Pediatric Patient Information Sheet

PATIENT:

Last Name: _____ First Name: _____ Middle initial: ____

Prefer to be called: _____

Gender: M F Other Date of Birth: ____ / ____ / _____ Age: _____ SS#: _____

Primary Guardian/s Name and Relationship to Child _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you? _____

Employer Name: _____ Occupation: _____

Work Address: _____

Guardian Relationship status: Married ___ Separated___ Partner___ Single___

Living in home with child: Parents___ Siblings ___ Other___

How did you hear about our clinic? _____

2nd PARENT OR OTHER GUARDIAN INFORMATION

Last Name: _____ First Name: _____ Middle initial: ____

Phone: (h) _____ (w) _____ (c) _____

Other information we may need: _____

Other guardian at different address? Y N

EMERGENCY: *Name and address of relative or friend* **not living with child**:

Last Name: _____ First Name: _____ Middle initial: ____

Phone: (h) _____ (w) _____ (c) _____

Relationship to Patient: _____

INSURANCE: *Please present your insurance card(s) to the receptionist if you wish us to bill your insurance. Please see our financial policy for details.*

Name of insured: _____ Date of birth of insured: _____

RESPONSIBLE PARTY: *Fill out if you are not responsible for the bill.*

Responsible Party: _____ Relationship to the patient: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Phone: (h) _____ (w) _____ (c) _____

Email _____ What is the best way to contact you?_____

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

I request services X _____ Date _____

Date: _____ Child's Name: _____

Prefers to be called: _____ Age: _____ Date of Birth: _____ Gender M F non-binary

Parent/Legal Guardian Name and Relationship: _____

2nd Parent/Legal Guardian Name and Relationship: _____

Please note if living at different address.

Sibling Names and Ages: _____

How did you hear about our clinic? _____

Pediatrician Name and Clinic _____

Medical History:

What are your current concerns regarding your child's health?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current medications and dosage

_____

_____

Known allergies to medications? _____

Current supplements and dosage _____

_____

Can your child swallow pills? Y N

Do you regularly put sunscreen on your child? Y N

Injuries/Surgeries/Hospitalizations?

1. _____
2. _____
3. _____

Has your child had any of the following special studies (please circle)?

MRI	CT scan	X-ray	Hearing assessment		EEG	EKG/ECG
Speech	Language	Reading/Writing	Psych eval	Allergy testing	Other _____	

Has your child been immunized to the CDC recommended schedule? Y N
Has your child had any adverse reactions to immunizations? Y N
If you have chosen an alternative vaccination schedule, or have chosen not to vaccinate, please specify here:

_____

_____

Guardian Initials _____

General Medical History.

Please circle: **Y= a condition your child has now; N= has never had ; P= has had in the past.**

Baby acne	Y	P	Sore throat	Y	P	Blood in urine	Y	P
Eczema	Y	P	Cough	Y	P	Bladder infection	Y	P
Hives	Y	P	Ear infections	Y	P	Frequent urination	Y	P
Chronic rash	Y	P	Frequent colds	Y	P	Sleep problems	Y	P
Easy bruising	Y	P	High fevers	Y	P	Nightmares	Y	P
Night sweats	Y	P	Asthma	Y	P	Excessive fatigue	Y	P
Stomach aches	Y	P	Wheezing	Y	P	Nervous	Y	P
Decreased appetite	Y	P	Hearing loss	Y	P	Cries easily	Y	P
Increased appetite	Y	P	Frequent headaches	Y	P	Unusual fears	Y	P
Diarrhea	Y	P	Bleeding gums	Y	P	Depression	Y	P
Constipation	Y	P	Nose bleeds	Y	P	Motion or car sickness	Y	P
Gas	Y	P	Mouth sores	Y	P	Sensitive to light	Y	P
Vomiting spells	Y	P	Body or breath odor	Y	P	Dizzy spells	Y	P
Flat feet	Y	P	Hair loss	Y	P	Bleeding tendency	Y	P
Joint pains	Y	P	Heart murmur	Y	P	Physical trauma	Y	P
“Growing pains”	Y	P	Jaundice	Y	P	Emotional trauma	Y	P
Seizures	Y	P	Anemia	Y	P	Abuse	Y	P

Anything else not mentioned: _____

Family medical history (if known.)
Please specify: M=mother, F=father, PA/PU= paternal aunt or uncle, MA/MU= maternal aunt or uncle, MGF/MGM= maternal grandfather or grandmother, PGF/PGM= paternal grandfather or grandmother.

Allergies	Hypertension	Diabetes	Thyroid disease
Arthritis	Heart Disease	Mental Illness	Asthma
Cancer	Eczema	Other	

Mother’s Prenatal History (if known.)

Gestational age at child’s birth _____ Was your child adopted? Y N

Health issues for mother during pregnancy, please circle Y or N.

Bleeding	Y N	Diabetes	Y N	Alcohol/Drugs	Y N
Nausea	Y N	Thyroid problems	Y N	Physical trauma	Y N
Severe stress	Y N	Cigarettes	Y N	Emotional trauma	Y N
Infectious disease	Y N	Birth complications	Y N		

1. On a scale of 1-10 how committed are you to working to improve your child’s health? _____
2. On a scale of 1-10 how much change are you willing to make to improve your child’s health? _____
3. How does your child’s state of health affect his or her daily life?

Guardian Initials _____

HEALTH HABITS AND PERSONAL SAFETY					
Exercise	In a typical week, how many times does your child do the following kinds of exercise for **more than 15 minutes** during their free time…				
	□ Sedentary (No exercise)				
	_____ times per week Mild exercise (climb stairs, walk 3 blocks, yogs, golf)				
	_____ times per week Moderate exercise (fast walking, tennis, dancing)				
	_____ times per week Vigorous exercise (running, jogging, soccer, long distance bicycling)				
Diet	Does your child follow a special diet? □ Yes □ No	If yes, specify:			
	Does your child avoid any foods? □ Yes □ No	If yes, specify:			
	How much water does your child drink per day?	Is it filtered water? □ Yes □ No □ Sometimes			
	On how many of the last SEVEN DAYS did your child eat five or more servings of fruits and vegetables? 0 1 2 3 4 5 6 7				
	On how many of the last SEVEN DAYS did your child eat fast food or sweets? 0 1 2 3 4 5 6 7				
	Please list the typical foods your child eats for:				
	Breakfast:				
	Lunch:				
	Dinner:				
	Snacks:				
Caffeine	□ None	□ Coffee	□ Tea	□ Cola/Soda	
	# of cups/cans per day?				
Drugs	Does your child currently use recreational or street drugs?			□ Yes	□ No

Activity History

What does your child do with his/her free time?_____

What does your child do after school?_____

Does your child participate in any sports? _____ Summer camp?_____

Have regular household chores/responsibilities?_____

How many hours of TV does your child watch each day?_____

How many hours of non-school screen time does your child have each day? _____

School History

Has your teacher identified any special problems? Y N What?_____

How many hours per day does your child spend doing homework?_____

Does your child get along with other children? Y N Describe _____

Days absent per year:_____ Does your child look forward to school?_____

How does your child do in school? (circle)

Well Average Needs some help In special education Needs tutoring Needs special counseling

Yakima Integrative Health
307 S 12th Ave, STE 9
Yakima, WA 98902
P: 509-469-2483 F: 509-469-8870

CONSENT FOR TREATMENT – NATUROPATHIC CARE

I give permission for Yakima Integrative Health (Drs Dunlap, Nauman and/or Robel) to give me medical treatment.

I allow Yakima Integrative Health providers to file for insurance benefits to pay for the care I receive.

I understand that:

- Yakima Integrative Health will have to send medical information to my insurance company.
- I must pay my share of the cost.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand that:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Signature: _____ Date: _____

Parent/Guardian (if under 18)_____ Date: _____

Print Name: _____

Yakima Integrative Health
307 S. 12th Ave, Ste 9; Yakima, WA 98902
P: 509.469.2483; F: 509. 469.8870

Additional Consent and Release Form

Please list any other parties who can have access to your medical information. (This includes parents, step parents, grandparents, and any care takers who can have access to your records.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to confirm my appointments, treatment, and billing information via:

- ○ Cell Phone Confirmation
- ○ Home Phone Confirmation
- ○ Work Phone Confirmation
- ○ Text Message to my Cell Phone
- ○ Email Confirmation
- ○ U.S. Mail/Postcard
- ○ Any of the above

I authorize information about my appointments and medical health to be conveyed via:

- ○ Message on Cell Phone
- ○ Message on Home Phone
- ○ Message on Work Phone
- ○ Text Message
- ○ Email Message
- ○ U.S. Mail/Postcard
- ○ Any of the above

I approve being contacted about special services, events, or new medical info via:

- ○ Phone message
- ○ Text message
- ○ Email
- ○ U.S. Mail/Postcard
- ○ Any of the above

Date: _____

_____ _____

Please **print** your name Please **sign** your name

_____ _____

Legal Representative Description of Authority

Yakima Integrative Health
307 S. 12th Ave, Ste 9
Yakima, WA 98902
509 469-2483

OFFICE POLICIES

Welcome! Thank you for selecting Yakima Integrative Health for your health care needs. Please take a few moments to familiarize yourself with our policies.

Office Hours

Monday – Friday 9-5PM

Payment Policy

Payment is required at the time of service. For your convenience, we accept cash, personal checks, MasterCard and Visa debit/credit.

Insurance Billing

Currently, we accept most Premera and Regence Insurance. Any co-pay is due at the time of service. Deductible and co-insurance fees are also the patient's responsibility. We ask that you check with your insurance provider before your first appointment to confirm coverage as naturopathic and acupuncture services vary among insurances. At this time, Medicare does not cover our services.

Missed Appointments

If you need to reschedule your appointment, please give us 24 hours' notice. We charge $75 for appointments missed or canceled in less than a 24-hour notice.

Telephone Consultation

We are happy to answer short questions and clarify instructions from a previous visit on the phone without charge. If you have a question about a new topic or a change in condition, please make an appointment.

Appointment Rates

Appointment rates vary by service and provider. Please inquire with the front desk for specific information.

Office Policies Agreement

I, _____ have read the above office policies and understand them.

Date_____ Signature _____

307 S. 12th Ave, Ste 9 Yakima, WA 98902 www.yakimaintegrativehealth.com.
509.469.2483

Financial Agreement

I, _____, being a patient of _____ located at the Yakima Integrative Health in Yakima, WA do hereby acknowledge that my health insurance policy is an arrangement between the Health Plan and myself.

I understand it will be my responsibility to understand my insurance policy and its benefits before arriving to my appointment. I also understand that certain services and tests may be ordered by the doctors located at Yakima Integrative Health which may not be covered by my insurance. I agree to be financially responsible for these services and tests.

Annual exams and dual licensed providers
If medical treatment is requested during an annual physical exam, I understand that my provider is allowed to bill the insurance carrier for those services separately from the annual exam charge. I also understand that if my provider is credentialed as both an acupuncturist and naturopath and both modalities are used during the visit my provider will also bill both visits separately.

<u>Important questions to ask yourself before your appointment:</u>

Do I have naturopathic benefits?
If not you will be responsible for paying at the time of your visit. A 20% time of service payment discount is offered to patients paying out of pocket.

Do I have a co pay? What percentage of my visit is covered by my insurance and do I have a deductible?
Co-pays are due at the time of service. Deductible and co-insurance fees are also a patient responsibility.

How many office, acupuncture, and/or preventive visits am I allowed each year?
If coverage is denied due to overage amount of visits, the patient will be responsible for the balance.

Do I need a referral?
Please make sure referrals are in before the time of your appointment.

Date: _____ Signature: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Yakima Integrative Health respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:
We may request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For health care operations:
We use your medical records to assess quality and improve services.

We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.

We may contact you to remind you about appointments and give you information about treatment alternative or other health-related benefits and services.

We may use and disclose your information to conduct or arrange for services including: medical quality review by your health plan, accounting, legal, risk management and insurance services, audit functions including fraud and abuse detection and compliance programs.

Your Health Information Rights:

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

Receive, read and ask questions about this Notice; Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted; Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information; Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing; Have us review a denial of access to your health information-except in certain circumstances; Ask us to change your health information. You may

give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your Records. When you request, we will give you a list of disclosure of your health information. The list will not include disclosures of third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request information more than once in 12 months. Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing; Cancel Prior authorizations to us or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain Insurance.

Our Responsibilities

We are required to: Keep your protected health information private; Give you this Notice; Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Yakima Integrative Health. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Yakima Integrative Health**.** You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

-Notification of Family and Others
Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use or disclose your protected health information with out your authorization as follows:

With Medical Researchers if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

To funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.

To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store or transplant organs.

To the Food & Drug Administration in relation to problems with food, supplements and products.

To Comply With Workers' Compensation Laws if you make a makes workers' compensation claim.

For Public Health and Safety Purposes as Allowed or Required by Law to prevent or reduce a serious, immediate threat to the health or safety, to public health or legal authorities, to protect health and safety, to prevent or control disease, injury or disability, to report vital statistics such as births or deaths.

To Report suspected Abuse or Neglect to public authorities

To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.

For Law Enforcement Purposes such as when we receive a subpoena, court order or other legal process, or you are the victim of a crime.

For Health & Safety Oversight Activities. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.

To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.

In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.

For Specialized Government Functions. For example, we may share information for national security purposes.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or Legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of the patient Relationship
(parent, legal guardian, representative)

This form will be retained in your medical record.