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
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 3 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 3 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-GLP-1 Support
- 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 do not bill your insurance. We will provide you with an itemized bill that you can submit to your insurance. If you want to call your insurance and ask them if you will be reimbursed for any care, Dr. Jackson is an **Out-of-Network Provider** with all insurance companies. 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.***

EXAMPLE OF FEES

New Patient Visit (approximately 60 minutes)..... $295.00

Return Office Call (approximately 30 to 45 minutes)…….....$182.00 to $242.00

Letters ……Starting at $40.00

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

Dr. Jackson does not bill insurance, thus your bill is always your responsibility because insurance is an agreement between you and your insurance carrier. Your insurance may not pay for late arrival or cancellation, you as the patient are still responsible for amounts denied or reduced.

_____ **PRIVATE INSURANCE:** We do not bill your insurance. We will provide you with an itemized bill that you can submit to your insurance. If you want to call your insurance and ask them if you will be reimbursed for any care, Dr. Jackson is an Out-of-Network Provider with all insurance companies. Please note that the full patient responsibility is due at the time of service, by cash, check, Visa, Mastercard and most credit cards including HSA/FSA cards.

_____ **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.

_____ **Medicare:** Does not pay for any naturopathic services.

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

*** There is a 4%surcharge added for credit and debit payments.**

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 UNDERSTAND THE ABOVE INFORMATION****

Patient's signature _____ Date _____

Print Name:_____Date of Birth_____

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Patient Information

Name _____Preferred Pronoun_____
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):

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_____

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

_____
Print Name Date of Birth

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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) _____

_____

2. Other Providers that are co-manging your care with your PCP:_____
3. Please additionally list the name of whoever else may have referred you for our services _____

A 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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
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_____

Print Name_____Date of Birth_____

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 _____

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?

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.

III. PAST MEDICAL HISTORY

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

Now	Past	Never	
☐	☐	☐	Anemia
☐	☐	☐	Arthritis
☐	☐	☐	Asthma
☐	☐	☐	Alcoholism
☐	☐	☐	Bleeding
☐	☐	☐	Cancer
☐	☐	☐	Colitis
☐	☐	☐	Heart Murmur
☐	☐	☐	High Blood Pressure
☐	☐	☐	Injury (serious)
☐	☐	☐	Kidney Disease
☐	☐	☐	Liver Disease/Jaundice
☐	☐	☐	Overweight
☐	☐	☐	Ulcers
☐	☐	☐	Other (Specify) _____

Now	Past	Never	
☐	☐	☐	Diabetes
☐	☐	☐	Hypoglycemia
☐	☐	☐	Allergies
☐	☐	☐	Candida (yeast) Infections
☐	☐	☐	Emphysema
☐	☐	☐	Eczema
☐	☐	☐	Drug/alcohol use (Specify)_____
☐	☐	☐	Heachache
☐	☐	☐	Pneumonia
☐	☐	☐	Rheumatism
☐	☐	☐	Thyroid ____Hyper ____ Hypo
☐	☐	☐	Tuberculosis
☐	☐	☐	Venereal Disease

CHILDHOOD ILLNESSES

Have you performed the "normal" immunizations schedule? _____

☐ Rubella (German 3-day measles)	☐ Measles (2 weeks)	☐ Mumps	☐ Chicken Pox
☐ Whooping Cough	☐ Polio	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Roseola	☐ Asthma	☐ 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. <u>FAMILY HISTORY</u> 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>

Grandfather _____

Grandmother _____

Mother _____

<u>Father's Side</u>

Grandfather _____

Grandmother _____

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	
☐	☐	☐	Anemia	☐	☐	☐	Hay Fever
☐	☐	☐	Arthritis	☐	☐	☐	Heart attack
☐	☐	☐	Asthma	☐	☐	☐	High blood pressure
☐	☐	☐	Bleeding (easily)	☐	☐	☐	Seizure/Epilepsy
☐	☐	☐	Cancer (type _____)	☐	☐	☐	Sickle Cell Anemia
☐	☐	☐	Diabetes	☐	☐	☐	Stroke
☐	☐	☐	Eczema	☐	☐	☐	Thyroid (hyper/hypo)
☐	☐	☐	Glaucoma	☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Gout	☐	☐	☐	Venereal Disease
☐	☐	☐	Other (Specify) _____				(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 1st 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_____

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 Bloood 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		Now	Past	
		Dizziness (Vertigo)			Double vision
		Severe headaches			Fainting spells
		Seizures, convulsions			

Eyes

Now	Past		Now	Past	
		Itching			Puffy lids
		Blurring of vision			Allergic shiners
		Tearing			Pain from Bright Light

Ears

Now	Past		Now	Past	
		Fluid in ears			Excessive ear wax
		Ringing in ears			Hearing loss

Nose

Now	Past		Now	Past	
		Nose bleeds			Loss of smell
		Sinus congestion			Sinus infections
		Postnasal discharge			

Mouth

Now	Past		Now	Past	
		Sore mouth or tongue			Bleeding Gums
		Speech difficulties			Cold sores, blisters

Throat

Now	Past		Now	Past	
		Persistent hoarseness			Loss of voice
		Difficulty swallowing			Pain
		Recurrent strep throat			Chronic sore throat

Neck

Now	Past		Now	Past	
		Stiffness			Injuries
		Swelling			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) _____

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
(1) = MILD (2) = MODERATE (3) = SEVERE
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		Now	Past	
		Overweight			Decreased appetite
		Difficulty losing weight			Low body temperature
		Constipation			Heart palpitations
		Tired upon arising/Easily fatigued			Irritable/restless
		Low sex drive			Increased appetite
		Dry or scaly skin			Underweight
		Chilly/sensitive to cold			Flush/get hot easily

Adrenals

Now	Past		Now	Past	
		Easily stressed			Nails weak, ridged
		Easily/chronically fatigued			Facial hair (women)
		Dizziness			Rheumatism/arthritis
		Headaches			Poor circulation
		Crave salt			Increased blood pressure

Central and Peripheral Nervous System

Now	Past		Now	Past	
		Dizziness regularly			Numbness or tingling (circle one)
		Convulsions (seizures)			Temporary loss of sensation
		Tremor (shaking, trembling)			Lack of strength
		Blurred/double vision			Where? _____
					Continual headaches

Mental Status

Now	Past		Now	Past	
		Anxiety/Restlessness			Memory difficulty, forgetting
		Lack of self-confidence			Mental confusion
		Excessive worry			Decreased concentration, comprehension
		Depression/Despair/Discontent			Shy, timid
		Suicidal thoughts			Critical of self
		Suicidal attempts			Critical of others
		Loneliness/feel alone			Sensitive to noise
		Mood swings			Fears- (Please specify)_____
		Confident, secure			_____

Patient Signature:_____ **Date Signed**_____

Print Name:_____ **Date Of Birth**_____

VII. REVIEW OF SYMPTOMS - Continued

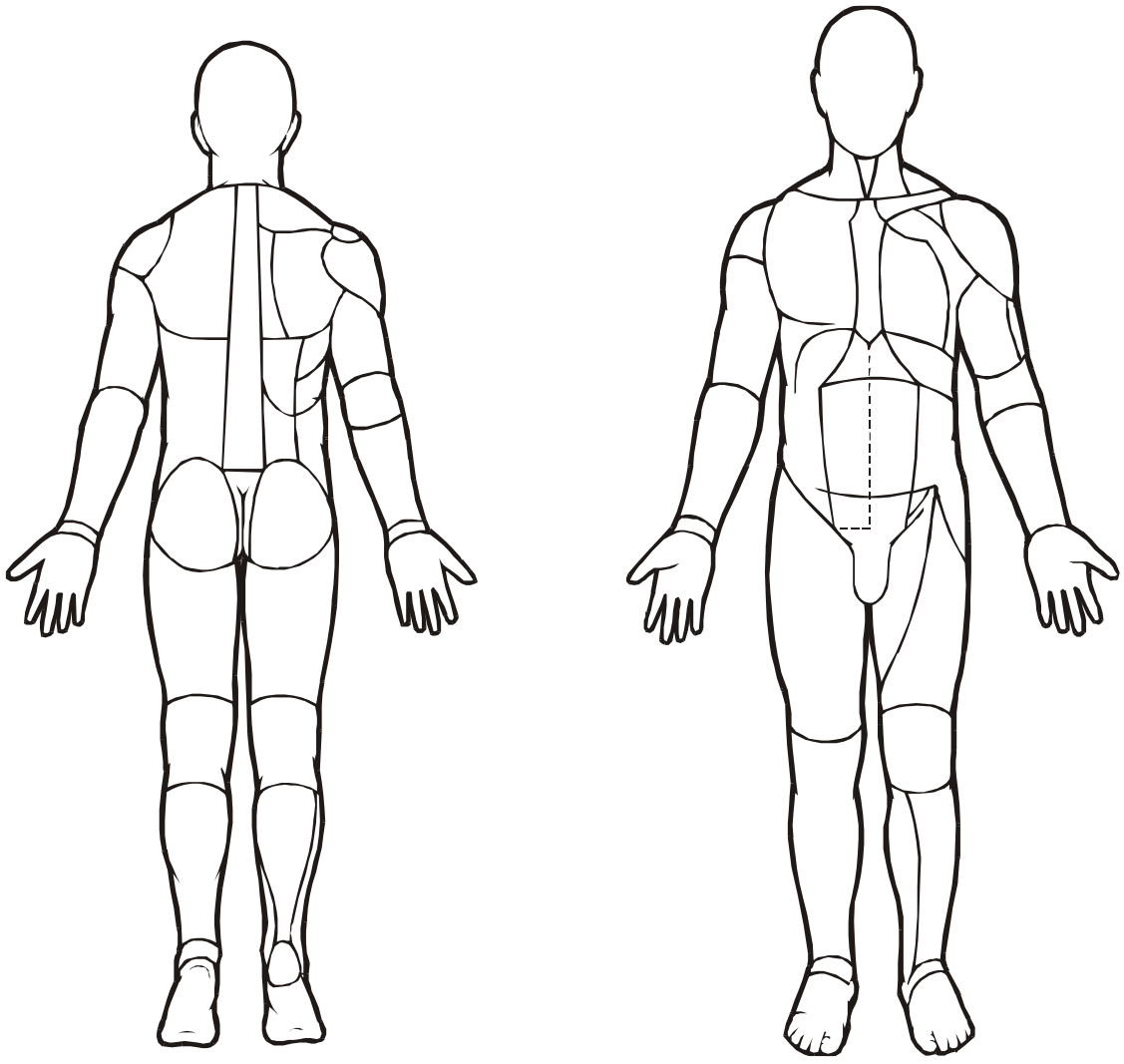
NOTE: PLEASE MARK THE FOLLOWING WITH A NUMBER
(1) = MILD (2) = MODERATE (3) = SEVERE
next to the symptoms that apply to you NOW or in the PAST.

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

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 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.

Date of Service The following is	**Service Code** a list of expected	**Service/Item** charges:	**Diagnosis Code**	**Quantity**	**Expected Cost**
	CPT Code: 99205	Initial New Patient Visit	203.89	1-60 min appointment	$295.00

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 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 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
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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 TELEMEDICNE 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 Telecommunical technology such as interactive HIPPA compliant 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 breech 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: _____