

Dr. Kelley R. Reís
503-693-0904
The Natural Medicine Center
172 SE 6th Ave
Hillsboro, OR 97123

6 MONTH RETURN

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip code: _____ Phone: (_____) _____

1. What are your chief concerns at this time:

2. Please list medications, supplements, vitamins, minerals, herbal medicines and homeopathics that you are taking on a consistent basis:

3. How frequently have you been exercising? **Daily** >3x/wk **Seldom**

What type(s) of exercise? _____

4. Describe any lab work, imaging or special studies you have had since your last visit?

5. Have you undergone a surgery or hospitalization? Please describe:

6. Have you experienced any major "life events" since your last visit? Please describe:

7. What is your present level of commitment to address underlying causes of your signs and symptoms which relate to your lifestyle? (Rate from 0% to 100% committed)

0% 10 20 30 40 50 60 70 80 90 100%

8. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list) _____

That does *not* support your health? (Please list) _____

9. Any additional comments?

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Dear New Patient,

Welcome to our clinic. We look forward to providing for your health needs and encourage your questions and participation in all aspects of your health care.

_____ **Payment for all services and dispensary items is due at the time of the visit.**
Initials

_____ **We are not providers on all insurance plans, therefore you may be required to bill your own insurance. We will provide you with all the necessary information for you to send your claim for reimbursement. You have the primary relationship with your insurance company and are responsible for the entire amount that is owed.**
Initials

_____ **You will be charged a Missed Appointment fee for any missed appointments or late cancellations (less than 24 hours notice).**
Initials

_____ **I give permission for the staff at The Natural Medicine Center to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.**
Initials

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of \$25.00 for every returned check(s). We can arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care providers who may be providing similar services at The Natural Medicine Center. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at The Natural Medicine Center.

Your health care provider may prescribe medication, which may be purchased either at The Natural Medicine Center or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Your Signature (parent signature if minor)

Print your name (parent name if minor & patient name)

Date