Welcome

forget me not medicine

1 Patient Information

Date: _____

Patient Name: _____
Last Name

_____
First Name Middle Initial

Address: _____

City: _____

State: _____ Zip: _____

E-mail: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

I identify as: _____ Pronouns: _____

☐ Married ☐ Single ☐ Separated ☐ Minor

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

_____

Employer/School Phone: _____

Home: (___) _____ Cell: (___) _____

Best time to contact you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

2 Insurance

Who is responsible for this account? _____

Relationship to Patient: _____

Insurance Co: _____

Group #: _____ ID#: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name: _____

Birthdate: _____ SS#: _____

Relationship to Patient: _____

Insurance Co: _____

Group #: _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of insurance company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered.I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Please list your top three health concerns: _____

_____

_____

_____

Please add any other comments and/or health goals:

_____

_____

Date and reason of your last physical examination: _____

What is a typical day of eating for you?

Breakfast: _____

Lunch: _____

Dinner: _____

Other (Snacks, etc.): _____

3 Family History

ALIVE DECEASED	Father ☐ ☐	Present health or cause of death	Mother ☐ ☐	Present health or cause of death	Spouse ☐ ☐	Present health or cause of death
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED		CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Stroke ☐ Bleeding Internally ☐ High Blood Pressure ☐ Kidney Failure ☐ Nervous Illness ☐ Tuberculosis ☐ Allergy ☐ Autoimmune Condition ☐ Other _____

5 HEALTH HISTORY

forget me not medicine

Check (✓) symptoms you currently have or have had in the past year:

GENERAL
- ☐ Chills
- ☐ Depression/Anxiety
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Unintentional weight loss
- ☐ Numbness/Tingling
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐ Involuntary movement/ Twitching

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Muscle cramps

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ BloatingBowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Irregular/rapid heartbeat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Abnormal Sense of Smell/Taste
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Light Sensitivity
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sound Sensitivity
- ☐ Vision - flashes/halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last Menstrual period _____

Date of last Pap smear _____

Have you had a a mammogram? _____

Are you pregnant? _____

Number of children? ____

Check (✓) conditions you have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Addiction/Dependency
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Sensitivity
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ EMF Sensitivity
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illness or operations with dates: _____

6 MEDICATIONS/ALLERGIES

Pharmacy Name _____

Phone (_____) _____

List allergies to medications or substances _____

_____

_____

Current medications (attach extra sheet if needed): _____

_____

7 HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if you work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

8 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please Print name of Patient, Parent, Guardian or Personal Representative — Relationship to Parent

_____ _____
Reviewed By — Date

FORGET ME NOT MEDICINE
re-membering health

Financial Policy

We are doing everything possible to hold down the cost of patient care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE
Unless your practitioner is a preferred provider on your insurance pan.

Forget Me Not Medicine accepts cash, personal check (in-state only), VISA, MasterCard, Discover and American Express. There is a $25 service charge for returned checks. To be in compliance with the new FTC Red Flag Rules and to further protect your credit from Identity Theft, we now require photo ID for bank card and check payments and at your first visit to verify your identity.

INSURANCE: We bill your primary insurance as a courtesy to you. You are expected to pay in full at the time of service. As a service to you, our customers, we we will submit an insurance claim to your primary insurance company with the reimbursement to come directly to you unless other arrangements have been made between you and your care provider. You are responsible for filing with your secondary insurance company after receiving notice from your primary about what is covered.

At the time of service you will receive a receipt that includes all the information necessary for submitting claims to your insurance company for yourself.

If you need assistance or have questions, please contact our office between 9:00 am and 3:00pm, Monday, Tuesday and Thursday at 541-799-6097. Appointments are available for detailed financial consultation when necessary.

EXCEPTION: If you receive services from a practitioner who is a preferred provider on your health plan, we will accept your co-pay and bill your primary insurance the balance. You are still responsible for billing your secondary insurance.

REFUNDS: Overpayments will be refunded upon written request to the responsible party within 30 days.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments.

PAST DUE PAYMENTS: Any past due payment will be charged a 1.5% late fee per month or partial month. Accounts more than 90 days past due will be sent to collections.

I have read and understand the Forget Me Not Medicine Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections.

Signature of responsible party _____

Date _____

Insurance Policy Addendum for Benjamin Bell LMT: We expect that you will pay our “Cash discount” price at the of service. We will be happy to bill your primary insurance as a courtesy to you, but ***please note that the “Insurance Price” is different and we will only be refunding amounts that are in excess of our posted prices.*** You are responsible for filing with your secondary insurance company after receiving notice from your primary about what is covered. If you need assistance or have questions, please contact our office between 9:00 am and 3:00, Monday, Tuesday and Thursday at 541-799-6097. Appointments are available for detailed financial consultation when necessary.

Cash(discount) price: Initial 1 hour CST: $120, 1 hour follow-up appointments: $90
Non-Cash payments (If you need us to bill your insurance): $180 per hour.

forget me not medicine

Dr. Lisa Del Alba ND, Benjamin Bell LMT, CMA

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Forget Me Not Medicine privacy practices. A copy is available on our website or may be picked up or mailed from our office.

_____ _____

Patient Name Date

_____

Patient/Representative Signature

___ I **DO NOT** want to have my medical information disclosed to family and friends.

Forget Me Not Medicine
1695 Jefferson St.
Eugene OR 97402
541-799-6097 scheduling line

forget me not medicine

Prescription Refill Policy

In order to better serve our patients, we recommend you schedule an appointment to discuss the need for refills and or adjustments of your medications when your prescription refills run out. Please call our office if you have questions about your particular case. _____(please initial)

Also, to ensure that patient prescriptions are processed in the most efficient and expeditious manner, we require that our patients call their pharmacy for all prescription refills **one week before you run out** of your prescription. The pharmacy will contact our office electronically or by fax to continue the refill process. _____(please initial)

Please do not wait until the last minute to call your pharmacy. We also encourage you to call your pharmacy before going to pick up your prescription to make sure it is ready. If you do run out of your medications, some pharmacies provide emergency pills to fill the gap between prescriptions. You may ask your pharmacist if that is a service that they provide. _____(please initial)

Thank you for choosing our office for your patient needs.

_____
Signature Parent/Guardian

_____
Date

_____
Signature of Forget Me Not Medicine (witness)