CENTER FOR ENVIRONMENTAL MEDICINE LLC

Integrating the best of conventional and complementary medicine

Dear Patient,

Welcome to the Center for Environmental Medicine. Your appointment is scheduled with Chris Hatlestad, MD or Ami Kapadia, MD. Attached you will find New Patient Forms. Please fill out the entire Intake Form & Extended Medical History Form. The doctor will want to discuss your history with you at the time of your appointment. Sign the Business Agreement and Registration Form. If you take supplements, please list what you take.

Please fill out all forms before your appointment time assigned during our phone conversation. Medical history forms that are complete allow the doctor to review them and form a picture of what needs to be accomplished in the new patient interview. Also, any pertinent laboratory or xray tests you can bring or release to us prior to your appointment may be helpful. Be sure to bring your insurance card. We will be happy to bill your insurance as a courtesy for you under the terms of our business agreement. Insurance co-payments are due at the time of service as well as all non-covered procedures or visits.

Attached are instructions of how to get to the Center. Allow 1.5 to 2 hours for your visit and orientation. Please call if we can answer any questions for you or can be of further assistance. Please be aware that we require a 48 hour cancellation on all patients. If you are unable to make your scheduled appointment, kindly give us adequate notice.

Finally, for the comfort of all ***we ask that you not wear perfume, aftershave, or other scented products*** *such as strong scented detergent, or clothes dried with dryer sheets.* Many of our patients are chemically sensitive and may experience allergic-type reactions including headache, flu-like symptoms, mood swings and aggressive agitation, and the inability to think and process information. We look forward to serving you.

Sincerely,

Darlene B., Medical Receptionist

Sharon J., Bookkeeper

Jami B., Medical Office Assistant

10748 NE Halsey Street, Suite A
Portland, OR 97220-3961
www.cemmed.com

Phone: 503-261-0966
Fax: 503-252-3691
info@cemmed.com

CENTER FOR ENVIRONMENTAL MEDICINE LLC

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Date _____

PATIENT REGISTRATION FORM

To provide you with the best service and to update our records, please complete **both pages** of this form in its entirety at the time of your visit. This information is for our use only unless released by your permission. **Thank You.**

Patient's _____ (Last Name) _____ (First Name) _____ (M.I.)

By what name do you prefer to be called? _____ Drivers Lic. _____

Date of Birth _____ Age _____ Gender: ☐M ☐F SSN _____

Address _____ Email _____

City _____ State _____ Zip _____

Phone _____ (Home) _____ (Work) _____ (Cell) _____ (Pager)

Employer/School _____ Occupation _____ ☐PT ☐FT

Are you: Do you live with:

Spouse/Partner's: _____ (Last Name) _____ (First Name) _____ (M.I.)

Phone _____ (Home) _____ (Work) _____ (Cell) _____ (Pager)

Employer/School _____ Occupation _____ ☐PT ☐FT

Emergency Contact: _____ (Name) _____ (Relationship)

Address _____

City _____ State _____ Zip _____

Phone _____ (Home) _____ (Work) _____ (Cell)

Financially Responsible party: _____ (Name) _____ (Relationship)

Would you like to get personal medical information, e.g. test result, appt. reminders by email? ☐YES ☐NO

Would you be interested in a clinic newsletter, blog or general medical information sent by email/Website? ☐YES ☐NO

How did you hear about us? Other / Website _____

Friend _____ Relative _____ Physician _____

10748 NE Halsey Street
Portland, OR 97220-3961
www.cemmed.com

— OVER —

Phone: 503-261-0966
Fax: 503-252-2691
info@cemmed.com

Please provide a copy of your insurance card.

Primary Insurance: _____ _____ _____ _____
Company Name | Policy # | Plan # | Group #

_____ _____ _____ _____ _____
Address | City | State | Zip | Phone

_____ _____ _____ _____
Insured Name: | Relationship | DOB | SSN

Deductible: $ _____ Copay: $ _____

Motor Vehicle, Work related injury or Secondary Insurance: Claim #_____ DOI _____

_____ _____ _____ _____
Company Name | Policy # | Plan # | Group #

_____ _____ _____ _____ _____
Address | City | State | Zip | Phone

_____ _____ _____ _____
Insured Name: | Relationship | DOB | SSN

_____ _____
Agent or Attorney | Phone

Credit Card Authorization

I, (print name) _____ authorize Center for Environmental Medicine , located at 10748 Halsey Street, Suite A, Portland, OR 97220 to bill my credit card as listed below for services or products received.

Credit Card Details: Visa Card # _____ Exp date _____ Code _____
MasterCard Card # _____ Exp date _____ Code _____
Discover Card # _____ Exp date _____ Code _____

Card Billing Information: ☐ Same as registering patient ☐ Other

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Authorization: Card Holder's Signature _____ Date _____

This authorization may be revoked at any time when the following stipulations have been performed:

1. Patient has made a new financial arrangements to cover any services or products received.
2. The card holder/patient has submitted to our office a written request to stop using this credit card (signed and dated).
3. Patient's account is paid in full and no further care is anticipated.

The Center for Environmental Medicine (CEM) will bill my medical or accident insurance as a courtesy. It is my responsibility to provide accurate and complete insurance information. Failure to do so will result in the inability to file a claim with my insurance carrier in a timely manner and could result in no paid benefits. This would make me entirely financially responsible for all services provided. I understand that it is my responsibility to provide payment for all copays and non-covered benefits at the time of service. I grant CEM permission to release to my insurance carriers any information necessary to pursue any medical claim for services received. I have read, understand and agree to abide by the *Office Policies and Procedures* document in the initial patient registration packet. I herby authorize the doctors at CEM to perform any diagnostic tests and therapeutic forms of treatment indicated and deemed necessary by mutual agreement for my care under the standards of medical and naturopathic care.

_____ _____ _____
Print Name | Signature | Date

NAME _____ DATE _____

PATIENT MEDICAL HISTORY

This is a confidential record of your medical history and will be kept in this office. Information will be released only with your written permission. Please complete the questionnaire as thoroughly as possible. Place a question mark by anything you do not understand. If you have a complicated history, if may help to add your own time line of health problems, testing and treatments tried from earliest recollection to present and list of current symptoms on separate sheets. Please be as complete as possible.

Primary Health Concerns:

When did your health concerns begin?

MAJOR HOSPITALIZATIONS OR ILLNESSES:

Operations	Year	Illnesses Requiring Hospitalization	Year
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

Description and date of any serious injuries or accidents you have had:

List the names of all medications and doses you are currently taking: (See page 2)

List all vitamins, herbs or other supplements you are currently taking: (See page 2)

Medications, supplements, foods or other things you are allergic to:

Please list any foods or tastes that you have particular craving or aversion to:

MEDICATIONS

NAME	DOSE	W/ FOOD	W/O FOOD	AM	MID	PM	BED

SUPPLEMENTS

NAME	DOSE	COMPANY	W/ FOOD	W/O FOOD	AM	MID	PM	BED

REVIEW OF SYMPTOMS AND ILLNESSES

Please Mark C for current / recent or P if the problem was in the past. Circle the correct option if more than one.

HEENT

_____Bleeding gums
_____Eye infections
_____Far / Near sighted
_____Grinding teeth / Jaw pain
_____Mercury fillings / root canal
_____Hay fever
_____Sinusitis
_____Hearing loss
_____Recurrent ear infections
_____Ringing in ears
_____Sores in mouth / lips

RESPIRATORY

_____Asthma
_____Chronic cough
_____Recurrent bronchitis
_____Emphysema
_____Pneumonia
_____Shortness of breath

CARDIAC / CIRCULATION

_____Angina / Chest Pain
_____Cold hands / feet
_____Edema or swelling
_____Fainting
_____Leg pain with exercise
_____High / Low blood pressure
_____Palpitations

ABDOMINAL / DIGESTIVE

_____Difficulty swallowing
_____Abdominal bloating / pain
_____Irritable before meals
_____Pain before / after eating
_____Tired after eating
_____Distress from fatty foods
(Nausea, dizziness, headaches, etc.)
_____Food allergies
_____Hypoglycemia
_____Heartburn / reflux
_____Ulcers
_____Gallstones
_____Hepatitis / Liver disease
_____Hemorrhoids
_____Bleeding from rectum
_____Colitis
_____Constipation / Diarrhea
_____Change in bowel habits
_____Belching / Flatulence (gas)

GENITOURINARY

_____Bladder infections
_____Frequent urination
_____Kidney disease / stones
_____Venereal disease

HORMONAL

_____Diabetes
_____Goiter / Thyroid problems
_____Temperature sensitivity
_____Abnormal hair growth
_____Reduced sex drive

NEUROLOGIC

_____Childhood hyperactivity
_____Dizziness / Vertigo
_____Epilepsy / seizures
_____Weakness
_____Memory loss
_____Migraines / Headaches
_____Neuralgia / Neuritis
_____Concussions

MUSCULOSKELETAL

_____Arthritis / Joint pain
_____Osteoporosis
_____Sciatica / Low back pain
_____Muscle pain / fibromyalgia
_____Tendonitis / Bursitis
_____Fractures

PSYCHOLOGICAL

_____Depression / SAD
_____Anxiety
_____Mania
_____Nervous breakdown
_____Nightmares / Vivid dreams
_____Restless sleep / Insomnia
_____Sleep Apnea

DERMATOLOGIC

_____Brittle nails
_____Dandruff/dry scalp
_____Eczema or rash
_____Hives
_____Recurrent sores
_____Skin Cancer / mole changes

INFECTIOUS

_____Candida
_____Chickenpox / Shingles
_____Herpes I / II
_____Malaria
_____Measles / Mumps
_____Meningitis
_____Mononucleosis
_____Polio
_____Rheumatic / Scarlet fever
_____H. pylori
_____Tuberculosis

OTHER

_____Alcohol or drug abuse
_____Anemia
_____Bed wetting
_____Bruise / Bleeding tendency
_____Cancer / Leukemia
_____Weight problems / changes
_____Fatigue
_____Chemical sensitivities
_____ Known toxic exposures

FEMALES ONLY

Date of your last menstrual period: _____ Age of menopause? _____

How many days do your periods last? _____ Days in your monthly cycle? _____

Age you first began to menstruate?

Did you breast feed?

Do you perform self-breast exams?

Date of last mammogram:

Do you get a pap smear annually? ☐ YES ☐ NO Date of last exam _____

Number of miscarriages _____ / abortions _____ / still-births _____ / children _____

Current Ages of your children:

Any difficulty getting pregnant or complications of pregnancy (explain)?

Do you currently take birth control pills? ☐ YES ☐ NO

Did you ever take birth control pills? ☐ YES ☐ NO for how long _____

Current contraception used?

_____vaginal dryness / itching _____abnormal Pap smears _____decreased sex drive

_____vaginal discharge _____problem periods _____night sweats / hot flashes

_____pain with intercourse _____PMS _____breast discharge

_____breast tenderness _____irregular bleeding _____breast lumps or fibrocystic

MALES ONLY

Please check any problem that you now have or have ever had. Mark __C__ for current or __P__ if the problem was in the past.

_____Urine stream weak/slow

_____Dribbling after urination

_____Burning on urination

_____Frequent or nocturnal urination

_____Prostate problems

_____Discharge from penis

_____Nocturnal urination

_____Premature ejaculation

_____Swelling/lumps on testicles

_____Loss of sexual interest function

_____Loss of sexual function

_____Low sperm count or impotency

SOCIAL HISTORY

Do you eat:	**Yes**	**No**	**Serv./wk**
Meat	_____	_____	_____
Fish	_____	_____	_____
Fowl	_____	_____	_____
Dairy	_____	_____	_____
Eggs	_____	_____	_____
Refined Sugar	_____	_____	_____
Margarine	_____	_____	_____
Grains	_____	_____	_____
Veggies	_____	_____	_____
Fruit	_____	_____	_____

Water (# of glasses per day?) _____

Time of day you eat: Breakfast: _____
Lunch: _____
Dinner: _____
Late snack: _____

	Never	How Much / Often / Long	Quit
Cigarettes	_____	_____	_____
Chewing tob.	_____	_____	_____
Cigar	_____	_____	_____
Pipe	_____	_____	_____
Marijuana	_____	_____	_____
Rec. drugs	_____	_____	_____
Liquor	_____	_____	_____
Beer	_____	_____	_____
Wine	_____	_____	_____
Coffee	_____	_____	_____
Soft drinks	_____	_____	_____

Travel History

Have you traveled/lived outside the USA? Yes___ No___ If Yes, where: _____

Did you develop an illness as a result of your travels? _____

FAMILY HISTORY

Please list any family history of illness: **Adopted _____**

Father:

Mother:

Paternal Grandfather:

Paternal Grandmother:

Maternal Grandfather:

Maternal Grandmother:

Siblings:

Aunts, Uncles, Cousins:

Children:

EXTENDED ALLERGY HISTORY

Typical onset of symptoms: ☐ sudden ☐ progressive ☐ chronic ☐ fluctuates

CHECK MEDICATIONS YOU CURRENTLY TAKE

Prednisone
Actifed or Dimetapp (brompheniramine)
Atarax or Vistaril (hydroxyzine)
Benadryl (diphenhydramine)
Chlortrimeton (chlorpheniramine)
Allegra (fexofenadine)
Claritin (loratadine)
Clarinex (desloratadine)
Zyrtec (certirizine)
Phenergan (promethazine)
Singulair (montelukast)
Accolate (zafirlukast)
Zyflo (zileuton)
Tagament (cimetadine) or Zantac (ranitidine)
Pepcid (famotidine) or Axid (nizatidine)
Tavist (clemastine)
AllerChlor, Actifed, Bromfed, Drixoral, Dura-tab, Novafed-A, Ornade, Poly-Histine-D, Trinalin,

ANTIHISTAMINE NOT LISTED_____
BETA BLOCKERS _____
ANTIDEPRESSANTS_____
Any recent changes at home or work or diet?

SYMPTOMS EXPERIENCED

INFANTS:
_____ eczema or dermatitis
_____ cradle cap
_____ colic or always fussy
_____ frequent vomiting
_____ Burned Butt Syndrome
_____ frequent diaper rash
_____ poor sleeper
_____ does not smile
_____ hyperactive

MARK WHEN YOU HAVE SYMPTOMS:

W-Winter S-Spring Su-Summer F-Fall

EYES:
_____ allergic shiners or lines under eyes
_____ tearing
_____ swelling or angioedema
_____ redness

NOSE:
_____ Allergic nasal crease
_____ runny nose - clear
_____ nasal congestion or chronic mouth breathing
_____ pale intranasal mucosa
_____ dark, blue-purple nasal mucosa
_____ nasal polyps

EARS
_____ frequent ear infections
_____ red ears
_____ cracking of ear lobe/behind ear
_____ eczema of ear canal

MOUTH:
_____ inflammation of mucous membrane/tongue
_____ geographic tongue
_____ black hairy tongue

PHARYNX / NECK:
_____ post nasal discharge or drainage
_____ vascular injection
_____ itchy throat
_____ vocal cord swelling or inflammation
_____ enlarged tonsils
_____ enlarged lymphoid glands

LUNGS:
_____ coughing
_____ sneezing
_____ wheezing
_____ snoring
_____ hiccoughs

INTESTINAL:
_____ colitis
_____ belching, bloating after meals

URINARY:
_____ frequent bladder infections
_____ burning or pain with urination

SKIN:
_____ cracked nails - hands or feet
_____ severe itching - often continuous
_____ hives
_____ psoriasis

NEURO / PSYCH:
_____ chronic headaches/migraines
_____ mental confusion
_____ dizziness

ADDITIONAL:
_____ insomnia
_____ chronic Fatigue
_____ tired after 6-8 hours of sleep

EXTENDED ALLERGY HISTORY

Do you have a family history of allergy? ☐ Food ☐ Inhalant ☐ Mold/ Dust etc. ☐ Pollen
☐ Hives ☐ Itching ☐ Asthma ☐ Chemical Sensitivity Other _____

Does any member of your family have celiac (gluten sensitivity) or inflammatory bowel disease? _____

Are you currently receiving allergy injections? _____ **For How long?** _____

Are you under the direct care of an allergist?_____**Direct care of another provider for allergies?**_____

Do you have any allergies not under treatment? _____

Have you suffered from asthma in the past? _____**Do you have wheezing now?**_____

Do you suffer with gastro-intestinal problems?_____

Do you have food allergies? Please list:_____

Do you follow a special diet? Describe:_____

PREVIOUS ALLERGY TESTING:

Exposed to:	Testing Method:
☐ foods	☐ skin test (RAST)
☐ chemicals	☐ intradermal
☐ mold/dust/pollen	☐ blood panel
☐ pets	☐ elimination diet
☐ other	☐ other

DISCRIBE YOUR HOME ENVIRONMENT:

☐ House	☐ Residential	☐ Clean air
☐ Apartment	☐ Industrial	☐ Polluted air
☐ Mobile Home	☐ Freeway	☐ Mold
☐ Other	☐ Busy street	☐ Central
☐ Urban	☐ Old construct	☐ Filter units
☐ Suburban	☐ New construct	☐ Sunny
☐ Rural	☐ Insulation type	☐ Window

HEATING/AIR CONDITIONER AT WORK AND HOME:

☐ natural gas ☐ electric ☐ solar ☐ good ventilation
☐ oil heat ☐ fireplace ☐ pellet ☐ poor ventilation
☐ filters changed ☐ ducts cleaned

PETS: ☐ dog ☐ cat ☐ bird ☐ other _____
Do you know if you react to animals? _____
Which animals?_____
How?_____

HOME FURNISHINGS

☐ **Upholstery** ☐ cotton ☐ leather ☐ synthetic ☐ wool
☐ **Flooring** ☐ wood ☐ linoleum ☐ carpet, kind ☐ tile
☐ **Bedroom** ☐ carpet ☐ natural ☐ synthetic ☐ Feather
☐ **Cookware** ☐ stainless ☐ enamel ☐ glass ☐ teflon
☐ crock pot ☐ non-stick ☐ aluminum

Do you rotate foods: ☐ yes ☐ no
Do you use dietary supplements? ☐ yes ☐ no

DAILY / FREQUENT EXPOSURES:

☐ gas ☐ asphalt ☐ computer ☐ fluorescent lights
☐ auto exhaust ☐ diesel exhaust ☐ heavy equipment
☐ fly frequently ☐ new building ☐ pesticides/herbicides
☐ perfumes/aftershave ☐ make-up ☐ lotions
☐ nail products ☐ new fabrics ☐ mold

TRANSPORTATION: ☐ car ☐ bus ☐ walk ☐ bike

DO CHEMICALS OR ODORS MAKE YOU SICK?

How?_____

Which?_____

Have you ever had an anaphylactic reaction? ☐ yes ☐ no
If yes, what where you reacting to? _____

POSSIBLE ALLERGY RELATED CONDITIONS
(Please check any that apply to you)

☐ Unexplained fatigue or malaise
☐ Atopic Eczema
☐ Arthritis
☐ Ankylosing spondylitis
☐ Malnutrition
☐ Neuropsychiatric symptoms
☐ Carbohydrate Intolerance
☐ Abdominal Pain
☐ Flatulence
☐ Diarrhea
☐ Constipation
☐ Irritable Bowel Syndrome
☐ Crohn's or Ulcerative colitis
☐ Other inflammatory or autoimmune disorders

List your favorite, craved, or particularly enjoyed foods/beverage:

List foods that disagree with you and the symptoms they cause:

SOCIAL & ENVIRONMENTAL HISTORY

Patient Name: _____DATE: _____

_√_Check where applicable--Describe when line is present and if applicable

Onset of symptoms: ☐ sudden ☐ progressive ☐ chronic ☐ fluctuation _____

CHECK MEDICATIONS YOU CURRENTLY TAKE

5 Claritin (Loratadine) Prednisone
Allegra (Fexafenadine) Clarinex (Desloratadine)

- 4 Actifed®, Dimetapp® (Brompheniramine)
- 4 Atarax®, Vistaril® (Hydroxyzine)
- 4 Benadryl® (Diphenhydramine)
- 4 Chlortrimeton® (Chlorpheniramine)
- 4 Phenergan® (Promethazine)
- 4 Claritin® (Loratadine)
- 4 Allegra® (Fexofenadine)
- 4 Clarinex® (Desloratadine)
- 4 Sigulair® (montelukast)
- 4 Accolate® (zafirlukast)

AM Zyflo Tagament Zantac Pepcid Axid
(Zileuton) (cimetadine) (ranitidine) (famotidine) (nizatidine)

3 Tavist (Clemastine) Zyrtec (Certirizine) AllerChlor, Actifed, Bromfed, Drixoral, Dura-tab, Novafed-A, Ornade, Poly-Histine-D, Trinalin, PM Singulair, Accolate

4 ANTIHISTAMINE NOT LISTED_____

BETA BLOCKERS_____

MARK WHEN YOU HAVE SYMPTOMS:
W-Winter S-Spring Su-Summer F-Fall

- EYES: Allergic shiners
  Tearing
  Conjunctival edema
  Conjunctivitis
- NOSE: Allergic nasal crease
  Rhinorrhea-clear
  Nasal congestion & chronic mouth breathing
  Pale intranasal mucosa
  Nasal polyps
- EARS Otitis media frequent (ear infection)
- MOUTH: Inflammation of mucous of the tongue
  Geographic tongue
  Black hairy tongue
- PHARYNX- ORO: ADDITIONALLY
  Post nasal discharge Coughing
  Vascular injection Sneezing
- PHYARNX- HYPO: Itchy throat
  Vocal cord edema eyes
  Vocal cord inflammation mental confusion

ANTIDEPRESSANTS_____

Any recent changes at home or work including diet?

_____

_____

MARK ANY ADDITIONAL SYMPTOMS:

- EYES: Lines under eyes
- NOSE: Allergic nasal crease
  Chronic nasal congestion
  Dark, blue-purple nasal mucosa
- EARS Red ears
  Cracking of ear lobe/behind ear
  Eczema of ear canal
  Otitis media
- MOUTH: Same as above
- PHARYNX ORO:
  Enlarged pharyngeal bands pharynx
  Enlarged lymphoid glands
- PHYARNX HYPO:
  Vocal cord edema
  Vocal cord inflammation

Angioedema
Eczema
Hives
Cracked nails-hands & feet
Burned Butt Syndrome
Hiccough
Food cravings
Insomnia
Chronic Fatigue
Tired after 6-8 hours of sleep
Fatigue after meals
Chronic headaches/migraines
Severe itching-often continuous
Itching of palate and throat
Colitis
Belching, bloating after meals
Dizziness
Psoriasis :

<u>INFANT</u>
Colic
Vomiting
Always fussy
Poor sleeper
Does not smile
Hyperactive

PLEASE TURN PAGE OVER AND CONTINUE

SOCIAL & ENVIRONMENTAL HISTORY

Do you have a family history of allergy? ☐ Food ☐ Inhalant ☐ Mold/ Dust etc. ☐ Pollen
☐ Hives ☐ Itching ☐ Asthma ☐ Other _____
Does any member of your family have celiac (gluten sensitivity) or inflammatory bowel disease? _____
Are you currently under treatment with allergy injections? _____How long? _____
Do you have wheezing now?_____ Are you under the direct care of an allergist?_____
Direct care of a non-allergist?_____Do you have any allergies not under treatment? _____
Have you suffered from asthma in the past? _____
Do you suffer with gastro-intestinal problems?_____
Do you have food allergies? Please list:_____
Do you follow a special diet? Describe:_____

PREVIOUS ALLERGY TESTING FOR:
☐ foods
☐ chemicals
☐ mold/dust/pollen
☐ pets
☐ other

TESTING METHOD:
SKIN TESTS
☐ Prick
☐ Intradermal
☐ other

DESCRIBE YOUR HOME ENVIRONMENT:
☐ House ☐ Sunny ☐ Rural
☐ Apartment ☐ Moldy ☐ Suburban
☐ Mobile Home ☐ Age ☐ Residential
☐ Other ☐ Industrial
☐ Clean air ☐ Polluted air ☐ Freeway ☐ Busy street
PETS: ☐ dog ☐ cat ☐ bird ☐ other _____

Do you know if you react to your pets or other peoples? _____

How?_____

HOME FURNISHINGS
Upholstery ☐ cotton ☐ leather ☐ synthetic ☐ wool
Flooring ☐ hardwood ☐ linoleum ☐ carpet, kind

Cookware ☐ stainless ☐ enamel ☐ glass ☐ aluminum
☐ crock pot ☐ non-stick bake wear

TRANSPORTATION: ☐ car ☐ bus ☐ walk ☐ bike

Have you ever had an anaphylactic reaction? ☐ yes ☐ no
If yes, what where you reacting to? _____
Do you rotate foods: ☐ yes ☐ no
Do you use dietary supplements ? ☐ yes ☐ no

List your favorite, craved, or particularly enjoyed foods/beverage:
_____
_____
_____

DESCRIBE YOUR DAILY ENVIRONMENT -- Exposed to:
☐ gas ☐ asphalt ☐ computer ☐ florescent lights
☐ diesel ☐ heavy equipment ☐ fly frequently
☐ auto exhaust
☐ new building ☐ pesticides ☐ perfumes/aftershave
☐ nail products ☐ make-up ☐ lotions ☐ new fabrics
VENTILATION: ☐ good ☐ poor ☐ newly constructed
DO CHEMICALS MAKE YOU SICK? _____
_____

HEATING/AIR CONDITIONER AT WORK AND HOME:
☐ window ☐ central ☐ filter units
☐ some natural gas ☐ all natural gas ☐ all electric
☐ oil heat ☐ fireplace ☐ pellet

POSSIBLE RELATED CONDITIONS-Please check
Irritable Bowel Syndrome
Inflammatory or autoimmune disorders:
Crohn's, or Ulcerative colitis

Atopic Eczema
Unexplained fatigue or malaise
Arthritis
Ankylosing spondyulitis
Malnutrition
Neuropsychiatric symptoms
Carbohydrate Intolerance
Abdominal Pain
Flatulence
Diarrhea
Constipation

List foods that disagree with you and the symptoms they cause:
_____
_____
_____

FOR EXTENSIVE EVALUATION OF CHEMICALS, FILL OUT ADDITIONAL PAGE.

CENTER FOR ENVIRONMENTAL MEDICINE, L.L.C.
10748 NE HALSEY
PORTLAND, OREGON 97220

PATIENT CONSENT TO TREATMENT & OFFICE POLICIES ~ READ CAREFULLY

OFFICE HOURS ~ APPOINTMENTS ~ FEES ~ PAYMENTS ~ BILLINGS
EMERGENCIES ~ INSURANCE ~ COLLECTIONS~CONFIDENTIALITY

CLINIC POLICY ~ GENERAL INFORMATION

We share the concern of the patient regarding the increasing cost of medical care. Our financial policy is designed to meet the needs of the patient and Center. Unless prior arrangements have been made, payment is required at the time of service. This minimizes unnecessary bookkeeping, record keeping, and collection cost. WHEN A PATIENT'S INSURANCE PROVIDES ACCEPTABLE COVERAGE, WE WILL ACCEPT INSURANCE COVERAGE ON THE DATE OF SERVICE TO THE EXTENT OF THE COVERED ITEMS IN ADDITION TO ANY DEDUCTABLES OR CO-PAYMENTS. CO-PAYMENTS MUST BE THE PAID ON THE DATE OF SERVICE. Regardless of your insurance coverage and agreements, full payment is the responsibility of the patient. We will file your insurance claim usually within the week. We provide, upon request, all the necessary information for your proper filing of secondary insurance. For your convenience, we do accept cash, check, MasterCard and Visa. Any insurance payments received by this office over and above your current balance will be either refunded to you or applied as credit, however you desire. In the event your insurance company determines they have overpaid, you agree that you will be responsible for any reimbursements due. This consent serves as Advance Beneficiary Notice that your insurance company may not pay for our therapies. We do not bill for chelation and IV therapy except for denial. In cases where billing occurs, the complete procedure, chart note, is sent with the bill. We collect payment up front on all IV and non-covered procedures. In the event your insurance company does not pay for services rendered you understand and accept responsibility for the bill as well as any collections should you default.

~We DO accept assignment on most BCBS products, ODS, LifeWise, Mail Handlers, Coventry, First Health, Healthnet, and other contracts for MD services. Most other insurance company's cover us or we have out-of-network status. Please check with our office for your insurance coverage concerns.

~We DO accept Medicare Assignment. We have participating status with Medicare. That means we will send Medicare a bill on your behalf and they will reimburse us directly. Your Co-Payment is due on the date of service.

~We DO NOT accept Personal Injury cases unless accompanied by a referral. We limit our case load regarding Personal Injury cases. You must have an insurance primary policy in place. Providing proper insurance information in a timely manner is the patient's responsibility. Failure to do so and our inability to file a claim may result in the patient being completely responsible for all services provided to you at this clinic. The claim must be valid and open. Once you have exceeded your protection limit, payment will be due the date of service unless you have personal insurance that will pick up the difference. You must provide signature to a lien so all billings are secured.

~We DO NOT accept Workers Compensation cases.

~We DO NOT accept Medicaid assignment. <u>We do not have a provider number; thus we cannot bill.</u>

~<u>Appointments</u>: To guarantee being seen, patients are given appointments. If you become ill, the doctor will see you as soon as possible if you call 503-261-0966 for an appointment.

~Cancellation Policy: We require 48 hour notice for all doctor visits. Illness is not a valid reason for cancellation. If you call on a weekend to cancel a Monday appointment, you will not be allowed to reschedule on a Monday in the future. Calling in advance allows us to use the doctor's time for another patient. There is a minimum charge for any appointment not cancelled providing 48-hour advance notice.

~<u>Regular Office Hours</u>: **Friday afternoon is administrative only**; doctors are not available for appointment.
Monday through Thursday 8:00 a.m. 5:00 p.m.
No clinic activity on Fridays

<u>Emergencies</u> after hours: Non-urgent situations not requiring an immediate physician contact, call our regular Portland phone number and leaving a message. For URGENT situations, call our CALL GROUP at 503-778-8530

I authorize Center for Environmental Medicine and its personnel to provide ongoing medical care, treatment and procedures as ordered by the physicians and/or other health care providers. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed. Insurance coverage is not guaranteed.

Consent to Release of Information: I authorize Center for Environmental Medicine to release to my insurance carrier information about my identity, treatment, diagnosis, prognosis and or services rendered as permitted by state and federal law which may be required or requested, thus releasing the Center for Environmental Medicine from any liability for furnishing such information. I understand information may be released through electronic or paper media. See exceptions in Notice of Information and Privacy Practices. I acknowledge that I have received Notice of Information and Privacy Practices.

Financial Agreement: I understand and agree that I (or a parent, if patient is a minor) am financially responsible for all services provided. As a courtesy, the Center for Environmental Medicine will bill my insurance carrier. Full payment of outstanding balances is due within 60 days of the date of service. If my account is referred to a collection agency, I understand that I am responsible for collection expenses (an additional 50% charge is assessed to the balance) attorney's fees and court costs. We gladly accept MasterCard or Visa. Our strength is medical advice on behalf of our clients; commercial lenders are better equipped to provide financial services. Therefore, in the event that it is necessary to finance the cost of services, we will be happy to work with your bank to arrange suitable financing. This policy constitutes a security agreement.

I authorize my insurance benefits be paid directly to Center for Environmental Medicine. I agree not to bill my insurance except for services CEM cannot bill. I certify all information given in applying for payment under the Social Security Act or other health insurance is correct, and authorize verification of coverage by Center for Environmental Medicine. A photo static copy of this authorization shall be considered as effective and valid as the original. In the event the insurance company mistakenly pays me, I will direct payment immediately CEM. By signing this letter I am stating that I expect CEM to bill my insurance company for all billable services. In the event I subsequently file claims with my insurance company for which CEM has already collected, I agree that I will repay my insurance company, and CEM shall not be liable.

I understand that my insurance does not guarantee coverage when called regarding verification and neither does CEM. I am responsible for understanding my insurance regarding payment policy including those regarding routine tests and preauthorization. While CEM verifies insurances as a courtesy, CEM shall be held harmless regarding all information obtained by your insurance company.

Other Policies:

- Patients will be charged based on complexity and length of consult including coordination of care. New Patient fees are reflected in the first appointment. Without knowing the actual length of what a visit will be, the office staff can give you only an approximate cost of your visit.
- Returned checks: $25.00 per incident; a finance charge of 1.5% per month is generally applied to any balance of 60 days with a minimum charge of $5.00. These fees may be waived if certain conditions exist.
- You are financially responsible for all services rendered.
- Services inadvertently missed or incorrectly charged will be charged to your account.
- Prices are subject to change without prior notice.

When you sign this policy you are agreeing you understand and accept the terms listed herein.

_____ _____

Signature of Patient, Parent or Guardian Date

CENTER FOR ENVIRONMENTAL MEDICINE LLC

Integrating the best of conventional and complementary medicine

CONSENT TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION (HIPPA)

I, _____ authorize the Center for Environmental Medicine and Drs. Hatlestad or Kapadia to use and disclose my personal health information (PHI) for the following limited purposes:

- To carry out investigation, treatment, or other healthcare operations/procedures.
- The preparation of reports to other healthcare providers or facilities involved in your care with only the minimum amount of necessary information being disclosed for this purpose.
- The analysis of medical research projects without personal identification.
- To assist in the payment of any of my medical care or submission for insurance claims.
- The types of information that will be used or disclosed may include the following:
  - The health condition that I have.
  - The alternative modalities that I choose to use.
  - The types of healthcare products or prescriptions that I use.
  - The type of health insurance that I have.
  - Copies of clinic visit transcription including laboratory, pathology and/or xray results.

_____ I understand that once the information is disclosed to others, the recipients of that information may disclose it to other individuals or organizations that are not subject to HIPAA regulations and that the information may no longer be protected.

_____ I have been given a copy of the Notice of Privacy Practices and have had the opportunity to review it before signing the consent to treatment. I acknowledge that the Notice of Privacy Practices may change from time to time and patients may access the updated Notice by submitting a request in writing to this office.

_____ I understand that I have the right to restrict how my personal health information is used and what is shared or disclosed to carry out investigation, treatment, payment or medical research and that the Center for Environmental Medicine, Dr. Hatlestad and Dr. Kapadia have the right to refuse my request. If they agrees to my request, it will be bound by that agreement. I understand that I have the right to revoke this consent in writing as long as it has not already been relied upon.

_____ I understand that the Center for Environmental Medicine, Dr. Hatlestad or Dr. Kapadia will not condition treatment, payment, enrollment or eligibility based upon obtaining this authorization unless permitted by law or regulation.

_____ _____

signature of patient date

10748 NE Halsey Street, Suite A
Portland, OR 97220-3961
www.cemmed.com

Phone: 503-261-0966
Fax: 503-252-2691
info@cemmed.com

CENTER FOR ENVIRONMENTAL MEDICINE LLC

Integrating the best of conventional and complementary medicine

Directions to the Clinic

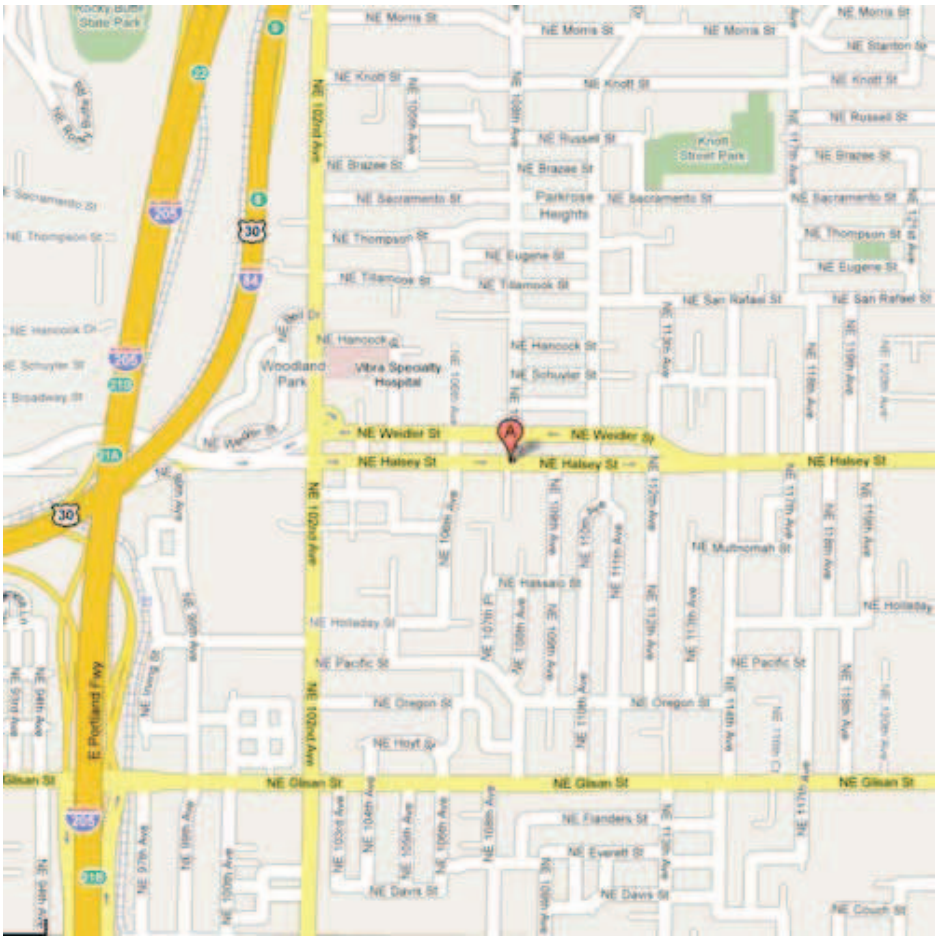
10748 NE Halsey Street
Portland, OR 97220-3961

From I-205 North, take the Glisan exit, make a right off of the exit. Turn left at 102nd Street. Go to Halsey which is the street just beyond Fred Meyers, and turn right. Go to 107th, look for our large sign and turn into the parking area.

From I-84 East, take the Gateway-Halsey exit and continue up to 107th. Look for our large sign and turn into the parking area.

From I-205 South and I-84 South, take the Glisan-Stark exit, turn left onto Glisan. Go to 102nd and turn left again. Go to Halsey which is the street just beyond Fred Meyers and turn right. Go to 107th, look for our large sign and turn into the parking area.

TriMet stops right outside of our building. The Max Station is approximately 9 blocks away. You may easily transfer to TriMet or take a brisk walk.



CENTER FOR ENVIRONMENTAL MEDICINE LLC

Integrating the best of conventional and complementary medicine

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

This is to authorize: _____ Fax:_____

_____ _____
address phone

To release copies my medical record to:
For the purposes of continuing medical care.

Limited to time period of _____ years.

CENTER FOR ENVIRONMENTAL MEDICINE, LLC
CHRIS HATLESTAD, MD, PC
AMI KAPADIA, MD, PC
10748 NE HALSEY STREET, SUITE A
PORTLAND, OR 97220-3691
503-261-0966: PHONE 503-252-2691: FAX

Please send the records indicated below:

___ Clinician office chart notes
___ Transcribed hospital records
___ Most recent three year history
___ Consultations
___ Problem list
___ Other: _____
___ Emergency & urgent care records
___ Diagnostic imaging reports
___ Laboratory reports
___ Pathology reports
___ Medication list

* ***The following items must be initialed by patient to be included in requested chart information (federal regulations require a description of how much and what kind of information is to be disclosed).***

_____ HIV/AIDS related records
_____ Genetic testing information
_____ Mental health information
_____ Drug/alcohol diagnosis, treatment or referral information

Describe: _____

I agree to waive the privilege of confidentiality and privacy of my medical record in order to gain insurance reimbursement. I understand that this is not a blanket authorization to release information. It is intended for one-time use and expires _____ or 3 months after signing. I must re-execute it should additional requests for information occur. I understand that this authorization has been prepared in accordance with OR 433.045 and OAR 333-12-270. I also understand that Oregon Law allows HIV test information to be entered in my medical record and to be seen by or shared orally with persons who must review the record for the purpose of delivering health care to me or for routine administrative purposes. I further understand Oregon Law requires my physician to report my identity and/or HIV antibody test result to Public Health Authorities under certain circumstances without my authorization. I understand that I may revoke this release at anytime in writing.

_____
Patient Signature Date

_____
Signature of lawful representative if patient is a minor or incompetent. (Relationship)