WELCOME

I welcome you to my private Naturopathic Medical practice. Naturopathic medicine is based on a philosophy that incorporates six vital concepts.

THE HEALING POWER OF NATURE
FIRST DO NO HARM
IDENTIFY AND TREAT THE CAUSE
DOCTOR AS TEACHER
PREVENTION
TREAT THE WHOLE PERSON

As a Naturopathic physician I have been trained in a multitude of disciplines including nutrition, homeopathy, botanical medicine, physical medicine, stress management and lifestyle counseling.

OFFICE LOCATION:
15645 SE 114th Ave, Suite 102
Clackamas, OR 97015
Phone: 503.387.3348
Fax: 503.387.3347
www.drjennoleary.com

OFFICE HOURS ARE AVAILABLE BY APPOINTMENT ONLY:

Monday	10:00am-4:30pm (Telemedicine)
Tuesday	10:00am-3:00pm (Telemedicine)
Wednesday	10:00am-4:00pm (Telemedicine)
Thursday	11:00am-3:00pm (Bio-Tuning and Breast Exams)

24 hour notice for cancellation of appointments is required.

APPOINTMENTS AND FEES:

Office visit fees vary depending on complexity and length of appointment. Please contact us for this information.

An initial visit lasts 1 hour. Follow-up visits will vary in length, approximately 30 minutes. Times may vary depending upon the condition and your treatment.

Payment is expected at the time of service. Cash, check and credit cards are accepted. We do bill insurance.

I thank you for your interest in health and wellness and look forward to working with you.

Sincerely,

JENNIFER L. O'LEARY, ND
Naturopathic Physician
Certified Neuroacoustic Therapist

CONSENT FOR NATUROPATHIC TREATMENT

GENERAL DIAGNOSTIC PROCEDURES: Dr. O'Leary may perform any of the following diagnostic procedures as necessary to provide proper assessment, determine treatment approach, and otherwise address your health concerns. This includes but is not limited to: general physical exam, gynecological exam, pap smear, blood, urine and saliva lab work, neurological and psychological assessments.

GENERAL TREATMENT MODALITIES: Due to the diversity of Naturopathic medicine your treatment plan may include any of the following methods:

- **Herbs/Natural Medicine**: prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given as teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, washes, suppositories, or other forms. Homeopathic remedies may also be used.
- **Dietary Advice and Therapeutic Nutrition:** use of foods, diet plans or nutritional supplements for treatment- may include intramuscular injection of vitamins or minerals.
- **Counseling:** lifestyle counseling, stress management, exercise prescriptions and programs.
- **Thermal Therapies**: hydrotherapy, use of alternation of warm to cold, infrared therapy.
- **Pharmaceuticals**: in some cases, the physician may recommend a pharmaceutical medication within scope of practice.

POTENTIAL RISKS: Allergic reactions or side effects from herbs, supplements, or medications; pain or discomfort from manual therapies, hydrotherapy, or injection; aggravation of pre-existing symptoms.

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, as some of the therapies used could present a risk to pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and discontinue participation in these procedures at any time. I do not expect the physician to be able to anticipate and explain all possible risks and complications of treatment, and I accept that my physician will exercise judgment during the course of treatment which she thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement.

Patient's Name (Printed)	Patient's Signature
Guardian/Representative Name (Printed)	Guardian/Representative Signature

PATIENT NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED, AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION.

PATIENT RIGHTS, USES AND DISCLOSURES OF HEALTH INFORMATION: During the course of your care with Jennifer O'Leary, ND we may use or disclose personal and health related information.

- Personal health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of your services.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care. (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care.)

Under federal law, we also may disclose your health information without consent under these circumstances:

- In providing health care services based on the orders of another health care provider.
- In an emergency.
- If we are required by law to provide care, and are unable to obtain your consent.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will only be made upon your written authorization. You have the right to inspect and/or copy your health information. You have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

PHYSICIAN LEGAL DUTIES: We are required by state and federal law to maintain the privacy of your patient file and the protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is en effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible.

COMPLAINTS AND QUESTIONS: If you have a complaint regarding our privacy notice or privacy practices, or if you would like more detailed information, please contact: Dr. Jennifer O'Leary at 503.387.3348. This notice is effective as of May 1, 2006. This notice and any alterations or amendments will expire seven years after the date upon which the record was created.

Signature acknowledges that I have received a copy of this notice.

Patient Name (Printed)	Signature	Date
Responsible Party (Printed)	Signature of Responsible Party	Date

CONSENT FOR TELEMEDICINE APPOINTMENT

PLEASE READ

Telemedicine involves the use of electronic communications to enable health care for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education. Live two-way audio and video will be used through **https://doxy.me**. Security electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS:

- Improved access to medical care by enabling a patient to remain at a remote site
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist
- Maintaining patient safety during a pandemic or declared state/federal emergency

POSSIBLE RISKS (AS WITH ANY MEDICAL APPOINTMENT: There are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (ie. poor quality of video) to allow for appropriate medical decision making by the physician. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment.

In the event that my telemedicine session is disrupted or distorted by technical failures, I would like to be contacted via TELEPHONE at: _____

By signing this form, I understand the following: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information according to the patient medical records policies set by the clinic. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. I understand that my telemedicine appointment may involve electronic communication of my personal medical information to other medical practitioners if a referral is warranted. I understand that it is my duty to inform my physician of electronic interactions regarding my care that I may have had with other healthcare providers. I understand that I may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured. I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I understand that I will not have a physical exam. I agree to consult with a local health care provider in person for any necessary physical examinations. By signing this form, I certify that I have read this form and that I fully understand its content, including risks and benefits of Telemedicine. I have been given ample opportunity to ask questions and all questions have been answered to my satisfaction

Signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Patient Name (Printed)	Signature	Date
_____	_____	_____
Responsible Party (Printed)	Signature of Responsible Party	Date

PATIENT INFORMATION SHEET

PATIENT:

Last Name: _____ First Name: _____ Middle initial: ____

Gender: _____ Date of Birth: _____ Age: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip : _____

Telephone: (h) _____ (w) _____ (w II or cell) _____

Email: _____ What is the best way to contact you? _____

Employer Name: _____ Occupation: _____

Work Address: _____

Relationship status: Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Single ☐

Live with: Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone ☐ Other ☐

How did you hear about our clinic? _____

_____

EMERGENCY CONTACT #1

Last Name: _____ First Name: _____ Middle initial: ____

Telephone: (h) _____ (w) _____ (w II or cell) _____

Relationship to Patient: _____

EMERGENCY CONTACT #2

Last Name: _____ First Name: _____ Middle initial: ____

Telephone: (h) _____ (w) _____ (w II or cell) _____

Relationship to Patient: _____

INSURANCE: Please present your insurance card(s) to the receptionist.

Insurance Company 1: _____ Insured's Name: _____

Insured's date of birth: _____ ID/Policy #: _____ Group #: _____

Insurance Company 2: _____ Insured's Name: _____

Insured's date of birth: _____ ID/Policy #: _____ Group #: _____

RESPONSIBLE PARTY: Fill out if you are not the patient but are responsible for the bill.

Responsible Party: _____ Relationship to the patient: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip : _____

Telephone: (h) _____ (w) _____ (w II or cell) _____

Email: _____ What is the best way to contact you? _____

SIGNATURE:

I request services

X _____

(Patient, Parent, Legal Guardian or Responsible Party)

INSURANCE & FINANCIAL POLICIES

PLEASE READ

Thank you for choosing us for your health care. If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. If you do not, payment is expected at the time of service. Co-pay or co-insurance is also due at the time of service.

INSURANCE: In many cases we will be able to call to verify your coverage during your first visit. If we are not able to verify coverage, payment in full is expected at the first visit. If your insurance company remits payment you will be reimbursed. In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (for example: lab tests, well child and annual exams, pre-existing conditions, etc.) Please check with your insurance company to find out if there are any exclusions in your individual policy.

It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment. As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. We are happy to assist you with this process.

SUPPLEMENTS: Most insurance companies do not cover supplements. Payment in full is expected at time of purchase. We are prohibited from accepting returns once a safety seal has been broken. There is no requirement to purchase recommended supplements from our office; there are several local stores that may carry similar products. Please call the office or email me directly at ajafamilyhealth@gmail.com to request a refill. It is important that you give a minimum of 72 hour notice for a refill request. Please do not wait until you run out. Refill request must be over email or by phone call. Make sure your refill is ready before stopping by the clinic. **Initial here** _____

LATE CANCELLATION/MISSED APPOINTMENTS: As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. Patients who do not give 24 hour notice for a missed appointment will be charged a fee of $50.00. After two missed appointments, you will be charged for the entire time reserved for you on the schedule. Please note, we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies. **Initial here** _____

METHODS OF PAYMENT: We accept cash, checks, debit, Visa, and MasterCard. There is a $25.00 fee for returned checks to cover bank fees. We understand that on occasion, financial problems may affect timely payment of your account. If such a situation arises, please contact our office promptly so payment arrangements can be made. If you have questions about any of the above please contact the office. We appreciate that you have chosen us for your health care and are glad to be of service to you.

AUTHORIZATIONS: I have read the above information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance deems to be patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.

AND

I authorize the release of any medical or other information necessary to process any claims.

AND

I authorize payment of medical benefits to Jennifer O'Leary, ND for all services rendered.

_____	_____	_____
Patient or Responsible Party Name (Printed)	Signature	Date

PATIENT INTAKE FORM: AGES 10-16

PATIENT INFORMATION

Today's date: _____

Legal Name First: _____ Last: _____

Preferred Name: _____ Date of Birth: _____

Mother's Name: _____

Father's Name: _____

Sibling Names and Ages: _____

Pediatrician: _____

Clinic name and phone number: _____

MEDICAL HISTORY

What are your child's health concerns (why are you bringing him/her in)?

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

MEDICATION HISTORY

Please list type and dosage of any prescription medications or over the counter medications, vitamins or other supplements you are currently taking. Please attach a list if necessary.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Known allergies to medications: _____

X-RAYS AND SPECIAL STUDIES

If you have had any imaging studies (x-ray, ultra sound, MRI etc) or special testing done please list test, approximate date and outcome.

1. _____ 2. _____

3. _____ 4. _____

INJURIES/SURGERIES/HOSPITALIZATIONS

1. _____ 2. _____

3. _____ 4. _____

IMMUNIZATIONS:

measles ☐ polio ☐ MMR ☐ small pox ☐ diphtheria ☐

mumps ☐ DPT ☐ tetanus ☐ influenza ☐ other(s): _____

Please note any adverse (bad) reactions to immunizations: _____

CHILDHOOD DISEASES:

chicken pox ☐ rubella ☐ mumps ☐ measles ☐ bronchitis ☐

pneumonia ☐ croup ☐ scarlet fever ☐ other(s): _____

_____

PATIENT INTAKE FORM: AGES 10–16

REVIEW OF SYSTEMS

Y: Yes/Current N: No/Never P: Past

Hives	○ Y	○ N	○ P	Burning of Urine	○ Y	○ N	○ P
Eczema	○ Y	○ N	○ P	Frequent Urination	○ Y	○ N	○ P
Allergies	○ Y	○ N	○ P	Bloody Urine	○ Y	○ N	○ P
Nose Bleeds	○ Y	○ N	○ P	Vomiting Spells	○ Y	○ N	○ P
Bleeding Gums	○ Y	○ N	○ P	Anemia	○ Y	○ N	○ P
High Fevers	○ Y	○ N	○ P	Stomach Aches	○ Y	○ N	○ P
Rash	○ Y	○ N	○ P	Jaundice	○ Y	○ N	○ P
Acne	○ Y	○ N	○ P	Easy Bruising	○ Y	○ N	○ P
Mouth Sores	○ Y	○ N	○ P	Diarrhea	○ Y	○ N	○ P
Sore Throat/Tonsillitis	○ Y	○ N	○ P	Constipation	○ Y	○ N	○ P
Frequent Headaches	○ Y	○ N	○ P	Gas	○ Y	○ N	○ P
Frequent Colds	○ Y	○ N	○ P	Easy Bleeding or Bruising	○ Y	○ N	○ P
Wheezing or Asthma	○ Y	○ N	○ P	Joint Pains	○ Y	○ N	○ P
Cough	○ Y	○ N	○ P	Dizzy Spells	○ Y	○ N	○ P
Ear Infections	○ Y	○ N	○ P	Motion/Car Sickness	○ Y	○ N	○ P
Unusual Fears	○ Y	○ N	○ P	Change in Appetite or Weight	○ Y	○ N	○ P
Cries Easily	○ Y	○ N	○ P	Heart Murmur	○ Y	○ N	○ P
Nervous or Anxious	○ Y	○ N	○ P	Flat Feet	○ Y	○ N	○ P
Sleep Problems	○ Y	○ N	○ P	Body/Breath Odor	○ Y	○ N	○ P
Night Sweats	○ Y	○ N	○ P	Excessive Fatigue	○ Y	○ N	○ P
Nightmares	○ Y	○ N	○ P	Behavior Problems	○ Y	○ N	○ P
Sensitive to Light/Sound	○ Y	○ N	○ P	Hair Loss	○ Y	○ N	○ P

Any other condition/s not mentioned: _____

_____

_____

_____

PATIENT INTAKE FORM: AGES 10-16

Family Medical History: **IF KNOWN** If child or parents are adopted, please check here: ☐

Please specify M=mother, F=father, S=sister, B=brother, A=aunt, U=uncle,
PGM or PGF=paternal grandparent, MGM or MGF=maternal grandparent

Allergies/Hay Fever _____ High Cholesterol _____

Arthritis _____ Cancer _____

Heart Attack/MI _____ Diabetes _____

High blood pressure _____ Other _____

Birth Mother's Prenatal History: **IF KNOWN**

Mother's age at child's birth _____

Any known problems regarding mother's health during pregnancy? ☐ Y ☐ N

Please note any particular psychological stress, drug, tobacco, or alcohol exposure as well as medical issues or complications of delivery: _____

_____

_____

_____

For Young Women Only:

Have menses started: ◯ Y ◯ N If yes, age menses began:

Cramps ◯ Y ◯ N ◯ P PMS ◯ Y ◯ N ◯ P

DR. JENNIFER O'LEARY