PATIENT PROFIILE-CHILD

Section I: Patient Information

Today's Date: _____

Child's Last Name: _____ First Name:_____ Nick Name:_____

Birth Date: _____ Sex: M / F

Mothers Last Name: _____ First Name: _____

Fathers Last Name: _____First Name: _____ Married ___ Single ___ Divorced ___

Child's Address: _____

City/State: _____ Zip: _____

Home phone: ( ) _____ - _____

Mother mobile phone: ( ) _____ - _____ Father mobile phone: ( ) _____ - _____

Permission to call (Re: Health care services, appointments, billing, etc.) Mother: Y / N Father: Y / N

Mother's Employer Name and Address: _____

Occupation: _____

Father's Employer Name and Address: _____

Occupation: _____

In case of Emergency contact: _____ Phone: ( ) _____ - _____

How did you hear about Dr. Taylor-White? _____

Health Insurance Billing Information: Name of insurance: _____

Subscriber Name: _____ Birth Date: _____

Relationship to child: _____

ID Number: _____ Group Number: _____

Section II: Current Health Concerns

PRESENT HEALTH CONCERNS: Please begin with the most important to deal with today.

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Olympic Naturopathic Wellness Center
Stephanie Taylor-White, ND
17528 W. Main St.
Monroe, WA 98272
Phone: (360) 794-8183 Fax: (360) 794-0305

Childs Last Name, First Name_____ **DOB** _____

Section III: General Health Information

Is your child seeing any health care professionals (e.g., Naturopath, Medical Doctor, Chiropractor, Acupuncturist, Therapist, etc.)? Y / N If yes, Name: _____

Section IV: Child's Medical History

- ☐ Allergies
- ☐ Ear Infections
- ☐ Diarrhea
- ☐ Skin problems/rashes
- ☐ MMR

Immunizations

- ☐ DPT
- ☐ HEP B
- ☐ Polio
- ☐ Other _____

Section V: Family Medical History

Please list any illnesses in your family.
Father: _____
Mother: _____
Siblings: _____

Please mention any significant illnesses / diseases of your grandparents, aunts, uncles, etc.

_____

Section VI: Child's Medications / Hospitalizations

Please list any prescription medications, non-prescription medications, vitamins, herbs, etc. that your child takes on a regular basis.

_____

Please list any allergies to drugs, food, or other substances such as pollen, mold, chemicals, etc.

_____

Please list any hospitalizations, surgeries, or serious illnesses and the year they occurred.

_____

Is there anything else you would like the doctor to know?

_____

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Dr. Douglas K. White and Dr. Stephanie Taylor-White
Naturopathic Physicians

PATIENT RESPONSIBILITY AND INSURANCE DISCLOSURE

Olympic Naturopathic Wellness Center understands how difficult it can be to determine the costs your insurance plan may or may not cover for alternative health care services. This questionaire is designed to assist you with your personal insurance account information. Please use the following questions to help you understand and verify your insurance benefits when you call the toll free number on your insurance card.

We DO NOT verify benefits for you.

You should know the following:

- Does the plan cover Naturopathic Doctors?
- Do you need a referral to see a Naturopathic Doctor?
- Is there a limit on the number of visits per year?
- Is there a maximum dollar limit per family member on coverage annually?
- Is there a maximum percentage per family member on coverage annually?
  - Insurance rarely covers the entire office visit
  - You will receive a bill for the portion your insurance deems your responsibility
- Is there a maximum dollar limit for specialists?
  - i.e.; massage, physical therapy, acupuncture, or any other specialist
- Does the insurance plan cover lab test/results?
- What is your deductible?
- Do you have a co-payment?
  - These are due at time of office visit

By signing below, I agree to be personally and financially responsible for services not covered by my insurance plan or for any services not covered as outlined above.

Patient Signature:_____ Date:_____

Patient Name Printed:_____

Parent or Responsible Party Signature (if a minor):_____

OR

I have **NO health insurance/or coverage under my current insurance plan**, therefore, I agree to be personally and financially responsible for services rendered and I will pay for the office charges at the time of service.

Patient Signature:_____ Date:_____

Patient Name Printed:_____

Please note Medicare does NOT pay for Naturopathic services.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on January 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Notice of Privacy Practices at any time.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION Cont'd

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. We are happy to give patients a copy of their lab tests when they come in. Requests beyond this may be charged as much as $2.00 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to offer you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____
Employee signature *Date*

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CONSENT TO LEAVE MESSAGES & EMAIL / SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I have received or been offered a copy of Notice of Privacy Practices. I further understand that, in order for us to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission for us to do so.

Consent for Leaving Messages

I understand that when I give my consent, information regarding my or my child's (under the age of 18) lab test results or detailed appointment reminders/instructions may be left on my voice mail or answering machine. I understand that "sensitive" information as noted below will be excluded. (note: We do not sell/share your information to any third party. We will respond to your emails and send only occasional newsletters from our office.)

I give my permission for messages to be left on my phone number(s) below. Also, please circle the number which you prefer to receive your messages on.

☐ Cell #_____ ☐ Home #_____ ☐ Work #_____

☐ I prefer not to have voice mail messages from the clinic.

Consent for Email Communication

I understand that email communication is not strictly protected. We do not share/sell your email address to any third party. Also, our outgoing email is limited to responses to your emails or requests.

☐ I consent to email communication and my preferred email address is: _____

☐ I prefer not to be contacted via email.

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

The name(s) listed below are family members or friends to whom I grant permission for my health care providers and their representatives at our clinic to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment.

I understand that I must check the specific boxes in order for my provider or his/her designee to release any information considered as "sensitive".

☐ Mental Health/Psychiatric disorders (including depression)
☐ Chemical Dependency (drug and or alcohol abuse/treatment)
☐ Pregnancy information
☐ HIV/AIDS Virus
☐ Sexually Transmitted Diseases

	NAME	RELATIONSHIP	PHONE NUMBER
1.			
2.			
3.			

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____ _____ _____
Printed Name (Patient/Parent) Signature (Patient/Parent) Date