Mississippi Health Center
Dr. Justin Yohalem Ilsley
Naturopathic and Chinese Medicines
Clinic 503-282-5358 Fax 503-546-0033 I DrIlsley@mississippihealthcenter.com

Name: _____
(First) (Middle) (Last)

Address: _____
Street

_____
City, State, Zip

Phone:_____(Home)

_____(Cell)

Email:_____

SSN:_____

Date of birth:_____age:_____

Insurance_____
(name of company)

_____

(insurance ID/group number)

_____

(Primary person covered by insurance)

Emergency contact
name/relationship:_____
_____

phone:_____

how were you referred to our clinic?

_____

Have you been to an **acupuncturist** before? Y/N

Have you been to a **naturopath** before? Y/N

What are your most important health concerns?

_____
_____
_____

Major Illnesses and hospitalizations with dates, illness/reason and outcomes:

_____
_____
_____

Current medications with name/brand, dose, how long and any adverse reactions?

_____
_____
_____

Current Supplements with name/brand, dose, and how long?

_____
_____
_____

What was the date of your last physical and bloodwork? _____

_____

Pregnancy: Are you currently pregnant?

___yes ____no ___maybe

Do you have high: **Blood Pressure? Y/N**

Cholesterol? Y/N Blood Sugar? Y

Health habits:

	What form(s)	Amount	How often/how long
Alcohol			
Tobacco			
Caffeine			
Recreational drugs			
Exercise			

Sleep: sleep well? ___yes ___no average number of hours/ day? _____

Diet: typical foods eaten: **Breakfast:_____**

Lunch:_____

Dinner:_____

Snacks:_____Sweets:_____

Average amount of **water** you drink per day:_____

Family history:

Check if your blood relatives have had any of the following	Relation	Age	Age at Death	Cause of Death
Arthritis, Gout				
Cancer				
Chemical Dependency (alcohol,drug)				
Heart Disease				

What to expect on your first visit? Naturopathic and Chinese medicines take time to search for the underlying cause of your illness or symptoms and not just provide you with symptomatic relief. Because of this, please be prepared to take the time necessary to give us a detailed history, to review body systems, and to come up with an individualized treatment plan for you. If you do not understand your treatment or are having problems with following your treatment plan, then we encourage you to call us, so we can help you appropriately.

Cancellation policy 24 hours notice is necessary for cancelled appointments. This allows space for acute and walk in appointments. You will be billed $50 for missed appointments except due to a real emergency or at the discretion of Dr. Ilsley. There is an additional charge for IV patients if we have prepared an IV solution for you.

Payment is due at the time of treatment. We accept Visa/Discover/Mastercard, check or cash.

Signature_____ date _____

Mississippi Health Center

Financial Agreement

I, _____(print name), agree to be responsible for full payment of goods and services received at the Mississippi Health Center (MHC). I also agree to be responsible for a $50 missed appointment/late cancellation fee.

Insurance

Billing of insurance is a courtesy performed by MHC staff. In the event of financial discrepancies between your insurance company and MHC staff and providers, the balance of services rendered is your responsibility up to the fullest extent of your and your provider's contract with the insurance company. This may include paying out of pocket for services performed that are not covered under your policy. Generally you will receive notification of such a scenario in your Explanation of Benefits statement sent to you by your insurance. In this case you are required to pay the balance of your visit fee as determined by that statement.

Additionally, deductibles and co-pays are fees that are required by your insurance policy to be paid out of pocket to your practitioner.

Missed appointments and late cancellations (less than 24 hr notice)

These situations are charged a **flat fee of $50**. This is a non negotiable fee unless there is a medical emergency (i.e. emergency room care). Feeing sick is not considered a medical emergency since MHC providers are qualified to treat you for non emergency illnesses. If you are unsure how to approach an unexpected change in your schedule that may conflict with your appointment at MHC, call your provider to discuss options.

I have read and understand the MHC financial agreement and agree to be responsible for payment of goods and services rendered at Mississippi Health Center.

_____(signature)

I have read and agree to a **$50** missed appointment/late cancellation fee.
_____(signature)

Mississippi Health Center

Consent Form

What to expect on your first visit

Naturopathic and Chinese medicines take time to search for the underlying cause of your illness or symptoms and to not just provide you with symptomatic relief. Because of this, please be prepared to take the time necessary to give us a detailed history, to review body systems, and to come up with an individualized treatment plan for you. If you do not understand your treatment or are having problems with following your treatment plan, then we encourage you to call us, so we can help you appropriately.

Types of services rendered

Treatment techniques of Mississippi Health Center staff include acupuncture, cupping, moxa, massage, cranio-sacral therapy, guided visualizations, detailed pelvic work, herbal medicine, homeopathy, nutritional counseling and lifestyle advice. These techniques are practiced at the discretion of the provider and with the consent of the patient.

Consent

I understand that treatment of any type may have side effects. I also understand that I have the right to stop treatment at any point and that it is my responsibility to inform my practitioner of my discomfort or preference to stop treatment. I understand that Mississippi Health Center practitioners are skillfully trained and are practicing with the intention of helping me in my healing process.

Cancellation policy

24 hours notice is necessary for cancelled appointments. This allows space for acute and walk-in appointments. We reserve the right to bill for missed appointments.

I have read and understand the above information.

I the undersigned agree to pay for services rendered at time of treatment.

I further agree to the discretion of the health care provider and give my consent for treatment.

Signature _____ **Date** _____

(parent or guardian signature) _____