

**Michelle K Jackson ND, PC.**  
**61535 S. HWY 97**  
**Suite 5-404**  
**Bend, OR 97702**  
**Phone (541) 385-0775**  
**Fax (541) 330-1466**  
[www.drjacksonnd.com](http://www.drjacksonnd.com)  
[office@drjacksonnd.com](mailto:office@drjacksonnd.com)

## *Welcome*

### **Dear Patient:**

We would like to take this opportunity to thank you for choosing Dr. Michelle K. Jackson ND, for your health care needs. Please fill out these forms as completely as possible and send them to us 2 business days or more prior to your appointment. If you have copies of any previous laboratory work through other doctors, please send these to us also. Should you have any questions, please contact our office at (541) 385-0775. We will be happy to help you.

Your first appointment will take 60-90 minutes on average, which includes consultation time with the doctor and examination if needed. **A Brief In Person Exam will be required if Controlled Substances, such as Testosterone, are prescribed by Dr. Jackson.** Any laboratory tests or pharmacy recommended are not included in your office call fee. Due to the extended time set aside especially for you, we must ask that, should you need to reschedule or cancel your appointment, that you contact the office 24 to 48 hours prior to your appointment (via voice mail is okay also). Unless notification is given, the first office call will be charged to your account. Please keep this in mind to avoid these charges.

Dr. Jackson is available by email or phone for questions. Simple questions may be handled by a brief exchange of messages, otherwise, it is better to schedule appointments. While we do not charge for very brief issues requiring five minutes or less of Dr Jackson's time, letter writing, form completion, records review, laboratory result review, medication prior authorizations, and other requests outside of scheduled appointments will incur a charge, depending on the amount of time needed.

**We are looking forward to seeing you on:** \_\_\_\_\_

**Please have all forms back to us 2 business days prior to your appointment**

## **INFORMATION ABOUT THE DOCTOR**

Dr. Michelle Jackson is a OREGON STATE LICENSED NATUROPATHIC PHYSICIAN. Dr Jackson's undergraduate education was completed at the University of Colorado at Boulder with a major in Kinesiology.

Dr. Jackson graduated from the National College of Naturopathic Medicine in Portland, Oregon. She received her Doctorate in Naturopathic Medicine in June of 2001. Dr. Jackson is a member of the American Association of Naturopathic Physicians and the Oregon Association of Naturopathic Physicians.

Dr Jackson conducts a specialized telemedicine practice, with a focus on male and female hormone imbalances, thyroid and adrenal issues, food sensitivities, and neurotransmitter disorders. Although Dr. Jackson no longer serves as a Primary Care physician, Dr. Jackson can advise naturopathic treatment for most and all diseases and conditions. Dr. Jackson orders many blood and urine tests. Licensed medical laboratories are used for all laboratory tests and may include local laboratories, Central Oregon Regional Laboratories, Doctors Data, US Biotek, and Diagnos-Techs). If X-rays, CT scans, or MRI's are needed, they are ordered through local hospitals or radiology centers. Dr Jackson works with, and refers out to, other health care specialists whenever the need arises.

Our clinic's naturopathic pharmacy is on the premises so that naturopathic medications can be conveniently picked up from our location. Mailings are done routinely so that refills do not require a trip to the office.

Thank you! We look forward to serving your health care needs!

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## *Type of Practice*

Dr. Jackson specializes in Male and Female Hormone balancing, Thyroid and Adrenal disorders and conditions relating to Neurotransmitter imbalances.

The following is a brief list of conditions that Dr. Jackson commonly treats:

### **NATUROPATHIC CARE**

- | Allergies – both food and environmental
- | Immune support therapy
- | Candida infections
- | Chronic fatigue syndrome
- | Fibromyalgia
- | PMS and Hormonal Imbalances
- | Natural hormones replacement therapies/Bioidentical Hormone Replacement- for Men and Women
- | Acne, psoriasis, eczema, dermatitis
- | Digestive problems, ulcers, irritable bowel
- | Attention deficit disorders with hyperactivity
- | Arthritis, rheumatoid and osteoarthritis
- | Thyroid Imbalances
- | Adrenal Imbalances
- | Weight management
- | Insomnia
- | Headaches and Migraines
- | Anxiety
- | Depression
- | Memory Issues

Please note that all health issues can be multifaceted and although Dr. Jackson focuses on hormone, thyroid, adrenal and neurotransmitter imbalances, you as the patient, should continue to see your Primary Care Physician and any specialist, and you may need to be co-managed with other providers.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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## COMMITMENT TO CHANGE

*Policies are necessary for any office to run effectively. However, it is important to keep in mind the goals of the office. We are here to help people change in positive ways. To be committed to positive changes means openness, collaboration, and personal responsibility. Ultimately, your health is your responsibility. Our job is to facilitate your progress to health.*

## SERVICES

A first office call generally runs 60 minutes. Return office calls are scheduled for approximately 30-45 minutes. It is important to be on time because appointments will not be extended beyond the scheduled time as a result of a late arrival. *Because your initial appointment is held especially for you, we require a full business day's notice to cancel or reschedule your appointment.* This office policy will be strictly enforced, so please give us 24 hours advance notice of your need to cancel/reschedule.

## CHARGES AND PAYMENT

Charges are typically accumulated on the basis of length of visit. Laboratory testing, pharmacy items, consultations (phone included), letter writing and written summaries are examples of additional services rendered. *Patients are advised that payment will be expected upon receipt of services or pharmacy. Payment may be made by check, cash, MasterCard or Visa.*

## INSURANCE COVERAGE

We are an **Out-of-Network Provider** with all insurance companies. If you do have *out-of-network Naturopathic benefits* we will bill your insurance company for you. Please note that the full patient responsibility is due at the time of service. *If insurance coverage for your visit is of the utmost importance, please check with your carrier prior to your scheduled appointment.*

## EXAMPLES OF CURRENT FEES

New Patient Visit (approximately 60 minutes)..... Starting at \$283.00  
Return Office Call (approximately 30 to 45 minutes).....\$165.00 to \$220.00  
Letters .....Starting at \$35.00  
If your visit exceeds your anticipated time, extended visits are billed in 15 minute increments.

*I have read and agree to abide by the above office policies:*

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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### **OTHER OFFICE POLICIES**

Dr. Jackson can be reached by calling the office phone number, 541-385-0775. If you suspect your condition is an emergency, please call 911 or proceed to the ER.

Prescriptions are not given by Dr. Jackson without a recent visit or labs as needed. Please contact your Primary Care Physician for refills on other prescriptions not prescribed by Dr. Jackson. For prescriptions prescribed by Dr. Jackson always call your pharmacy first and ask for a refill request, even if your prescription states there are no refills.

### **Email Policies**

Please note that Dr. Jackson is available by email, simple questions may be handled by brief exchange of messages, otherwise, it is best to schedule an appointment. While Dr. Jackson does not charge for very brief issues requiring five minutes or less of her time, extensive email responses, medication requests or a request for a change of medication, letter writing, form completion, record review, review of laboratory results, prior authorization forms, and other requests outside of a scheduled appointments will incur a charge, depending upon the amount of time needed to complete request.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ Date Birth \_\_\_\_\_

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## OFFICE BILLING POLICY

TO ALL OF OUR INSURED PATIENTS: It is our policy to bill your primary insurance carrier as a courtesy to you if you have coverage for out of network naturopathic services. However, your bill is always your responsibility because insurance is an agreement between you and your insurance carrier.

**On your first visit we ask that you pay any un-met deductible amounts, co-insurance, and non-covered charges.** Upon adequate request time, our front office can help review your coverage and the estimated cost of your care prior to your visit. Please read and check the information below that applies to you. Your insurance may not pay for late arrival or cancellation, you as the patient are still responsible for amounts denied or reduced.

\_\_\_\_\_ **PRIVATE INSURANCE:** Private insurance including managed care programs are accepted toward the payment of our fees if out of network naturopathic services are covered under your policy. As stated above, we will bill your primary insurance company as long as deductibles, co-pays, and non-covered services are paid up front. We will give you a copy of the superbill so that you can bill your secondary insurance.

\_\_\_\_\_ **UNINSURED PATIENTS:** You are expected to pay for services as they are rendered. Payment may be made by cash, check, Visa, Mastercard, and most Credit cards. If you cannot make these arrangements, a payment plan may be set up for you by our front office assistant prior to treatment upon the doctor's approval.

\_\_\_\_\_ **HMO's in OREGON:** I understand that if I am seen without a referral I will be responsible for any charges incurred.

\_\_\_\_\_ **Medicare:** Does not pay for any naturopathic services.

\_\_\_\_\_ **Nutraceuticals:** vitamins, supplements, and supplies are not returnable or refundable.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including attorney fees. I hereby authorize Dr. Michelle K. Jackson, ND, to release information necessary to secure the payment of benefits from my insurance company.

**\*\*I HAVE READ AND UNDERSTND THE ABOVE INFORMATION\*\***

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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## Patient Information

Name \_\_\_\_\_ Preferred Pronoun \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
Preferred name \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Live With: \_\_\_\_\_ Spouse \_\_\_\_\_ Parents \_\_\_\_\_ Relatives \_\_\_\_\_ Friend(s) \_\_\_\_\_ Alone \_\_\_\_\_ Other \_\_\_\_\_  
Education: \_\_\_\_\_ Current Grade Level \_\_\_\_\_ School Attending \_\_\_\_\_  
Religious Preference \_\_\_\_\_  
Emergency Contact (Name, phone number, and relationship): \_\_\_\_\_

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### INSURANCE

If you have no insurance, check here

*\*Medicare DOES NOT PAY for the services of a Naturopathic Physician*

Insurance Co. \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
Subscriber's Birthdate \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

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### FINANCIAL AGREEMENT

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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### AUTOMATIC RELEASE CONTRACT

I hereby authorize the release of any information necessary to provide appropriate medical care sent to Michelle K. Jackson ND. I further authorize the release of medical information to other health care providers for referral purposes only.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Patient Consultation Questionnaire

Dictated report and/or chart notes to follow

|                                                                                                   |                     |
|---------------------------------------------------------------------------------------------------|---------------------|
| Patient Name: _____                                                                               | Today's Date: _____ |
| 1. Primary Care or Referring Physician (Name, degree, address, ZIP, phone/fax) _____<br>_____     |                     |
| 2. Other Providers that are co-managing your care with your PCP: _____                            |                     |
| 3. Please additionally list the name of whoever else may have referred you for our services _____ |                     |

**NOTE TO OUR PATIENTS:** Naturopathic and preventative health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. This will make our consultation time much more efficient and is essential for your dictated report. Consider copying this for your own future records. Our initial visit involves an extensive review of this form with a dictated physician report and treatment plan.

### I. MEDICAL PROBLEM LIST

#### A. In your opinion, what are your most important health concerns?

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Others: \_\_\_\_\_

#### B. Which of the above concerns are of most immediate concern to you? #? \_\_\_\_\_

### II. HISTORY OF THE PRESENT ILLNESS

#### A. Describe further your health concerns (problem list). What makes them better or worse?

Problem #1: \_\_\_\_\_

Problem #2: \_\_\_\_\_

Problem #3: \_\_\_\_\_

Problem #4: \_\_\_\_\_

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_ - 7 -

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Dr. Michelle K. Jackson ND, PC.**

Feel free to describe beyond your first four problems from the previous page here if needed.

Vital Signs: Must be Completed Prior to Your Visit With Dr. Jackson

Height:

Weight:

Blood Pressure:

Patient Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_ - 8 -

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_



**B. ETIOLOGY**

How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated your health problems?

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**C. PRIOR TREATMENTS AND RESPONSE**

Please list all of the former treatments you have used, both conventional and alternative, and the degree of effectiveness of each treatment. Please be specific about the benefits you received (if any) from each treatment. This greatly aids us in developing an optimal treatment plan for you.

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**III. PAST MEDICAL HISTORY**

**A. YOUR HEALTH HISTORY: Please check those conditions that apply to you.**

| Now                      | Past                     | Never                    |                        | Now                      | Past                     | Never                    |                            |
|--------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Candida (yeast) Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colitis                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drug/alcohol use           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | (Specify) _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Injury (serious)       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Overweight             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | ____Hyper ____Hypo         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (Specify) _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease           |

**CHILDHOOD ILLNESSES**

Have you performed the "normal" immunizations schedule? \_\_\_\_\_

|                                                         |                                            |                                          |                                        |
|---------------------------------------------------------|--------------------------------------------|------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Rubella (German 3-day measles) | <input type="checkbox"/> Measles (2 weeks) | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Chicken Pox   |
| <input type="checkbox"/> Whooping Cough                 | <input type="checkbox"/> Polio             | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Roseola                        | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Others          | _____                                  |

Adverse reactions to childhood vaccinations? \_\_\_\_\_

Or any vaccinations? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**C. HOSPITALIZATIONS (List as best you can):**

| Type of illness or operation/procedure | Date  | Summary of findings (if known) |
|----------------------------------------|-------|--------------------------------|
| _____                                  | _____ | _____                          |
| _____                                  | _____ | _____                          |
| _____                                  | _____ | _____                          |
| _____                                  | _____ | _____                          |

**D. IMAGING (Chest-Spinal x-rays, CT scans, Mammogram, Ultrasounds, MRI, Angiogram, Arterial-venous studies, etc):**

|       | Date  | Summary of findings (if known) |
|-------|-------|--------------------------------|
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |

**E. PROCEDURES (PAP, EKG, Stress test, holter monitor, spirometry, sigmoid/colonoscopy, TB test, IVP, cystoscopy, bronchoscopy). If older than 50, list date of last glaucoma check, etc.**

|       | Date  | Summary of findings (if known) |
|-------|-------|--------------------------------|
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |

**F. LAB (Blood, urine analysis, PSA, thyroid, etc.):**

|       | Date  | Summary of findings (if known) |
|-------|-------|--------------------------------|
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |
| _____ | _____ | _____                          |

**IV. FAMILY HISTORY** Please list ages and if deceased, what they died from and at what age.  
Please list any chronic health problems of your living parents or siblings.

**A. ANCESTRAL MEDICAL HISTORY**

|                      |                      |
|----------------------|----------------------|
| <u>Mother's Side</u> | <u>Father's Side</u> |
| Grandfather _____    | Grandfather _____    |
| Grandmother _____    | Grandmother _____    |
| Mother _____         | Father _____         |
| Sisters _____        |                      |
| Brothers _____       |                      |

Patient Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**B. Has any BLOOD RELATIVE had any of the following:**

| Yes                      | No                       | Don't Know               |                       | Yes                      | No                       | Don't Know               |                      |
|--------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart attack         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding (easily)     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizure/Epilepsy     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer (type _____)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid (hyper/hypo) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB)    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gout                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (Specify) _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | (Specify type) _____ |

**V. ALLERGIC HISTORY**

**A. Please list any drugs, foods, airborne or other substances that you are allergic to:**

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

**B. What happens when you have an “allergy attack”?**

\_\_\_\_\_

**C. List any chronic problems you have that may have resulted from a prior medication? What was the medicine and what problems did you develop?**

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

**D. Please be able to discuss all prescriptions, over the counter drugs and supplements at your 1<sup>st</sup> visit**

**E. Please list all prescription and over the counter medications that you take, dose per pill, number of pills taken and the time of day(e.g. lanolin 0.25mg 2 pills 9am and 9pm).**

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

**F. Please list any natural medications that you currently take (Vitamins, minerals, herbs, homeopathic). Number of pills and time of day taken.**

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

**G. Please list any prescriptions, over the counter or natural medications that you recently stopped taking.**

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

Patient Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**VI. HEALTH HABITS**

**A. ALCOHOL**

How often do you drink: wine \_\_\_\_\_ beer \_\_\_\_\_ other alcohol \_\_\_\_\_  
(daily, weekly, monthly)

**B. TOBACCO**

Do you use tobacco or have you in the past? \_\_\_ Yes \_\_\_ No. Total years stopped smoking: \_\_\_ Total packs/years smoked: \_\_\_

**C. OTHER DRUGS**

Do you now or have you in the past used marijuana or other drugs? \_\_\_ Yes \_\_\_ No. Please list \_\_\_\_\_

**D. CHEMICAL EXPOSURES**

Have you ever been exposed to toxic chemicals, solvents, or other possible toxins? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

**E. EXERCISE**

Do you exercise? \_\_\_ Yes \_\_\_ No. Which of the following do you do on a regular basis? \_\_\_ Jog \_\_\_ Swim \_\_\_ Walk  
\_\_\_ Bicycle \_\_\_ Gardening \_\_\_ Breathing Exercises \_\_\_ Weightlifting \_\_\_ Other \_\_\_\_\_

How often do you exercise? \_\_\_\_\_

**F. RELAXATION**

Do you make time for rest, relaxation, or prayer during the day and/or before bed? \_\_\_ Yes \_\_\_ No

How often? \_\_\_\_\_ How do you relax? \_\_\_\_\_

**G. HOBBIES**

What are your interests or hobbies? \_\_\_\_\_

**H. DIET**

How many meals do you generally eat each day? \_\_\_ One \_\_\_ Two \_\_\_ Three \_\_\_ More than three

Where do you usually buy your food? \_\_\_\_\_

Who cooks the food you eat? \_\_\_\_\_

List the primary foods included in your diet.

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

List the foods you exclude from your diet.

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

Patient Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_ - 12 -

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

List any of the following (and relative amounts) eaten regularly by you. Coffee, caffeinated teas, highly seasoned foods, processed foods, preservatives, refined foods, and other foods you suspected may be harmful to your health.

\_\_\_\_\_

List any foods you crave, regardless of their nutritional value (include sweets, chocolate, salty, sour, bread, rich/fatty foods, etc):

\_\_\_\_\_

List any foods to which you have a bad reaction:

\_\_\_\_\_

Are you satisfied with your diet as it is now? \_\_\_\_ Yes \_\_\_\_ No If no, why not? \_\_\_\_\_

\_\_\_\_\_

**I. WATER CONSUMPTION**

Are you thirsty? \_\_\_\_ Yes \_\_\_\_ No. Amount of liquid you drink each day: \_\_\_\_\_

What temperature do you prefer to drink? \_\_\_\_ Hot \_\_\_\_ Cold \_\_\_\_ Room temperature

**J. SLEEP**

Do you have trouble falling asleep? \_\_\_\_ Yes \_\_\_\_ No. If yes, what keeps you up?

\_\_\_\_\_

Do you sleep straight through the night? \_\_\_\_ Yes \_\_\_\_ No. Do you wake feeling refreshed? \_\_\_\_ Yes \_\_\_\_ No

**VII. REVIEW OF SYMPTOMS**

**NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER  
(1) = MILD (2) = MODERATE (3) = SEVERE  
next to the symptoms that apply to you NOW or in the PAST.**

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_ **Pulse** \_\_\_\_\_

**Integumentary (Skin)**

| Now | Past |                                                                     |
|-----|------|---------------------------------------------------------------------|
|     |      | Skin rough, dry, scaly, bumpy, itchy (please circle if appropriate) |
|     |      | Rashes, warts, moles, cysts (circle those appropriate)              |
|     |      | Have any of these changed in size or color recently? _____          |
|     |      | Pimples. List location(s) _____                                     |
|     |      | Loss of hair. List location(s) _____                                |
|     |      | Hives. List what causes them _____                                  |

**Hematopoietic, Lymph, Immune**

| Now | Past |                              | Now | Past |                    |
|-----|------|------------------------------|-----|------|--------------------|
|     |      | Painful lymph nodes          |     |      | Wounds heal slowly |
|     |      | Difficulty stopping bleeding |     |      | Anemia             |
|     |      | Bruising easily              |     |      | Fluid retention    |

**Patient Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**X. REVIEW OF SYMPTOMS - Continued**

**NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER  
 (1) = MILD (2) = MODERATE (3) = SEVERE  
 next to the symptoms that apply to you NOW or in the PAST.**

**Head**

| Now | Past |                       |
|-----|------|-----------------------|
|     |      | Dizziness (Vertigo)   |
|     |      | Severe headaches      |
|     |      | Seizures, convulsions |

| Now | Past |                 |
|-----|------|-----------------|
|     |      | Double vision   |
|     |      | Fainting spells |

**Eyes**

| Now | Past |                    |
|-----|------|--------------------|
|     |      | Itching            |
|     |      | Blurring of vision |
|     |      | Tearing            |

| Now | Past |                        |
|-----|------|------------------------|
|     |      | Puffy lids             |
|     |      | Allergic shiners       |
|     |      | Pain from Bright Light |

**Ears**

| Now | Past |                 |
|-----|------|-----------------|
|     |      | Fluid in ears   |
|     |      | Ringing in ears |

| Now | Past |                   |
|-----|------|-------------------|
|     |      | Excessive ear wax |
|     |      | Hearing loss      |

**Nose**

| Now | Past |                     |
|-----|------|---------------------|
|     |      | Nose bleeds         |
|     |      | Sinus congestion    |
|     |      | Postnasal discharge |

| Now | Past |                  |
|-----|------|------------------|
|     |      | Loss of smell    |
|     |      | Sinus infections |

**Mouth**

| Now | Past |                      |
|-----|------|----------------------|
|     |      | Sore mouth or tongue |
|     |      | Speech difficulties  |

| Now | Past |                      |
|-----|------|----------------------|
|     |      | Bleeding Gums        |
|     |      | Cold sores, blisters |

**Throat**

| Now | Past |                        |
|-----|------|------------------------|
|     |      | Persistent hoarseness  |
|     |      | Difficulty swallowing  |
|     |      | Recurrent strep throat |

| Now | Past |                     |
|-----|------|---------------------|
|     |      | Loss of voice       |
|     |      | Pain                |
|     |      | Chronic sore throat |

**Neck**

| Now | Past |           |
|-----|------|-----------|
|     |      | Stiffness |
|     |      | Swelling  |

| Now | Past |                            |
|-----|------|----------------------------|
|     |      | Injuries                   |
|     |      | Pain (describe area) _____ |

**Patient Signature:** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**X. REVIEW OF SYMPTOMS - Continued**

**NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER  
 (1) = MILD (2) = MODERATE (3) = SEVERE  
 next to the symptoms that apply to you NOW or in the PAST.**

**Pulmonary**

| Now | Past |                               | Now | Past |                     |
|-----|------|-------------------------------|-----|------|---------------------|
|     |      | Chest pain when breathing     |     |      | Night sweats        |
|     |      | Wheezing                      |     |      | Shortness of breath |
|     |      | Difficulty breathing at night |     |      | Daily cough         |

Have you ever been exposed to TB (tuberculosis)?  Yes  No

**Cardiovascular**

| Now | Past |                                                                                                      | Now | Past |                                   |
|-----|------|------------------------------------------------------------------------------------------------------|-----|------|-----------------------------------|
|     |      | Chest pain when walking                                                                              |     |      | Leg vein problems                 |
|     |      | Chest pain when sit/lying                                                                            |     |      | Leg pain when walking             |
|     |      | Ankle or abdominal swelling                                                                          |     |      | Numbness/tingling in extremities  |
|     |      | Hear palpitations – fibrillation, flutter, skipping beat, beating fast, beating slow (circle if yes) |     |      | Heart murmur (list type)<br>_____ |

Have you had rheumatic fever?  Yes  No If yes, when? \_\_\_\_\_

**Gastrointestinal**

| Now | Past |                                                                        | Now | Past |                                                                                          |
|-----|------|------------------------------------------------------------------------|-----|------|------------------------------------------------------------------------------------------|
|     |      | Constipation                                                           |     |      | Stomach pain 5 to 6 hours after eating, usually at night, relieved by eating or drinking |
|     |      | Indigestion 2 to 3 hours after a meal with fullness, bloating, or pain |     |      | Alternating constipation and diarrhea                                                    |
|     |      | Diarrhea                                                               |     |      | Above symptoms worse w/worry, stress, tension                                            |
|     |      | Change in bowel movements                                              |     |      | Bad breath                                                                               |
|     |      | Strain at stooling                                                     |     |      | Sudden strong cravings for sweets or alcohol                                             |
|     |      | Heavy, full after eating                                               |     |      | Intestinal parasites suspected                                                           |
|     |      | Hemorrhoids                                                            |     |      | Loss of appetite                                                                         |
|     |      | Black stools                                                           |     |      | Insatiable appetite                                                                      |
|     |      | Blood in stools                                                        |     |      | Over weight                                                                              |
|     |      | Heartburn                                                              |     |      | Under weight                                                                             |
|     |      | Excessive belching                                                     |     |      | Compulsive eating/Addictive eating                                                       |
|     |      | Excessive lower bowel gas                                              |     |      | Distress from fat or greasy foods                                                        |
|     |      | Stomach cramps, colic                                                  |     |      | Anorexia/Bulimia                                                                         |
|     |      | Bad taste in mouth                                                     |     |      | Stomach/abdominal pain                                                                   |

**Patient Signature:** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**X. REVIEW OF SYMPTOMS - Continued**

**NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER  
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 next to the symptoms that apply to you NOW or in the PAST.**

**Urinary**

| Now | Past |                          | Now | Past |                           |
|-----|------|--------------------------|-----|------|---------------------------|
|     |      | Frequent urination       |     |      | Painful urination         |
|     |      | Night urination          |     |      | Difficulty starting urine |
|     |      | Difficulty holding urine |     |      | Blood in urine            |

**Male Reproductive**

| Now | Past |                              | Now | Past |                                           |
|-----|------|------------------------------|-----|------|-------------------------------------------|
|     |      | Prostate problems            |     |      | Painful erection                          |
|     |      | Swelling, lumps in testicles |     |      | Difficulty achieving/maintaining erection |
|     |      | Pain in testicles            |     |      | Date of last prostate examination         |

**Female Reproductive**

| Now | Past |                         | Now | Past |                           |
|-----|------|-------------------------|-----|------|---------------------------|
|     |      | Lumps in breast(s)      |     |      | Painful Intercourse       |
|     |      | Breast Pain             |     |      | Lack of sexual desire     |
|     |      | Pelvic Pain             |     |      | Never/seldom have orgasms |
|     |      | Vagina Discharge        |     |      | Menstruation excessive    |
|     |      | Vaginal itching/burning |     |      | Menstruation absent       |
|     |      | Genital eruptions       |     |      | Bleed between periods     |
|     |      | Genital eruptions       |     |      | Spot between periods      |
|     |      | Type?                   |     |      |                           |

Are you currently sexually active?  Yes  No. Current form of contraception? \_\_\_\_\_

Age of first menstruation? \_\_\_\_\_ +

Periods occur every \_\_\_\_\_ days. Regular?  Yes  No. Periods usually last \_\_\_\_\_ Days (average)

Date of last period? \_\_\_\_\_

**Do you experience Premenstrual Tension symptoms such as nervous tension, mood changes, depression, breast tenderness, weight gain before, during, or after menstruation? Please explain symptoms and timing of symptoms.** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Have you in the past, or do you currently have problems with infertility?** \_\_\_\_\_

\_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ # of abortions

Any complications with pregnancy?  Yes  No. If yes, please explain. \_\_\_\_\_  
 \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_



**VII. REVIEW OF SYMPTOMS - Continued**

**NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER  
 (1) = MILD (2) = MODERATE (3) = SEVERE  
 next to the symptoms that apply to you NOW or in the PAST.**

**Thyroid**

| Now | Past |                                    |
|-----|------|------------------------------------|
|     |      | Overweight                         |
|     |      | Difficulty losing weight           |
|     |      | Constipation                       |
|     |      | Tired upon arising/Easily fatigued |
|     |      | Low sex drive                      |
|     |      | Dry or scaly skin                  |
|     |      | Chilly/sensitive to cold           |

| Now | Past |                      |
|-----|------|----------------------|
|     |      | Decreased appetite   |
|     |      | Low body temperature |
|     |      | Heart palpitations   |
|     |      | Irritable/restless   |
|     |      | Increased appetite   |
|     |      | Underweight          |
|     |      | Flush/get hot easily |

**Adrenals**

| Now | Past |                             |
|-----|------|-----------------------------|
|     |      | Easily stressed             |
|     |      | Easily/chronically fatigued |
|     |      | Dizziness                   |
|     |      | Headaches                   |
|     |      | Crave salt                  |

| Now | Past |                          |
|-----|------|--------------------------|
|     |      | Nails weak, ridged       |
|     |      | Facial hair (women)      |
|     |      | Rheumatism/arthritis     |
|     |      | Poor circulation         |
|     |      | Increased blood pressure |

**Central and Peripheral Nervous System**

| Now | Past |                             |
|-----|------|-----------------------------|
|     |      | Dizziness regularly         |
|     |      | Convulsions (seizures)      |
|     |      | Tremor (shaking, trembling) |
|     |      | Blurred/double vision       |

| Now | Past |                                   |
|-----|------|-----------------------------------|
|     |      | Numbness or tingling (circle one) |
|     |      | Temporary loss of sensation       |
|     |      | Lack of strength                  |
|     |      | Where? _____                      |
|     |      | Continual headaches               |

**Mental Status**

| Now | Past |                               |
|-----|------|-------------------------------|
|     |      | Anxiety/Restlessness          |
|     |      | Lack of self-confidence       |
|     |      | Excessive worry               |
|     |      | Depression/Despair/Discontent |
|     |      | Suicidal thoughts             |
|     |      | Suicidal attempts             |
|     |      | Loneliness/feel alone         |
|     |      | Mood swings                   |
|     |      | Confident, secure             |

| Now | Past |                                        |
|-----|------|----------------------------------------|
|     |      | Memory difficulty, forgetting          |
|     |      | Mental confusion                       |
|     |      | Decreased concentration, comprehension |
|     |      | Shy, timid                             |
|     |      | Critical of self                       |
|     |      | Critical of others                     |
|     |      | Sensitive to noise                     |
|     |      | Fears- (Please specify) _____          |

**Patient Signature:** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date Of Birth** \_\_\_\_\_

**VII. REVIEW OF SYMPTOMS - Continued**

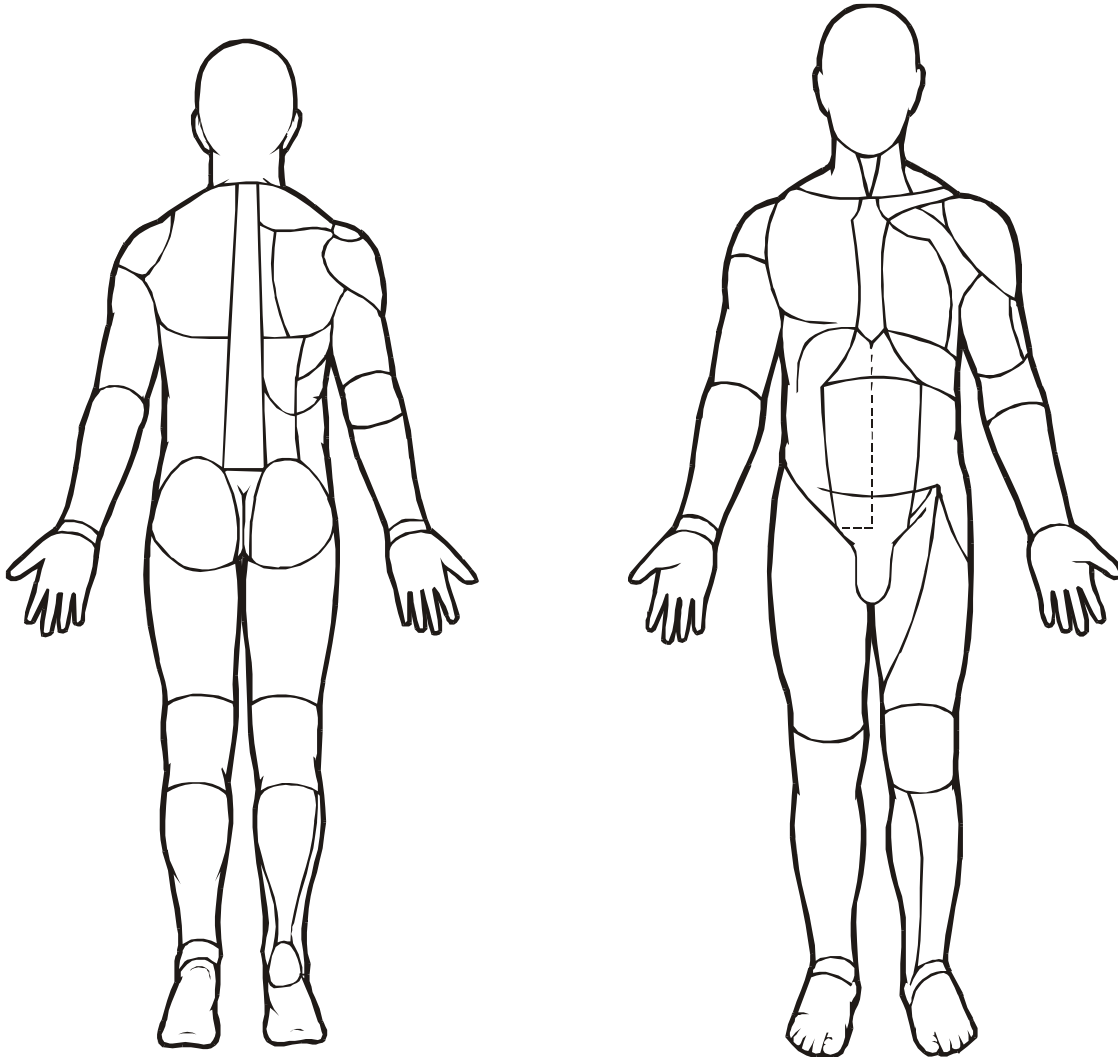
**NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER  
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 next to the symptoms that apply to you NOW or in the PAST.**

**Spine and Extremities**

| Now | Past |                                            |
|-----|------|--------------------------------------------|
|     |      | Joint swelling                             |
|     |      | Backaches                                  |
|     |      | Burning on soles of feet or palms of hands |

| Now | Past |                            |
|-----|------|----------------------------|
|     |      | Coughing, at stools        |
|     |      | Sneezing /straining stools |
|     |      | Rheumatism/arthritis       |

**Please mark your problem and painful areas as exactly as possible with an “X” on the diagram below.**



**I hereby acknowledge that I have provided complete and accurate information regarding my health history, medication and symptoms. I will notify Dr. Jackson if there are any changes to the same.**

***\*\*\*Thank you for your cooperation, patience, and thoroughness\*\*\****

**Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_**

**Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_**

**Dr. Michelle K. Jackson**  
**61535 S. HWY 97**  
**Bend OR 97702**  
**541-385-0775 Fax: 541-330-1466**  
**office@drjacksonnd.com**

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I authorize the following healthcare provider to release a copy of medical information to Dr. Michelle K. Jackson, ND, in order to coordinate care between providers.

Name of Healthcare Provider: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

By **initializing** the spaced below, I specifically authorize the release of the following medical records:  
Please initial next to the check mark, thank you.

- \_\_\_\_\_ Hospital Records (nursing notes, progress notes, transcribed notes)
- \_\_\_\_\_ Drug/alcohol treatment records
- \_\_\_\_\_ Most recent 5-year history
- \_\_\_\_\_ Emergency/urgent care records
- \_\_\_\_\_ Diagnostic imaging reports
- \_\_\_\_\_ Laboratory and pathology reports
- AIDS/HIV records
- Most recent 2 year history, labs, imaging and office visit notes
- \_\_\_\_\_ Mental Health Records
- \_\_\_\_\_ Other, please specify

\_\_\_\_\_

The reason for this request is to coordinate care for the patient between the other medical facility and Dr. Jackson.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient \_\_\_\_\_ Date Signed \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature of Person Authorized by Law \_\_\_\_\_

*East West Naturopathic Clinic  
Dr. Michelle K. Jackson, ND, PC  
61535 S. HWY 97  
Ste 5-404  
Bend, OR 97702  
Phone: 541-385-0775  
TIN #46-0501145  
NPI # 1821156142  
[office@drjacksonnd.com](mailto:office@drjacksonnd.com)*

**Acknowledgment of Primary Care Physician**

Since Dr. Jackson is not practicing Primary Care Medicine (she is only practicing Telemedicine with specific naturopathic specialized care) our office requires that all patients also have a Primary Care Physician (PCP) who can provide health care that Dr. Jackson can not.

Please provide below the information of your Primary Care Physician. Dr. Jackson routinely requests the last 12-24 months of office visit notes and recent labs from your Primary Care Physician. Once we have that information (ideally we have that information prior to your initial visit) we can coordinate care with your Primary Care Physician and Dr. Jackson can better understand your individual health needs. In addition to this form, please also fill out and sign the **Authorization To Disclose Medical Records** Document, in addition to this form, so we can sent that document to your PCP.

\_\_\_\_\_  
(your name) (date of birth)

\_\_\_\_\_  
(Primary Care Physician name)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
(Primary Care Physician address and/or phone # above)

\*If you do not currently have a Primary Care Physician Currently, please sign and date below. You must agree to obtain a Primary Care Physician within 4 months of the date of this signed Document. Dr. Jackson can not treat you for Primary Care issues during that 4 month time but you can seek Urgent or Emergency Care if needed.

\_\_\_\_\_  
Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

\_\_\_\_\_  
Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## GOOD FAITH ESTIMATE FOR HEALTH CARE COSTS AND SERVICES

|                              |                          |
|------------------------------|--------------------------|
| Patient Name:                | Patient Date of Birth:   |
| Patient Diagnosis: 203.89    | Services Requested:99205 |
| Date of Initial Appointment: |                          |

|                                                             |
|-------------------------------------------------------------|
| Practice Name: Dr. Michelle Jackson, ND                     |
| Mailing Address: 61535 S. HWY 97 Suite 5-404 Bend, Or 97702 |
| Phone #:541-385-0775                                        |
| Provider/Practice Tax ID#:46-0501145<br>NPI #:1821156142    |

You are entitled to receive this “Good Faith Estimate” of what the charges could be for naturopathic medical services provided to you. You may encounter additional laboratory, prescription, or supplement costs, but due to the variation in laboratory, pharmacy and supplement supplier costs, as well as insurance coverage depending on your individual insurance plan these costs are not included in this Good Faith Estimate. While it is not possible for a naturopathic doctor to know, in advance, exactly how many visits or what lab tests or supplements may be necessary or appropriate for a given individual (naturopathic doctors provide individual care), this form provides an estimate of the cost of services that may be provided. Your total cost of services will depend upon your individual circumstances, and the type and amount of services that are provided to you.

This is a new patient initial Good Faith Estimate. Your provider will update your Good Faith Estimate after your initial visit when your provider has more information about your case, and your provider may also provide you additional Good Faith Estimates after follow up visits if needed, so that you know what the continued cost of care will be.

| <b>Date of Service</b><br>The following is | <b>Service Code</b><br>a list of expected | <b>Service/Item</b><br>charges: | <b>Diagnosis</b><br><b>Code</b> | <b>Quantity</b>         | <b>Expected Cost</b> |
|--------------------------------------------|-------------------------------------------|---------------------------------|---------------------------------|-------------------------|----------------------|
|                                            | CPT Code:<br>99205                        | Initial New<br>Patient Visit    | 203.89                          | 1-60 min<br>appointment | \$283.00             |

Good Faith Estimates do not include the cost of any non medical services you request from us such as completion of medical forms, or other costs which are included in our financial policy's that you have control over. Good Faith Estimates do not include late cancellation fees.

**Disclaimer:**

This Good Faith Estimate only provides an estimate of the charges for items and services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute(appeal) the bill.

There may be additional items or services that may be recommended as part of your course of care that must be scheduled or requested separately and are not reflected in this Good Faith Estimate and additional Good Faith Estimate may be provided. This estimate is not a contract and does not obligate you to obtain any services from the provider listed, nor does it include any services rendered to you that are not identified here.

**If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.**

You may contact the health care facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with U.S. Department of Health and Human Services (HHS) if the actual amount charged to you exceeds \$400 of the Good Faith Estimate. If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days(about 4 months) of the date of original bill. There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-800-985-3059. **For questions or more information** about your right to a Good Faith Estimate or the dispute process, [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call 1-800-985-3059. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

**Patient Acknowledgment of Receipt:**

**Date of this Estimate:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

**East West Naturopathic Clinic**  
**Dr. Michelle K. Jackson, ND, PC**  
**TIN #46-0501145 NPI #1821156142**  
**61535 S. HWY 97 Ste 5-404 Bend, OR 97702**  
**Phone #541-385-0775**  
**Email: office@drjacksonnd.com**

## **TELEMEDICINE PATIENT CONSENT FORM**

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a Telemedicine consultation in connection with the following procedure(s) or service(s)...  
New or Return Consultation with Dr. Michelle K. Jackson
2. **NATURE OF TELEMEDICINE CONSULT:** During the Telemedicine consultation A. Details of your medical histories, examinations, x-rays, and test results will be discussed with Dr. Jackson through the use of interactive audio (phone) or other Telecommunicational technology such as interactive HIPPAcompliant Go To Meeting platforms. B. A physical examination of you may take place. There are limitations of Physical exams via Telemedicine and some conditions may require an inperson exam and/or labs before a treatment plan or prescriptions can be offered.
3. Telemedicine consultations with Dr. Jackson does not replace your relationship with your Primary Care Physician or Specialist.
4. **MEDICAL INFORMATION AND RECORDS:** All existing laws regarding your access to information and copies of your medical records apply to this Telemedicine consultation.
5. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with the Telemedicine consultation, and all existing confidentiality protections under federal and state Oregon laws apply to information disclosed during this Telemedicine consultation. Please remember as the patient, it is your responsibility to consider the environment of where you take Dr. Jackson's phone call, in order to keep your visit private and confidential. Dr. Jackson will ask you to identify any other attendees present on your phone call/visit with Dr. Jackson.
6. **RIGHTS:** You may withhold or withdraw consent to a Telemedicine consultation at any time without affecting your right to future care or treatment.
7. **RISKS, CONSEQUENCES AND BENEFITS:** Possible risks of a Telemedicine consultation include, but are not limited to: information transmitted may not be sufficient to allow for appropriate decision making by Dr. Jackson. Delays in evaluation and treatment may be due to failure of equipment. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. Expected benefits include improved access to medical care by enabling the patient to remain in a distant location. You have been advised of risks, benefits and consequences of Telemedicine. You have the right to ask questions about the information presented to you in this form.

**At the time of the consult, I will be physically present in the State of Oregon and I agree to participate in a Phone or Telemedicine consultation as described above:**

**Signature:** \_\_\_\_\_

**If signed by someone other than the patient, please indicate relationship:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date:** \_\_\_\_\_