PENINSULA NATURAL HEALTH CENTER

5603 38TH AVE NW
GIG HARBOR, WA 98335

T: 253 - 857 - 5544
F: 253 - 857 - 9088
FRONTDESK@peninsulanaturalhealth.com

CONFIDENTIAL NEW PATIENT FORM - PEDIATRIC

CHILDS NAME (last, first, m.) _____ AGE _____ DATE OF BIRTH ___/___/___

GENDER _____ IS ANOTHER RELATIVE A PATIENT HERE? _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY PHONE NUMBER ( ) _____ ALTERNATE PHONE-2 ( ) _____ SOCIAL SECURITY NUMBER _____

RESPONSIBLE PARTY EMAIL ADDRES _____ REFERRED BY _____

IS THE CHILD ENROLLED IN INSURANCE THROUGH A FAMILY MEMBER? ☐ YES ☐ NO

IF YES - PLEASE PROVIDE THE FOLLOWING INFORMATION: _____ ___/___/___

NAME (LAST, FIRST, M.) DATE OF BIRTH

EMERGENCY CONTACT NAME _____ HOME PHONE ( ) _____ RELATIONSHIP TO PATIENT _____

OF SIBLINGS_____ NAMES & AGES _____

Please list child's current health problems in order of importance:

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

SURGERIES (year/type) _____

_____

SERIOUS ILLNESS AND/OR ACCIDENTS (year/cause) _____

_____

_____

MEDICATIONS: (please list all supplements, prescriptions and non-prescription drugs)

NAME OF MEDICATION | TAKEN HOW OFTEN? | WHEN DID YOU START/STOP TAKING IT?

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS: _____

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING TESTS?

	WHEN	WHERE	RESULTS
EKG:			
EEG:			
PSYCHOLOGICAL EVAL:			
HEARING TEST:			
SPEECH TEST:			
ALLERGY TESTS:			

NAME/LOCATION/DATE OF LAST DOCTOR VISITED

OTHER PRACTITIONERS SEEN

DATE OF LAST COMPLETE CHECKUP / / PRACTITIONER

SLEEP HOURS/NIGHT GENERAL QUALITY OF SLEEP

DIET (CURRENT) **PLEASE DESCRIBE YOUR CHILDS TYPICAL DIET** *CIRCLE FOODS THAT ARE CRAVED/EXCESSIVELY CONSUMED*

MEDICAL HISTORY: **CHECK** if your child has had any of the following (**CIRCLE** if it has occurred in the past year):

☐ CHICKEN POX	☐ HEPATITIS	☐ PNEUMONIA	☐ SEIZURES	☐ TONSILLITIS # OF TIMES ____
☐ MEASLES	☐ RHEUMATIC FEVER	☐ TUBERCULOSIS	☐ DEVELOPMENTAL DISORDERS	☐ EAR INFECTIONS # OF TIMES___
☐ MUMPS	☐ SCARELT FEVER	☐ HIGH FEVERS	☐ CANCER	☐ RUBELLA

OTHER (please describe)

VACCINATIONS:

☐ MEASLES	☐ POLIO	☐ TETNUS	☐ OTHER:
☐ MUMPS	☐ DPT	☐ DIPHTHERIA	
☐ INFLUENZA	☐ MMR	☐ HEPATITIS	

BIRTH HISTORY: Check if mother had any of the following problems during pregnancy.

☐ BLEEDING	☐ DIABETES	☐ PHYSICAL/EMOTION TRAUMA	☐ THYROID PROBLEMS
☐ NAUSEA	☐ EXCESSIVE WEIGHT	☐ HYPERTENSION	☐ ILLNESS

☐ CIGARETTES, ALCOHOL, DRUG CONSUMPTION (describe)

☐ MEDICATIONS (list)

PREGNANCY

TERM: ☐ FULL ☐ PREMATURE ☐ LATE I N WEEKS_____ WEIGHT AT BIRTH_____LBS _____OZ COMPLICATIONS_____

ANYTHING ELSE YOU WOULD LIKE THE DOCTOR TO KNOW?

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself, and that I am ultimately responsible for any expenses incurred at Peninsula Natural Health Center. I authorize the doctor to examine and treat my condition(s), which may include diagnostic tests deemed necessary for my care, medication and therapy.

RESPONSIBLE PARTYS SIGNATURE / / DATE

PATIENT NAME / / DATE OF BIRTH

PENINSULA NATURAL HEALTH CENTER

PEDIATRIC REVIEW OF SYSTEMS

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Please circle each bullet point that applies to your child.

Constitutional • Good General Health • Recent Weight Change • Night Sweats, Fever • Fatigue/Fever • Developmental Disorders	**Eyes** • Wear Glasses/Contacts • Blurred Vision • EYE DISEASE OR INJURY • EYE PAIN/DRYNESS	**Ears** • DIFFICULTY HEARING • HEARING LOSS • EAR PAIN • EAR DRAINAGE • RINGING IN EARS
Nose • Sinus Problems • Nose Bleeds • Sneezing • Snoring	**Mouth/Throat/Voice** • Lip Sores/Cold Sores • Mouth Sores • Tongue Sores • Trouble Swallowing • Painful Swallowing • Gum Bleeding • Hoarse Voice • Voice Change	**Hematologic/Lymphatic** • Anemia • Bruise Easily • Slow to Heal • Enlarged glands
Respiratory • Shortness of Breath • Cough • Asthma • Wheezing	**Cardiovascular** • Chest pain • Palpitations • Heart Throbs/murmur • Swelling hands/feet • Lightheaded/dizzy/faints	**Allergic/ Immunologic** • Food Allergies • Frequent Infections • Hay Fever
Gastrointestinal • Abdominal pain • Rectal Bleeding • Nausea/Vomiting • No appetite • Farting frequently • Constipation/diarrhea	**Endocrine** • Excessive Thirst/Urination • Hair loss • Cold hands/feet • Hormone Problems • Light Sensitivity	**Musculoskeletal** • Muscle pain/Cramps • Stiffness/swelling joints • Joint Pain • Trouble Walking • Flat Feet • Growth/bone disorders

PATIENT NAME

DATE OF BIRTH

PEDIATRIC REVIEW OF SYSTEMS cont.

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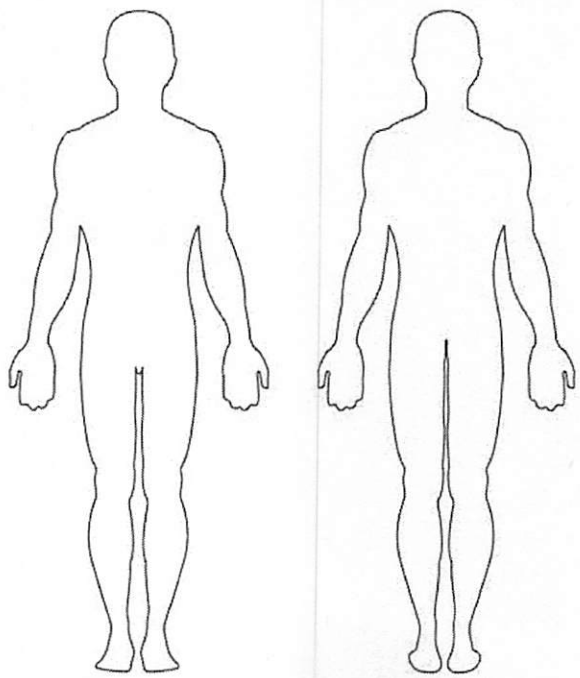
Please circle each bullet point that applies to your child.

Neurological	**Psychiatric**	**Integumentary Skin**
• Frequent Headaches • Paralysis or Tremors • Convulsions/seizures • Numbness/Tingling • Motion/Car Sickness	• Insomnia/nightmares • Confusion/memory loss • Depression/fears • Cries Easily • Anxiety/panic attacks	• Abnormal Nails • Rashes or Itching • Acne • Discolored/Dry Skin • Body Odor
Genitourinary	**Genitourinary cont.**	
• Blood in Urine • Pain/Burning on urination • Frequent Urination • Kidney Disease • Bed Wetting • Testicle Ovary Pain	• PMS • Cramps • Spotting • Irregular Periods • Irregular Period Flow	

Use diagram to illustrate the areas on your child's body where they feel any of the following sensations:

Use the following letters to mark the diagram:

A: Numbness
B:Deep Aching
C: Burning
D: Stabbing
E: Pins & Needles
F: Throbbing
G: Itching



FRONT *BACK*

PATIENT NAME _____ DATE OF BIRTH ___/___/___

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FAMILY HISTORY & ALLERGINS

FAMILY HISTORY - Check appropriate box

	MOTHER	FATHER	CHILDREN	MATERNAL GRANDPARENTS	PATERNAL GRANDPARENTS	SIBLINGS
allergies						
alcoholism						
anemia						
asthma						
bleeding tendency						
blindness						
cancer						
depression						
diabetes						
epilepsy						
heart disease						
hearing loss						
high blood pressure						
hypoglycemia						
kidney disease						
mental illness						
nervous/mental disorder						
stroke						
tuberculosis						

OTHER - PLEASE SPECIFY FAMILY MEMBER

DO YOU REACT TO POLLENS?

TO FOODS? (what type?)

PLEASE LIST ANY DRUG ALLERGIES YOU MAY HAVE AND INCLUDE REACTIONS TO THOSE DRUGS

DRUG REACT ON

RESPONSIBLE PARTYS SIGNATURE DATE / /

PATIENT NAME DATE OF BIRTH / /

PENINSULA NATURAL HEALTH CENTER

NO SHOW & LATE CANCELLATION POLICY

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This policy has been established to provide the highest level of service to all our patients. It has been proven that consistent attendance provides for the greatest opportunity for success. By providing us with notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

- **Patients must call at least 48 hours prior to their scheduled time for a First Office Visit, when they are unable to make their appointment to avoid a $250 fee.**
- **Patients must call at least 24 hours prior to their scheduled time for return office visits, when they knowingly are unable to make their appointment to avoid a $185 fee.**
- We do understand that emergencies arise and that it may not be possible to give such notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by the Medical Director.
- Patients will receive text and e-mail reminders of appointment dates/times the workday prior to scheduled appointment (unless patient chooses otherwise). Patients will always be provided with copies of their scheduled appointments.

RESPONSIBLE PARTYS SIGNATURE _____ DATE ___/___/___

PATIENT NAME _____ DATE OF BIRTH ___/___/___

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PATIENT FINANCIAL RESPONSIBILTY AGREEMENT

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Please read and acknowledge your receipt and understanding of the following service billings and your financial responsibility.

- First Office Visit Cash (courtesy) rate: $250-$310
- Return Office Visit (courtesy) rate: $185 (typical), $230 for extended visit

*Charges billed to insurance companies may vary depending on the specific treatment provided during each visit. Contracted rates may also vary from one insurance company to another.

If Peninsula Natural Heath Center is contracted with your health insurance company, we are **legally obligated** to bill your insurance for your visits. We can only offer the cash courtesy rate if you do not have health insurance, you have been denied coverage, we are out of network with your insurance company, or you do not have naturopathic benefits within your individual plan.

We are currently contracted with the following insurance companies for Naturopath: (These may change without notice.)

- Regence
- LifeWise
- BlueCross/BlueShield
- Premera
- South King Fire & Rescue
- First Choice

You have an obligation to pay the charges that are not covered by your insurance carrier. You are ultimately financially responsible for all services provided. Therefore, it is recommended that you familiarize yourself with your policy benefits. **In addition to the above, please note that we request notice of cancellation 24 hours prior to your scheduled visit. Repeated cancellations or missed appointments may result in billings for the appointment, for which you are financially responsible.**

By signing below, I acknowledge the receipt of the above information.

_____ _____ / _____ / _____

RESPONSIBLE PARTYS SIGNATURE DATE

_____ _____

PRINTED NAME RELATIONSHIP IF OTHER THAN PATIENT

_____ _____ / _____ / _____

PATIENT NAME DATE OF BIRTH

PATIENT REPRESENTATIVE IDENTIFICATION FORM

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PATIENT NAME _____ DATE OF BIRTH ___/___/___

By law, the HIPPA Privacy Rule prohibits Peninsula Natural Health Center from disclosing your Protected Health Information (PHI) to anyone without your authorization, except for treatment, payment and health care operations. This rule became active April 14th, 2000.

Please list the names of all people that you wish to have access to your CHILDS Protected Health Information (PHI):

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

Please list the name of the person(s) with whom we can discuss your child's bill:

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

NAME _____ RELATIONSHIP TO PATIENT _____

If applicable, please list the name of your legal representative.

NAME _____ RELATIONSHIP TO PATIENT _____

Check one: By what authority is this person, your child's legal representative?

☐ NEXT OF KIN ☐ GUARDIAN ☐ GENERAL POWER OF ATTORNEY ☐ HEALTH CARE POWER OF ATTORNEY

PLEASE NOTE: For us to disclose your Protected Health Information (PHI) the above representatives must be able to provide two (2) of the three (3) identifiers listed below:

› PATIENT'S SOCIAL SECURITY NUMBER
› PATIENT'S DATE OF BIRTH
› PATIENT'S ZIP CODE

RESPONSIBLE PARTYS SIGNATURE _____ DATE ___/___/___

NOTICE OF PRIVACY PRACTICES

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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.

Peninsula Natural Health Center 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.

HIPPA protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information related 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 care operations:

TREATMENT

- Information obtained by a medical assistant, 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 you care. This will help them stay informed about your care.

PAYMENT

- We 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 diagnosis, procedures performed or recommended care.

HEALTH CARE OPERATIONS

- We will 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 alternatives 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

EMAIL CONTACT RELEASE

I grant Peninsula Natural Health Center permission to contact me via this email:_____

I understand that this correspondence could contain personal health information (PHI). This correspondence will be used to provide care on patient's behalf and will come from kareo.com for electronic health records and correspondence with my physician. Emails from Square Retail for pharmacy/supplement receipts and notification on specials and newsletters from PNHC staff.

PNHC agrees to protect our patients' PHI in accordance with the HIPPA and will only share PHI with patients and their authorized representatives. Emails are never shared for other purposes other than patient care and direct contact with PNHC.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires us to do so. You may see your record or get more information about it by contacting a Peninsula Natural Health Center staff member. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

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

_____ _____/_____/_____

RESPONSIBLE PARTYS SIGNATURE DATE

_____ _____

PRINTED NAME RELATIONSHIP (if other than the patient)

_____ _____/_____/_____

PATIENT NAME DATE OF BIRTH

Peninsula Natural Health Center

ACKNOWLEDGMENT AND AGREEMENT Peninsula Natural Health Center (PNHC) will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, PNHC cannot guarantee that e-mail will be confidential. Additionally, PNHC will not be liable in the event that you or anyone else inappropriately uses or accesses your e-mail. PNHC will not be liable for improper disclosure of your health information that is not caused by PNHC intentional misconduct. By signing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between PNHC and me, and consent to the conditions outlined herein, as well as any other instructions that PNHC may impose to communicate with me by e-mail. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Please select an option below:

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to PNHC to send me personal health information via unencrypted email regarding patient_____

Patient name

_____

Signature Date Please clearly print ONE email address
(Parent or guardian if patient is a minor)

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL - ENCRYPTED EMAIL ONLY

I do not wish to receive personal health information via email for patient_____

Patient name

_____ _____ _____

Signature Date Please clearly print ONE email address
(Parent or guardian if patient is a minor)

ENCRYPTED EMAILS COME FROM PROOFPOINT ESSENTIALS

If you do not release your email from quarantine within 14 days it will automatically delete.

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WWW.PENINSULANATURALHEALTH.COM
FRONTDESK@PENINSULANATURALHEALTH.COM –PATIENT CARE
BILLING@PENINSULANATURALHEALTH.COM – BILLING QUESTIONS

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PNHC PHYSICAL/ WELLNESS EXAM POLICY

Physical Examination:

- A preventative visit only (done yearly).
- Billing for lab tests is separate from the billing from our clinic. You may receive bills from LabCorp depending on tests performed.
- Does not include Monitoring or diagnosing a specific medical condition or an ongoing health issue (Ex: Medication refills or a new health issue that has occurred.

Physical examination typically includes:

- Review of health history and family history.
- Various physical exams (eyes, heart, abdomen, ears, mouth, etc) to screen for abnormalities.
- Annual patient health questionnaires (PHQ-9, GAD 7).
- Possible examination of genitalia and rectum (Paps, Breast exams).
- Some lab testing at the discretion of the physician.

Addressing a new concern:

- Is not a part of a preventative examination.
- **If added with the physical exam, additional charges may incur****
- May result in rescheduling the physical exam as a typical appointment.

Insurance or self-pay will be billed depending on the service you received:

- We must bill according to the type of visit that appears in your medical record.
- You will be responsible for payment if you are self-paying or if your insurance refuses to pay for the visit. The providers nor clinic can change any codes billed.

Split visit billing:

- **If multiple concerns need to be addressed in addition to the physical exam, your insurance or you yourself will be charged for a physical exam and an office visit. This may require full payment, a copay, coinsurance, or deductible for these additional services which will be billed.

By signing below, I also understand the following:

- This exam does not include treatment of new or existing health problems.
- I understand that if any additional services are provided during this visit, they will be billed separately and may require full payments, copay, coinsurance, or deductible.

BY SIGNING BELOW I AGREE TO UNDERSTANDING THE ABOVE INFORMATION.

PATIENT SIGNATURE _____ DATE OF BIRTH _____ DATE _____