Jacqueline Engel, ND, LMT
Common Ground Wellness Center
5010 NE 33rd Ave, Portland, OR 97211

PATIENT INFORMATION

Date ________________ Patient Name ____
SSN ________________ Gender ____________ Birthdate __________ Home Phone ________________
Address ____ Cell Phone ________________
City ________________________ State ______ Zip ________ Driver's License ________________
___ Minor ___ Single ___ Married ___ Partner
Patient's or parent's employer ______________________________ Work Phone ________________
If patient is a student, name of school/college ________________________ City ____________ State ___
Whom may we thank for referring you? ____
Person to contact in case of emergency __________________ Relationship __________ Phone __________

Insurance Information:
Person Responsible/Primary Insured ____________________ Relationship to patient ______________
Address ______________________________ Home phone ____________ Primary's birthdate ____________
Employer ______________________________
Insurance Co. __________________ Subscriber ID# ______________________ Group# ____________
Insurance phone ________________

In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

Signature ____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have read and understand your Notice or Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time to obtain a current copy of the Notice of Privacy Practices. I have the right to revoke this authorization in writing except to the extent that Jacqueline Engel, ND, LMT has acted in reliance upon this authorization. My written revocation must be submitted to Jacqueline Engel, ND, LMT, Common Ground Wellness Center, Portland, OR 97211.

CONSENT FOR MEDICAL TREATMENT

I am requesting and hereby authorize services offered to me by Jacqueline Engel, ND, LMT, including physical examination, any tests and/or treatment deemed appropriate by my provider. Treatments may include the use of herbs, supplements, nutritional counseling, manual therapy and hydrotherapy. I will notify the doctor should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid treatments and herbs that could induce miscarriage. I understand that I am responsible for all fees regardless of insurance coverage and/ or treatment outcome.

I confirm that I have read and fully understand all of the above prior to my signing. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to my doctor.

Signature of Patient (parent or guardian if patient is a minor) ______________________________
Date ________________