

 **Carolyn Nygaard ND**

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**PERSONAL INFORMATION**

First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle name\_\_\_\_\_\_\_\_\_Last name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ok to text?\_\_\_\_\_\_\_\_

Other phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ok to leave messages pertaining to your health?\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to email your health records? \_\_\_\_\_\_\_\_\_\_

I am: Married\_\_\_\_ Divorced\_\_\_ Separated\_\_\_ Widowed\_\_\_ Single\_\_\_ In a partnership\_\_\_

I live with: Spouse\_\_\_ Partner\_\_\_ Parents\_\_\_ Self\_\_\_ Children\_\_\_ Friends\_\_\_

Do you have any children? Please list their names and ages:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WORK AND EDUCATION**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per week:\_\_\_\_\_\_ Do you enjoy it?\_\_\_\_\_\_\_\_\_

Name of Employer :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY INFORMATION**

In the event of an emergency, whom should we contact?

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

If you like us to bill your insurance for your visit, you must provide a current insurance card and vaild photo ID.

Name of Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

Please read and initial next to each policy:

\_\_\_\_ Payment for all copays, services and medicines are due at the time of service (except for the portion that insurance is estimated to pay).

\_\_\_\_ For cash-paying patients, the cost of the office visit is discounted by 20% and is due at the time of service. A sliding scale of payments will be provided based on individual need.

\_\_\_\_ A missed appointment fee of $50 will be charged for cancellations with less than 24 hours notice and for missed appointments.

\_\_\_\_ I understand that any balances which are over 60 days due will accrue late fees of 1.5% per month, which will be applied to the unpaid balance at the end of the month.

\_\_\_\_ I understand that I am responsible for knowing my insurance policy and coverage. I have the primary relationship with my insurance company. I am responsible to report any changes to my policy.

\_\_\_\_ I authorize the release of medical information that may be required by the insurance company. I authorize my insurance company to directly pay the physicians at Astoria Integrative Family Medicine for my medical care.

\_\_\_\_ Telephone calls are not generally a covered benefit of health insurance policies. Telephone calls in excess of 15 minutes for health related matters may be subject to a fee.

**I have read and understand all of the above policies and agree to comply with them.**

Signature (Parent if minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

 **HEALTH HISTORY**

Are you currently receiving health care? \_\_\_\_\_\_\_ From whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Location of Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, when and where was the last time you saw a doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all other doctors, therapists, specialists etc. on your health care team:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason you see them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason you see them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason you see them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your height? \_\_\_\_\_\_\_\_\_ What is your weight? \_\_\_\_\_\_\_

**ALLERGIES**

To drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To chemicals or environment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food allergies or sensitivities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIORITIES:**

What is the reason you are coming in today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any contagious disease at this time? \_\_\_\_ If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your most important health concerns? Please list as many as you can think of in order of importance:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIET**:

How often do you cook \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow a particular diet (paleo, vegetarian, vegan etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR THE FOLLOWING QUESTIONS PLEASE CIRCLE:**

**Y = YES I have this now N = I have NEVER had this P = Problem in the PAST**

**HABITS:**

Main interests and hobbies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you do for exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average 6-8 hours of sleep Y N P Sleep well Y N P

Wake feeling rested Y N P Enjoy life Y N P

Have a supportive relationship Y N P Have you ever been abused in any way Y N

Been treated for drug dependence Y N P Been treated for alcohol dependence Y N P

Use tobacco Y N P Type of tobacco: cigarette smokeless dip

How many packs per day \_\_\_\_\_\_ How many years\_\_\_\_\_\_\_\_

Do you have a spiritual or religious practice? If yes, can you tell me about it:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

**MENTAL AND EMOTIONAL**

Treated for emotional problems Y N P Depression Y N P

Mood swings Y N P Anxiety or Nervousness Y N P

Considered/Attempted suicide Y N P Brain fog Y N P

Poor concentration Y N P Memory problems Y N P

**IMMUNE SYSTEM**

Chronic infections Y N P Reactions to vaccinations Y N P

**ENDOCRINE SYSTEM**

Thyroid Disorder Y N P Hair loss Y N P

Low blood sugar (hypoglycemia) Y N P Diabetes Y N P

Heat or Cold intolerance Y N P Night sweats Y N P

Excessive thirst Y N P Excessive hunger Y N P

**NEUROLOGIC SYSTEM**

Seizures Y N P Paralysis Y N P

Numbness/Tingling Y N P Muscle weakness Y N P

Dizziness or Vertigo Y N P Loss of Balance Y N P

**SKIN**

Rashes Y N P Eczema/Hives Y N P

Acne/Boils Y N P Itching Y N P

**EYES**

Dry eyes Y N P Glaucoma Y N P

Cataracts Y N P Eye pain/strain Y N P

**HEAD**

Headaches Y N P Head injury Y N P

Migraines Y N P Jaw/ TMJ problems Y N P

**EARS**

Impaired hearing Y N P Earaches Y N P

Ringing Y N P Excess wax Y N P

**NOSE AND SINUSES**

Frequent colds Y N P Nose bleeds Y N P

Stuffiness Y N P Seasonal allergies Y N P

Loss of smell Y N P Sinus problems Y N P

**MOUTH AND THROAT**

Frequent sore throat Y N P Hoarseness Y N P

**RESPIRATORY SYSTEM**

Cough Y N P Spitting up blood Y N P

Asthma Y N P Bronchitis Y N P

Pneumonia Y N P Shortness of breath Y N P

**CARDIOVASCULAR SYSTEM**

Heart Disease Y N P Abnormal blood pressure Y N P Fainting Y N P Blood clots Y N P

Palpitations Y N P Ankle/Foot swelling Y N P

Chest pain Y N P Murmurs Y N P

**GASTROINTESTINAL SYSTEM**

Trouble swallowing Y N P

Abdominal pain Y N P Heartburn Y N P

Gas/Bloating Y N P Nausea/Vomiting Y N P

Diarrhea Y N P Constipation Y N P

Ulcers Y N P Hemorrhoids Y N P

Liver disease Y N P Gallbladder disease Y N P

How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**URINARY SYSTEM**

Pain with urination Y N P Increased frequency Y N P

Frequency at night Y N P Frequent infections Y N P

Inability to hold urine Y N P Kidney stones Y N P

**MUSCULOSKELETAL SYSTEM**

Joint pain or stiffness Y N P Arthritis Y N P

Muscle cramps or spasms Y N P Restless legs Y N P

**VASCULAR SYSTEM**

Easy bleeding/bruising Y N P Varicose veins Y N P

Anemia Y N P Cold hands/feet Y N P

**SEXUALITY**

With what gender do you identify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual orientation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active Y N P Birth control method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your sex drive (1-10) \_\_\_\_\_\_\_\_\_ Sexual satisfaction (1-10)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MALE HEALTH**

Hernias Y N P Testicular pain Y N P

Testicular masses Y N P Discharge or sores Y N P

Prostate disease Y N P Chlamydia Y N P

Gonorrhea Y N P Herpes Y N P

Condyloma Y N P Syphilis Y N P

Impotence Y N P Premature ejaculation Y N P

**FEMALE HEALTH**

Age of first menses \_\_\_\_\_\_\_ Age of last menses (if menopausal) \_\_\_\_\_\_

Length of cycle (from start to start) \_\_\_\_ Duration of bleeding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are cycles regular Y N P Painful menses Y N P

Heavy flow Y N P Bleeding between cycle Y N P

PMS Y N P

 If yes, what are your symptoms?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last Pap \_\_\_\_\_\_\_\_\_\_\_\_ Abnormal Pap Y N P

Endometriosis Y N P Pain with intercourse Y N P

Ovarian cysts Y N P Condyloma Y N P

Gonorrhea Y N P Chlamydia Y N P

Syphilis Y N P Herpes Y N P

Abnormal discharge Y N P PCOS Y N P

Breast pain Y N P Breast lumps Y N P

Nipple discharge Y N P Do do self-exams Y N

**OBSTETRICAL**

Number of pregnancies: \_\_\_\_\_\_\_\_\_ Difficulty conceiving Y N

Number of live births: \_\_\_\_\_\_\_\_\_\_\_ Vaginal? \_\_\_\_\_\_ C-section? \_\_\_\_\_ VBAC? \_\_\_\_\_\_\_\_

Number of abortions: \_\_\_\_\_\_\_\_\_\_\_ Number of miscarriages: \_\_\_\_\_\_\_\_\_

Complications of pregnancies/birth/post-partum \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITALIZATIONS AND PROCEDURES**

Please list all hospitalizations, surgeries, EKGs, EEGs, MRIs and procedures (including dates):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

Please list conditions for the following relatives:

Mother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandmother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandmother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandfather:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandfather:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aunt/Uncles/Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Here are some common conditions.

Cancer Diabetes Heart Disease High Blood Pressure Addiction Arthritis

Kidney Disease Epilepsy Autoimmune disease Stroke Mental illness

Tuberculosis Eczema/Psoriasis Osteoporosis Thyroid problems

**CURRENT MEDICATIONS AND SUPPLEMENTS**

Please list ALL prescriptions, over-the-counter medications, vitamins, herbs, hormones, homeopathics and supplements that you are taking and for what purpose: (feel free to use the back as well)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for taking the time to complete these forms. I am honored to work with you on your journey towards health.*

**\**

 **ACKNOWLEDGEMENT AND CONSENT TO PRIVACY PRACTICES**

 Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally can not give your information to your employer, share your information for marketing purposes, or share notes about your mental health without your written consent. It is our responsibility to keep your information safe and secure.

I understand that:

* A record will be kept of the health services provided to me. This will be kept confidential and not released unless specifically directed by myself or representative unless required by law.
* My information may be shared:
	+ For coordination of care with multiple health care providers
	+ With other clinic members or students
	+ With relatives and friends specifically identified below
	+ To protect the public’s health (such as flu reporting)
	+ To make required police reports (such as gunshot wounds)
	+ To obtain payment from third party payers (insurance companies)
* I have the right to request that my provider not tell my insurer about services I elect to pay out of pocket.
* I may look at my health record or request a copy of it at any time.
* I have the option of securely accessing my electronic health record.
* This clinic follows HIPAA guidelines to protect my health information.
* My provider will not sell my protected health information (PHI).
* My provider is required to notify me if there is a breach in security that involves my records.
* My health records will be kept for a minimum of seven years after my last date of service.
* I am entitled to receive updates if this policy is changed.

In order to best meet your privacy needs, please let us know the following:

\_\_\_\_ I give my permission to call me at home.

\_\_\_\_ I give my permission to call my cell phone.

\_\_\_\_ I give permission to leave messages on my answering machine about lab results and appts.

\_\_\_\_ I prefer to be contacted via \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I give permission to email me pertaining to my health information.

\_\_\_\_ Please do not share my health information with my health insurance carrier.

Please list those whom you are allowing us to share your health information with:

Signature (parent if minor):

Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy of Non-discrimination and Consent To Treatment**

It is the policy of Astoria Integrative Family Medicine (AIFM)I to provide equitable health care without discrimination against, or harassment of, any person on the basis of race, color, national origin, language, religion, sex, age, disability, citizenship, marital status, creed, **sexual orientation, gender expression or gender identity (the patient’s preferred gender will be respected, and the patient will be referred to by their name and pronoun of choice, whenever feasible)** or other non-medically relevant factor or any other characteristic protected by federal or state law. Any such discrimination or harassment is prohibited and will not be tolerated. This applies to admission, treatment, discharge or other participation in any of AIFM’s programs, services or activities, including, but not limited to: all patient visits; all care, whether inpatient, outpatient or emergency in nature; all patients’ rooms except in those cases where patient safety or health condition is a necessary consideration; and employee assignments to patient services.

 At AIFM, we believe in treating people, not disease. Therefore, each individual patient will receive a treatment plan that is specifically developed for them. Dr. Carolyn Nygaard also employs such therapeutic procedures as hydrotherapy, manual soft tissue work, and spinal/joint manipulation as needed on an individual patient basis. Other forms of treatment include preconception/prenatal management, doula services, clinical nutrition consultation and supplementation, herbal therapy, homeopathy, stress management and lifestyle changes, and home birth/post-partum care. It is understood that while our practices and procedures are safe and effective, not everyone responds the same way to different treatments, and occasionally side effects or complications may arise.

While the risk of complications or side effects from any of the above treatments is rare, it is our policy to inform our patients about them. These complications may include, but are not limited to, soreness, bruising, inflammation, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of specific treatments is available upon request.

The way in which we choose to treat people will often be different than the conventional care of your MD. It is our policy to always inform you of the procedure being performed and any risks and alternative treatments available to you. If Dr. Carolyn Nygaard’s explanation is not to your satisfaction, please ask for more information.

Please 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 provider who may be providing similar services at Astoria Integrative Family Medicine. Your health care practitioner 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 Astoria Integrative Family Medicine.

I have read and understand the above statements regarding policies of non-discrimination, treatments and adverse/side effects.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature or Guardian (if patient is a minor) Date