate whether you would like to opt-out from having these laboratories use your samples or health information for their research.

opt- out permission to use specimens

INSURANCE

Please provide a copy of the front and back of your Insurance card.

Insured's Address (if different from above): _____

Insurance Company: _____

Do you have any secondary or additional Insurance plans? **Yes No**

Name and Address of Insurance plan: _____ Phone: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature _____ Date _____

Everyday Wellness Clinic, LLC, 1033 SW Yamhill St., Ste. 300 Portland, OR 97205
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CONFIDENTIAL PATIENT INFORMATION *please print*

Name: _____ Mr. Mrs. Ms. Miss Age: _____ Sex: M F

Address: _____ / _____ / _____ / _____
Street #/PO Box City State Zip code

Telephone: (H) _____ (W) _____ (M) _____

Email: _____ SSN: _____ Date of Birth: _____

Most Recent Primary Care Information:

Physician's Name: _____ Phone: _____

Address: _____

How did you hear about us? _____

HEALTH CONCERNS *List, in order of importance, your health concerns and how long you have had these concerns or condition (s):*

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

What do you believe is the cause of condition #1? _____

If you were treated (self or doctor), what method or medicine? And what results? _____

Please check (✓) the box for condition #1 above:

- | | |
|--|--|
| <input type="checkbox"/> Is getting worse | <input type="checkbox"/> Interferes with school/work |
| <input type="checkbox"/> Is constant | <input type="checkbox"/> Interferes with sleep |
| <input type="checkbox"/> Is worse in the morning | <input type="checkbox"/> Interferes with movement and / or exercise |
| <input type="checkbox"/> Is worse in the afternoon | <input type="checkbox"/> You have had this or similar conditions in the past |
| <input type="checkbox"/> Is worse in the evening | <input type="checkbox"/> Notice it more during _____ |

When was your last visit to a doctor's office, medical clinic or hospital? What was the reason?

Date of last physical exam: _____ Any abnormal findings? **Y N** If yes, please explain: _____

Are you under the care of a health care practitioner? If yes, please explain _____

Are you currently under the care of or have you been treated in the past by a naturopathic physician or Chinese medicine practitioner? If yes, please give the names of providers and dates of treatment.

Date of last dental exam: _____ Dentist: _____

MEDICATIONS List all pharmaceutical medication(s) and dosage(s) that you are currently taking

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you allergic to any medications? **Y N**

If Yes, please list: _____

What is your reaction to these medications? _____

Do you have any other allergies to foods, drugs or other allergens in your environment (e.g. cats, mold, dust)? _____

Please check (✓) any of the following that you take:

- | | | |
|--|--|---|
| <input type="checkbox"/> Antacids (Rolaids, Tums) | <input type="checkbox"/> Diet pills, appetite suppressants | <input type="checkbox"/> Pain relievers (aspirin, Tylenol, Aleve, Motrin) |
| <input type="checkbox"/> Antihistamines (Claritin, Benadryl) | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Cortisone (cream or pills) | <input type="checkbox"/> Oral contraceptives or HRT | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Cough & cold medications | | |

What hospitalizations or surgery have you had? Please give dates and reasons:

Have you ever had a blood transfusion? **Y N** Was it your blood taken previously or a donor's blood?

What diagnostic imaging studies have you had?

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Bone Density Scan (DXA) | <input type="checkbox"/> Electroencephalogram (EEG) | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Colonoscopy/Sigmoidoscopy | <input type="checkbox"/> Echocardiogram (Echo) | <input type="checkbox"/> X- ray |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Mammogram | |
| <input type="checkbox"/> Electrocardiogram (ECG/EKG) | <input type="checkbox"/> MRI | |

What immunizations have you had? Include international travel vaccinations if applicable.

- | | | |
|---|--|--|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio - <input type="checkbox"/> inactive (IPV) |
| <input type="checkbox"/> Diphtheria, Tetanus | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> oral (OPV) |
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis | <input type="checkbox"/> Influenza (flu shot) | <input type="checkbox"/> Rubella, single |
| <input type="checkbox"/> Tetanus, single | <input type="checkbox"/> Measles, single | <input type="checkbox"/> Varicella (Chicken Pox) |
| <input type="checkbox"/> Haemophilus Influenza type b | <input type="checkbox"/> Mumps, single | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Measles, Mumps, Rubella (MMR) | |

If you are a child or healthcare worker, are your immunizations current? **Y N**

If not, please explain: _____

Have you had the following childhood illnesses? (✓) if you have, leave blank if unsure:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | |

SUPPLEMENTS List all homeopathic remedies, herbs, vitamins and minerals with dosage that you are currently taking.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

SOCIAL HISTORY

Occupation _____ (circle) Full Time /Part Time /Student /Retired/Disability

Employer / School _____

Are you currently: (circle) Single / Married / Long – term relationship / Widowed / Divorced / Other _____

Name of partner: _____ Number of children and ages? _____

Have you traveled outside the US? **Y N** If yes, where? _____ When? _____

Describe your support network: _____

Have you ever been abused or assaulted verbally, sexually or physically? **Y N**

Health Habits	Yes	No	If Yes, for how long and/or how often per week?
Do you exercise?			
Do you smoke tobacco? Past or present use?			
Do you drink alcohol?			
Do you use recreational drugs?			
Have you ever been treated for drug/alcohol dependence?			Explain:
Do you drink coffee, soda or black tea?			
Do you drink "diet" sodas or eat "diet" foods?			
Are you familiar with "safe sex practices"?			
Do you follow any dietary modifications?			Describe:
Do you follow a spiritual practice?			
Do you have any hobbies/ interests?			Describe:

General Review

Do you.....	Yes	No	General Review – cont.
Sleep well?			Current weight
Wake feeling rested?			Weight one year ago
Eat three meals daily?			Max adult weight, date
Enjoy your work?			Min adult weight, date
Spend time outside?			Max adult height
Take vacations?			Best energy level? (time of day)
Watch television? Hours/week			Lowest energy level? (time of day)
Read? Hours per week			Subjectively, do you feel your temperature runs warm or cool?
Use a computer? Hours per day?			Are you a morning, afternoon or night person?

FOOD & DIET

Please describe your typical food intake

Breakfast	Lunch	Dinner	Snacks	Beverages
				Water ____/day Filtered? Y N

Favorite Foods: _____

List the 3 healthiest foods you eat during an average week _____

List the 3 worst foods you eat during an average week _____

Do you consider yourself a picky or an adventurous eater? _____

What flavors do you like? (circle) sweet / salty / bitter / sour / aromatic / spicy / bland

Do you follow a certain type of diet? Y N Please explain. _____

Have you or do you regularly fast? Y N Please explain. _____

Do you or have you ever had an eating disorder? Y N If 'yes', please explain. _____

PAST MEDICAL HISTORY

Please mark **P** (*past*) or **C** (*current*) for any of the following that you or your family members have had:

Condition	Self	Father	Mother	Sibling(s)	Aunt/ Uncle	Grand- parent	Child
ADD/ADHD							
Alcoholism							
Allergies							
Anemia/ Blood Disorder							
Anxiety/Depression							
Arthritis							
Asthma							
Autoimmune Disease							
Blood Vessel Disorder							
Cancer (type)							
Chemical Sensitivities							
Diabetes							
Drug/Other Addiction							
Eating Disorder							
Epilepsy/Seizures							
Food Poisoning (type)							
Gallbladder Disease							
Gastrointestinal Disorder							
Glaucoma/Cataracts							
Gum Disease							
Headaches/Migraines							
Heart Disease							
Heart Murmur							
High Blood Pressure							
Hypoglycemia							
Infertility							
Kidney Disease							
Liver Disease							
Lung Disease							
Menstrual Disorder							
Mental Illness							
Mouth, Throat Disease							
Muscular Disorder							
Neurological Disorder							
Pain, Chronic							
Skeletal Disorder							
Skin Disorder							
Stroke							
Thyroid Disorder							
Tuberculosis							
Ulcer							
Urinary Disorder							
Vision Problems							
Yeast Infections							

Family's Health	Mother	Father	Siblings	Grandparents
Good				
Average				
Poor				
Age, if living				
Age, when deceased				
Cause of death				

REVIEW OF SYSTEMS

Please check(✓) the box for any conditions that you currently experience - for **Current**, **O** for **Past**

Blood/ Peripheral Vascular

C P

- Anemia
- Cold hands/feet
- Deep leg pain
- Easy bleeding/ bruising
- Thrombophlebitis
- Varicose veins

Cardiovascular

- Chest pain/pressure
- Fainting/ Light-headed
- Heat Disease
- High blood pressure
- High cholesterol
- Heart beat, irregular
- Heart murmur
- Palpitations, fluttering
- Rheumatic fever
- Swelling in ankles

Endocrine

- Fatigue
- Heat or cold intolerance
- Hypo/hyperglycemia
- Hypo/hyperthyroid
- Increasing hunger
- Increasing thirst
- Seasonal depression

Neck

- Goiter
- Lumps
- Pain or stiffness
- Whiplash injury

Neurologic

C P

- Loss of memory
- Numbness or tingling
- Paralysis
- Seizures
- Tremor

Mental/Emotional

- Anxiety, nervousness
- Poor memory
- Depression
- Concentration, difficult
- Contemplate suicide
- Critical of others
- Critical of self
- Experience loneliness
- Mood swings
- Tension, stress
- Treatment for mental/emotional concerns

Head

- Headaches
- Head injury
- Jaw; TMJ problems
- Migraines

Nose and Sinuses

- Hay fever
- Nose bleeds
- Red nose
- Runny nose
- Sinus problems
- Stuffiness, congestion

Eyes

C P

- Blurriness
- Cataracts
- Color blindness
- Diminished night vision
- Dryness, excessive
- Itchy eyes
- Eye pain
- Glasses or contacts
- Glaucoma
- Retinal detachment
- Spots in eyes
- Tearing, excessive

Ears

- Dizziness/Vertigo
- Earache
- Ear infections
- Ears, itchy
- Hearing, impaired
- Ringing, tinnitus
- Wax, excessive

Mouth and Throat

- Bad breath
- Dental cavities/fillings
- Dentures
- Frequent sore throat
- Frequently clearing throat
- Gum problems
- Hoarseness
- Metallic taste in mouth
- Mouth sores
- Saliva, excess
- Sore tongue, lips
- Teeth grinding

Respiratory**C P**

- Asthma
- Bronchitis
- Cough, chronic
- Difficulty breathing
- Emphysema
- Pain on breathing
- Pneumonia
- Pleurisy
- Shortness of breath
 - At night
 - Lying down
 - With exercise/exertion
- Spitting up blood
- Sputum
- Wheezing

Urinary

- Bed wetting
- BPH
- Frequency at night
- Frequent infections
- Increased frequency
- Inability to hold urine
- Kidney stones
- Kidney, back pain
- Low force of urine
- Pain with urination
- Urine retention
- Urgency with urination

Gastrointestinal**C P**

- Abdominal pain, cramps
- Alternating diarrhea/constipation
- Belching
- Blood in stool
- Change in stool
- Bowel movements, how often?
... per day/ 2days/ 3 days/ week
- Bulimia
- Change in appetite
- Change in thirst
- Constipation
- Diarrhea
- Fatigue after eating
- Flatulence/gas
- Gallbladder disease
- Heartburn
- Hemorrhoids
- Hepatitis
- Jaundice
- Liver disease
- Nausea
- Pain in rectum
- Painful stool
- Parasites, diagnosed
- Reflux
- Stomach pain
- Trouble swallowing
- Vomiting

Musculoskeletal**C P**

- Arch supports/heel lifts
- Arthritis
- Back pain
- Broken bones
- Joint pain or stiffness
- Joint swelling
- Muscle pain
- Muscle spasms/cramps
- Muscle weakness, tiredness
- Osteoporosis/osteopenia
- Sciatica

Skin

- Acne
- Boils
- Cancer
- Color change
- Eczema
- Flushing/hot flashes
- Hair loss
- Hives
- Itching
- Lumps
- Night sweats
- Moles
- Psoriasis
- Rashes
- Rosacea
- Skin Tag

REPRODUCTIVE, MALE

Please check (✓)the box for any which apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Birth control, type?
_____ | <input type="checkbox"/> Impotence | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Penile discharge | <input type="checkbox"/> Sexually transmitted
infection(s) _____ |
| <input type="checkbox"/> Ejaculation concerns | <input type="checkbox"/> Penile sores | <input type="checkbox"/> Testicular masses |
| <input type="checkbox"/> Fertility concerns | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Testicular pain |
| | <input type="checkbox"/> Sexually active | |

Date of last prostate exam? _____

Sexual orientation (*circle*): Men / Women / BisexualTransgender: **Y N****Please complete Health Goals on next page.**

REPRODUCTIVE, FEMALE

Age of first menses _____ Avg. length of blood flow ____ (days)
Number of days between menstrual cycles _____ (days) Date of last menstrual period _____
Are cycles regular? **Y N** Are you pregnant? **Y N** Age of last period (if menopausal) _____
Mother's age at menopause _____
Date of last annual exam/PAP _____ Do you do self-breast exam? **Y N** How often? _____
Please specify number of: Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____
Sexual orientation (*circle*): Men / Women / Bisexual Transgender: **Y N**

Please check (✓) the box for any which apply to you:

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Birth control, type?
_____ | <input type="checkbox"/> Hormone replacement
therapy | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Bleeding between cycles | <input type="checkbox"/> Hysterectomy, oophorectomy | <input type="checkbox"/> Premenstrual Syndrome
(PMS) |
| <input type="checkbox"/> Breast lumps, fibrocystic
changes | <input type="checkbox"/> Hysterectomy, ovaries intact | <input type="checkbox"/> Scanty menstrual flow |
| <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Increased or decreased
libido | <input type="checkbox"/> Spotting between periods |
| <input type="checkbox"/> Clotting | <input type="checkbox"/> Irregular cycles | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Cramping with menses | <input type="checkbox"/> Menopausal symptoms | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> DES exposure | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Sexually transmitted
infection _____ |
| <input type="checkbox"/> Difficulty getting pregnant | <input type="checkbox"/> Other
_____ | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian cysts/PCOS | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Genital warts | | |

HEALTH GOALS

What are you health goals? _____

What is your level of motivation regarding your healing? _____

What do you expect from your practitioner? _____

INSURANCE BENEFITS VERIFICATION

(Please consider allowing 1 hour for this form)

Please bring this completed form with you to your appointment.

Everyday Wellness Clinic will bill your insurance carrier if we receive verification of proper coverage. Please complete the insurance information below, as well as the insurance coverage verification information on the back of this form, and attach a front & back copy of your insurance card(s). We do not bill secondary insurance

This is a: New Insurance Application [] Change of Insurance Application []
For: Primary Insurance [] Secondary Insurance []

I. Patient Name _____
Address _____
City _____ State _____ Zip _____
Phone: Work _____ Mobile _____ Home _____
Social Security # _____

II. Insured's Name (if different) _____
Address _____
City _____ State _____ Zip _____
Phone: Work _____ Mobile _____ Home _____
Insured's Date of Birth ___/___/___ Relationship to patient _____

III. Name of **Insurance** Company _____
Claims Address _____
City _____ State _____ Zip _____
Phone: _____ Group or Policy # _____
Insurance ID # _____

Everyday Wellness Clinic will bill your primary insurance for your visit. ***It is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums.*** Please follow steps 1-9 when calling to find out benefits and eligibility.

To start, *call the number* on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions on page two.



1. Name of the representative I am speaking with _____ Date _____
2. When did my coverage begin and when is it valid through?
Beginning Date of Coverage _____ **Ending Date of Coverage** _____
3. Are my alternative claims billed to **American Specialty Health**? ___ **Yes** (If yes, stop here) ___ **No**
4. Do I need a *referral* from my primary care physician (PCP) for alternative services? ___ **Yes** ___ **No**
5. Is the doctor (Dr. Rebecca Akin ND, Dr. Lisa Shaver ND, LAc, or Dr. Laura Torgerson ND) I want to see *In-Network* or a *Preferred Provider* with my insurance company? ___ **Yes** ___ **No**
 - Naturopathic (ND) services? ___ **Yes** ___ **No**
 - Acupuncture (LAc) services? ___ **Yes** ___ **No**
 - Massage (LMT) services? ___ **Yes** ___ **No**

6. What are my benefits? *Be sure to find out which benefits apply to the doctor you are seeing. There will be different benefits depending on whether the doctor is In-Network or Out-of-Network, and whether your plan includes Out-of-Network benefits.

Naturopathic:		(circle)		
Office Visit	% Covered _____	Co-pay/	Co-Insurance _____	Year Max _____
Lab Work	% Covered _____	Co-pay/	Co-Insurance _____	Year Max _____
Physical Medicine	% Covered _____	Co-pay/	Co-Insurance _____	Year Max _____
Supplements	% Covered _____	Co-pay/	Co-Insurance _____	Year Max _____
Acupuncture:	% Covered _____	Co-pay/	Co-Insurance _____	Year Max _____
Massage:	% Covered _____	Co-pay/	Co-Insurance _____	Year Max _____

7. What are the preferred laboratories? LabCorp, Providence, Quest, Other _____
8. What is my deductible for the year and has any or all of it been met?
Deductible \$ _____ **Amount of Deductible met so far \$** _____ **Date** _____
9. What year is my deductible based on? Calendar year ___ Fiscal year ___

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Everyday Wellness Clinic (EWC). I also understand that all out-of-network (non-contracted) insurance billing services provided by EWC on my behalf are performed on a courtesy basis and can be discontinued by either myself or EWC, with written notice, at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to EWC. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature _____ Date _____
Must be signed or verification void



Reba Akin ND
Lisa Shaver ND LAc
Laura Torgerson ND

INFORMED CONSENT FOR PURPOSES OF TREATMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Everyday Wellness Clinic, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Everyday Wellness Clinic, LLC. I understand that diagnosis or treatment of me by my physician(s) at Everyday Wellness Clinic, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand that 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. Everyday Wellness Clinic, LLC is not required to agree to the restrictions that I may request. However, if Everyday Wellness Clinic, LLC agrees to a restriction that I request, the restriction is binding on Everyday Wellness Clinic, LLC and my physician(s) at Everyday Wellness Clinic, LLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Everyday Wellness Clinic, LLC or Everyday Wellness Clinic, LLC 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 clearing house. This protected health information relates to my past, present or future physical or mental health, or condition that identifies me, or there is reasonable basis to believe the information may identify me.

Naturopathic 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, and temporary worsening of symptoms. More serious complications are extremely rare. It is 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 for specific cure or result.

Signature _____

Date _____



Reba Akin ND
Lisa Shaver ND LAc
Laura Torgerson ND

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT

I hereby voluntarily consent to receive acupuncture and Oriental Medicine treatment for my present and future health condition. I understand that treatment will be administered by Dr. Lisa Shaver, ND, MSOM, Licensed Acupuncturist (LAc). On occasion, if Dr. Shaver is not available, I consent to treatment by a substitute LAc, as designated by Dr. Shaver and approved by myself. The treatments that will possibly be administered are described below.

Acupuncture and Oriental Medicine Treatments That May Be Administered:

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise (not painful). Other possible risks from acupuncture include dizziness and fainting. I will report to the LAc any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) include nerve damage, organ puncture, and infection.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the LAc of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with a TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent overwarming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Plum Blossom (or tapping): Multiple, mild needle pricks are applied in one area. Slight bleeding at the area is likely.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

By signing below, I show that:

- I have read, or had read to me, the information on this consent form,
- I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand that I can request more information at any time if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

Patient Name (please print)

Date

Patient (or Guardian) Signature

If a Guardian has signed, please print your name: _____

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