

**Linda Meloche, N.D., L.Ac.**  
12125 N.E. Penny Lane \* Carlton, OR 97111  
503-864-4797 fax 503-864-4941

## INSURANCE BILLING AND FINANCIAL AGREEMENT

**Billing your insurance is a service; we do the best we can to collect from them. As the insured patient, you will benefit most by taking the time to understand ALL your insurance benefits. KNOWING YOUR BENEFITS WILL SAVE YOU MONEY!**

### **Filing Primary Insurance**

If you have insurance coverage for naturopathic and/or acupuncture services and Dr. Meloche participates in their network, we will file the claim with your insurance company. Please make sure she is a participating provider (for the correct specialty) in the network your insurance uses. Being on their provider list does not mean you have the benefit.

### **Filing Secondary Insurance and Medicare**

You may be covered by more than one insurance plan. We bill secondary insurance except when Medicare is primary and secondary insurance requires Medicare denial first. We are **not** a Medicare provider and cannot bill Medicare for denial. See the CMS/Medicare website for the form to bill this or call Medicare with questions.

### **Paperwork, Prescriptions and Prior authorizations – KNOW YOUR BENEFITS!**

Many patients now need special receipts, prescriptions for their supplements or other paperwork to be filled out by the doctor for their reimbursement accounts. Please let the staff know if you need this at the time of service. Insurances are also restricting medications, requiring preauthorization approval of a medication you may be taking (most have tier explanations). **This information is in your insurance policy.** We will charge a fee for paperwork including prior authorizations done outside of an office visit.

There is also a fee for **prescription requests** outside of an office visit. Please ask your pharmacy to fax us a refill request.

### **Quotation of benefits is NOT a guarantee of payment.**

With the passage of the Affordable Care Act, naturopathic services should be covered. However, sometimes naturopathic care is covered at a specialist rate, or not at all, depending upon how the policy is written. There is also more managed care for acupuncture, including requirements for a preauthorization or referral; or limitations to coverage. Sometimes insurance misquotes your benefits to us. We will bill your insurance for you but if they do not pay, you are responsible for the balance.

### **Financial Agreement**

I have read the above insurance policies and understand that a certain portion of my care will/may not be covered by my insurance company/health plan/HMO/HSA under the terms of my benefit plan. I agree to pay, in full, for all non-covered and unbilled services which may include, but are not limited to, supplies, supplements, injections, vitamins used in injections and all other elective services not covered by my benefit plan for the patient named below. I also agree to pay for all services/items provided to me at the time they are rendered unless I have made other arrangements in advance with Dr Meloche and/or her staff.

\_\_\_\_\_  
Signature of Patient or Patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of patient or patient's representative

\_\_\_\_\_  
Relationship to Patient

Abbey Road Clinic

**Consent for Purpose of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information by **Abbey Road Clinic** for the purpose of diagnosis or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Abbey Road Clinic**.

I understand that diagnosis or treatment of me by **Abbey Road Clinic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Abbey Road Clinic** is not required to agree to the restrictions that I may request. However, if **Abbey Road Clinic** agrees to a restriction that I request, the restriction is binding on **Abbey Road Clinic and Linda Meloche, N.D., L.Ac.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Abbey Road Clinic** or **Dr. Linda Meloche** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Abbey Road Clinic's** Notice of Privacy Practices prior to signing this document.

The **Abbey Road Clinic's** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for **Abbey Road Clinic** is also provided at **12125 NE Penny Lane, Carlton, Oregon**.

This Notice of Privacy Practices also describes my rights and the duties of **Dr. Linda Meloche** with respect to my protected health information.

**Abbey Road Clinic** reserves the right to change the privacy practices that are describe in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office of **Abbey Road Clinic** and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

-----  
Signature of Patient or Personal Representative

-----  
Name of Patient or Personal Representative

-----  
Date

-----  
Description of Personal Representative's Authority

# Linda Meloche, N.D., L.Ac.

12125 Penny Lane, Carlton, OR 97111 503.864.4797

Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_  Retired

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Education \_\_\_\_\_

Status:  Married  Separated  Divorced  Widowed  Single  Partnership

Live with:  Spouse  Partner  Parents  Children  Friends  Alone

Next of Kin or who to reach in an emergency: \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

<b><u>FAMILY HISTORY</u></b>	<b><u>FATHER</u></b>	<b><u>MOTHER</u></b>	<b><u>BROTHERS</u></b>	<b><u>SISTERS</u></b>	<b><u>SPOUSE</u></b>	<b><u>CHILD</u></b>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____	_____
Age at Death (if deceased)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____
<u>Check all applicable:</u>						
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____

**HEALTH HISTORY QUESTIONNAIRE**

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Please mark anything you don't understand with a question mark.

Are you currently receiving healthcare?            Y            N

If yes, where and from whom? \_\_\_\_\_

If no, when and where did you last receive health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

What are your most important health problems? List as many as you can in order of importance.

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

Do you have any contagious diseases at this time?            Y            N

If yes, what? \_\_\_\_\_

**For the following sections, please check all that apply:**

**CHILDHOOD ILLNESSES**

Scarlet fever

Diphtheria

Rheumatic fever

Mumps

Measles

German Measles

**HOSPITALIZATION AND SURGERIES**

What hospitalizations or surgeries have you had? \_\_\_\_\_

\_\_\_\_\_

**X-RAYS AND SPECIAL STUDIES**

X-rays, CAT scans or other studies you have had: \_\_\_\_\_

\_\_\_\_\_

Electrocardiogram

Electroencephalogram

**IMMUNIZATIONS**

Polio

Pertussis

Tetanus Shot

Diphtheria

Measles / Mumps / Rubella

Other \_\_\_\_\_

## ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any foods? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CURRENT MEDICATIONS

Do you take or use:

Laxatives

Pain relievers

Antacids

Cortisone

Appetite suppressants

Antibiotics

Tranquilizers

Thyroid medication

Sleeping pills

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking?

1 \_\_\_\_\_

7 \_\_\_\_\_

2 \_\_\_\_\_

8 \_\_\_\_\_

3 \_\_\_\_\_

9 \_\_\_\_\_

4 \_\_\_\_\_

10 \_\_\_\_\_

5 \_\_\_\_\_

11 \_\_\_\_\_

6 \_\_\_\_\_

12 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## TYPICAL FOOD INTAKE

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

**REVIEW OF SYSTEMS**

**GENERAL**

Current Weight \_\_\_\_\_ lbs      Weight one year ago: \_\_\_\_\_ lbs  
Maximum Weight: \_\_\_\_\_      When? \_\_\_\_\_ Height: \_\_\_\_\_  
When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

*Please check all conditions you have now or have had in the past:*

**EMOTIONAL**

- |   |   |
|---|---|
| <input type="checkbox"/> Treated for emotional problems | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Mood Swings                    | <input type="checkbox"/> Anxiety of nervousness |
| <input type="checkbox"/> Considered / Attempted suicide | <input type="checkbox"/> Tension                |

**ENDOCRINE**

- |   |   |
|---|---|
| <input type="checkbox"/> Hypothyroid      | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Hypoglycemia     | <input type="checkbox"/> Diabetes                 |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Excessive hunger         |
| <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Seasonal depression      |

**IMMUNE**

- |   |  |
|---|--|
| <input type="checkbox"/> Vaccinations               | <input type="checkbox"/> Reactions to vaccinations |
| <input type="checkbox"/> Chronic Fatigue Syndrome   | <input type="checkbox"/> Chronic infections        |
| <input type="checkbox"/> Chronically swollen glands | <input type="checkbox"/> Slow wound healing        |

**NEUROLOGIC**

- |   |   |
|---|---|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Paralysis            |
| <input type="checkbox"/> Muscle weakness      | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Loss of memory       | <input type="checkbox"/> Easily stressed      |
| <input type="checkbox"/> Vertigo or dizziness | <input type="checkbox"/> Loss of balance      |

**SKIN**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Eczema, Hives       |
| <input type="checkbox"/> Acne, Boils  | <input type="checkbox"/> Itching             |
| <input type="checkbox"/> Color Change | <input type="checkbox"/> Perpetual Hair Loss |
| <input type="checkbox"/> Lumps        | <input type="checkbox"/> Night Sweats        |

**HEAD**

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Head Injury        |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Jaw / TMJ problems |

**EYES**

- |  |  |
|--|--|
| <input type="checkbox"/> Spots in eyes   | <input type="checkbox"/> Cataracts           |
| <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Glasses or contacts |
| <input type="checkbox"/> Blurriness      | <input type="checkbox"/> Eye pain / strain   |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Tearing or dryness  |
| <input type="checkbox"/> Double vision   | <input type="checkbox"/> Glaucoma            |

Please check all conditions you have now or have had in the past:

#### NOSE AND SINUSES

- |   |  |
|---|--|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Nose Bleeds   |
| <input type="checkbox"/> Stuffiness     | <input type="checkbox"/> Hayfever      |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Loss of smell |

#### MOUTH AND THROAT

- |   |   |
|---|---|
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Copious saliva     |
| <input type="checkbox"/> Teeth grinding       | <input type="checkbox"/> Sore tongue / lips |
| <input type="checkbox"/> Gum problems         | <input type="checkbox"/> Hoarseness         |
| <input type="checkbox"/> Dental cavities      | <input type="checkbox"/> Jaw clicks         |

#### NECK

- |                                 |  |
|---------------------------------|--|
| <input type="checkbox"/> Lumps  | <input type="checkbox"/> Swollen glands    |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Pain or stiffness |

#### RESPIRATORY

- |   |   |
|---|---|
| <input type="checkbox"/> Cough                        | <input type="checkbox"/> Sputum                         |
| <input type="checkbox"/> Spitting up blood            | <input type="checkbox"/> Wheezing                       |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Bronchitis                     |
| <input type="checkbox"/> Pneumonia                    | <input type="checkbox"/> Pleurisy                       |
| <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Difficulty breathing           |
| <input type="checkbox"/> Pain on breathing            | <input type="checkbox"/> Shortness of breath            |
| <input type="checkbox"/> Shortness of breath at night | <input type="checkbox"/> Shortness of breath lying down |
| <input type="checkbox"/> Tuberculosis                 |   |

#### CARDIOVASCULAR

- |  |  |
|--|--|
| <input type="checkbox"/> Heart disease             | <input type="checkbox"/> Angina                    |
| <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Murmurs                   |
| <input type="checkbox"/> Blood clots               | <input type="checkbox"/> Fainting                  |
| <input type="checkbox"/> Phlebitis                 | <input type="checkbox"/> Palpitations / Fluttering |
| <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Chest pain                |
| <input type="checkbox"/> Swelling in ankles        |  |

#### GASTROINTESTINAL

- |  |   |
|--|---|
| <input type="checkbox"/> Trouble swallowing      | Bowel movements – How often? _____            |
| <input type="checkbox"/> Change in thirst        | Is this a change? _____                       |
| <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Vomiting             |
| <input type="checkbox"/> Vomiting blood          | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Blood in stool          | <input type="checkbox"/> Change in appetite   |
| <input type="checkbox"/> Pain or cramps          | <input type="checkbox"/> Constipation         |
| <input type="checkbox"/> Belching or passing gas | <input type="checkbox"/> Diarrhea             |
| <input type="checkbox"/> Black stools            | <input type="checkbox"/> Gall Bladder disease |
| <input type="checkbox"/> Jaundice (yellow skin)  | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Hemorrhoids          |

### URINARY

- |  |  |
|--|--|
| <input type="checkbox"/> Pain on urination   | <input type="checkbox"/> Increased frequency     |
| <input type="checkbox"/> Frequency at night  | <input type="checkbox"/> Inability to hold urine |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Kidney stones           |

### MALE REPRODUCTION

- |  |   |
|--|---|
| <input type="checkbox"/> Hernias                   | <input type="checkbox"/> Testicular masses  |
| <input type="checkbox"/> Testicular pain           | <input type="checkbox"/> Prostate disease   |
| <input type="checkbox"/> Venereal disease          | <input type="checkbox"/> Discharge or sores |
| <input type="checkbox"/> Are you sexually active   | <input type="checkbox"/> Chlamydia          |
| <input type="checkbox"/> Sexual orientation _____  | <input type="checkbox"/> Gonorrhea          |
| <input type="checkbox"/> Impotence                 | <input type="checkbox"/> Condyloma          |
| <input type="checkbox"/> Premature ejaculation     | <input type="checkbox"/> Herpes             |
| <input type="checkbox"/> Birth control Type: _____ | <input type="checkbox"/> Syphilis           |

### FEMALE REPRODUCTION/BREASTS

- |  |   |
|--|---|
| Age of first menses _____                        | Are cycles regular Y N                            |
| Length of cycle _____ days                       | <input type="checkbox"/> Bleeding between cycles  |
| Duration of menses _____ days                    | <input type="checkbox"/> Pain during intercourse  |
| <input type="checkbox"/> Painful menses          | <input type="checkbox"/> Clotting                 |
| <input type="checkbox"/> Heavy or excessive flow | <input type="checkbox"/> Discharge                |
| <input type="checkbox"/> PMS                     | <input type="checkbox"/> Birth control _____      |
| If yes, symptoms: _____                          | Number of pregnancies _____                       |
| _____  | Number of live births _____                       |
|  | Number of miscarriages _____                      |
| <input type="checkbox"/> Endometriosis           | Number of abortions _____                         |
| <input type="checkbox"/> Ovarian cysts           | <input type="checkbox"/> Menopausal symptoms      |
| <input type="checkbox"/> Difficulty conceiving   | <input type="checkbox"/> Abnormal PAP             |
| <input type="checkbox"/> Cervical Dysplasia      | <input type="checkbox"/> Chlamydia                |
| <input type="checkbox"/> Sexual difficulties     | <input type="checkbox"/> Condyloma                |
| <input type="checkbox"/> Gonorrhea               | <input type="checkbox"/> Syphilis                 |
| <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Breast pain / tenderness |
| Are you sexually active? Y N                     | <input type="checkbox"/> Breast lumps             |
| Do you do breast self exams? Y N                 | <input type="checkbox"/> Nipple discharge         |
| Sexual orientation _____                         |   |

### MUSCULOSKELETAL

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Broken bones            | <input type="checkbox"/> Weakness  |
| <input type="checkbox"/> Muscle spasms or cramps | <input type="checkbox"/> Sciatica  |

### BLOOD / PERIPHERAL VASCULAR

- |  |  |
|--|--|
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> Deep leg pain             | <input type="checkbox"/> Cold hands / feet |
| <input type="checkbox"/> Varicose veins            | <input type="checkbox"/> Thrombophlebitis  |



**HABITS**

Main interests and hobbies? \_\_\_\_\_

Do you exercise? Y N If so, what kind? \_\_\_\_\_

How often? \_\_\_\_\_

Do you have a religious or spiritual practice? Y N If yes, what? \_\_\_\_\_

Do you eat three meals a day? Y N

Sleep well

Enjoy your work

Watch television - How many hours? \_\_\_\_\_

Take vacations

Have a supportive relationship

Have ever been treated for drug dependence

Use recreational drugs

Been treated for alcoholism

Drink coffee

Drink black tea

Drink cola

Eat sugar

Average 6 – 8 hrs sleep

Awaken rested

Spend time outside

Read - How many hours? \_\_\_\_\_

Any major traumas?

Have a history of abuse

Use alcoholic beverages

Use Tobacco

Smoked previously How many years? \_\_\_\_\_

How many packs a day? \_\_\_\_\_

Eat out often

Go on diets often

Eat salt

How does your condition affect you? \_\_\_\_\_

What do you think is happening? \_\_\_\_\_

Why? \_\_\_\_\_

What do you feel needs to happen for you to get better? \_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

How much change are you willing to make at this time for improving your health? MINIMAL SOME COMPLETE

Is there any information about your health you would like to add? \_\_\_\_\_