



PEDIATRIC INTAKE 0-12 years old

DATE: _____

Full Legal Name: _____ / _____ / _____
Last Name First Name Middle Initial

Preferred Name: _____ Age: _____ Date of Birth: _____ Birth Weight: _____

Mother's Name: _____ Father's Name: _____

Address _____ / _____ / _____ / _____
street #/PO Box city state zip code

Telephone: (H) _____ (W) _____ (M) _____

E-mail Address: _____ Gender: Female _____ Male: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: (H) _____ (W) _____ (M) _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

COMMUNICATION

What is the best way to communicate with you between office visits? E-mail / Home ph. / Work ph. / Cell ph.

Is there any place you do NOT want us to leave a message? _____

May our practitioner(s) discuss your private medical information with you via e-mail*? **Yes No**

May we send you educational/promotional materials such as newsletters via e-mail? **Yes No**

NOTE: Please be aware that email is not a secure communication, and that discussion of your medical care will become part of your medical record.

INSURANCE

Insurance? Yes / No Insurance Name: _____ Phone #: _____

Policy/ID Number: _____ Group Number: _____

Secondary Insurance? Yes / No Insurance Name: _____ Phone #: _____

Policy/ID Number: _____ Group Number: _____

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Northwest Natural Medicine LLC.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____ Date: _____

HEALTH HISTORY

What are your child's most important health concerns? List in order of importance.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

What has already been done for the above-mentioned concerns? And what results?

Does your child have a contagious disease at this time? Y N If yes, what? _____

MEDICATION & SUPPLEMENTS Please list all your child's prescription and over-the-counter medications, homeopathic remedies, herbs, vitamins and minerals, or other supplements, with dosages.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

BIRTH HISTORY

List major patterns of illness present in the child's birth mother, father, or their families:

Did mother receive:

- | | | |
|--------------------|---|---|
| prenatal care? | Y | N |
| prenatal vitamins? | Y | N |
| medications? | Y | N |

Please list: _____

Did mother:

- | | | |
|-------------------|---|---|
| smoke cigarettes? | Y | N |
| drink alcohol? | Y | N |
| illicit drugs? | Y | N |

Please list: _____

Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc)?

Type of birth (hospital, home, C-section, etc)? _____

Carried to term? Y N If no, how premature? _____

Complications of labor or delivery? _____

Patient Name: _____ Date of Birth: _____ Date: _____

PREVIOUS ILLNESSES

Describe difficulties during infancy (colic, ear infections, skin or lung problems, etc):

Has your child had any of the following childhood illnesses?

- Diphtheria
- German Measles
- Measles
- Mumps
- Rheumatic Fever
- Scarlet Fever
- Strep Throat
- Other _____

How often does your child get:

	never	occasionally	frequently	constantly
colds				
sore throat				
earaches				
coughs				
diarrhea				
constipation				
tummy aches				

Has your child had any of the following? When? Where?

electroencephalogram? _____
psychological evaluation? _____
hearing tests? _____
speech/language tests? _____

What hospitalizations, surgery, or injuries has your child had? Please give dates and reasons:

IMMUNIZATION HISTORY What immunizations has your child had?

- Diphtheria
- Diphtheria, Tetanus
- Diphtheria, Tetanus, Pertussis
- Tetanus, single
- Haemophilus Influenza type b
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Influenza (flu shot)
- Measles, single
- Mumps, single
- Measles, Mumps, Rubella (MMR)
- Polio - inactive (IPV)
 oral (OPV)
- Rubella, single
- Varicella (chicken pox)
- Other _____

Are your child's immunizations current? Y N

If not, please explain: _____

Reactions to immunizations? _____

Patient Name: _____ Date of Birth: _____ Date: _____

ALLERGIES

Is your child hypersensitive to:

Any drugs? _____
Any foods? _____
Any environmental? _____

Was/Is your child:

Breast-fed? Y N
Formula-fed? Y N

Age solid food was introduced? _____

First food introduced (if known)? _____

FOOD & DIET Please describe your child's typical food intake.

Breakfast	Lunch	Dinner	Snacks	Beverages

HEALTH HABITS Does your child:

Watch TV? Y N hours / day _____
Read? Y N hours / day _____
Play video games? Y N hours / day _____
Play sports? Y N hours / day _____

What are your child's favorite activities? _____

Day care / School / Home school? (circle) Grade level? _____

Does anyone in your household smoke? Y N

Are there pets in the home? Y N What kind? _____

Patient Name: _____ Date of Birth: _____ Date: _____

SOCIAL HISTORY

With whom does your child live? _____

Are parents together / divorced / separated? (circle)

If not together, what if any arrangements are made with the other parent (eg. visitation)?

List age and gender of siblings; indicate half or step-siblings where applicable.

Were any of the mother's pregnancies not carried to term?

ENVIRONMENTAL

What type of dwelling do you live in? _____ How old? _____

Water source? _____ Type of heat? _____

Any difficulties with school? Please describe.

How would you describe your child's personality? _____

Temper? _____

Sociability? _____

Describe any problems in the following areas:

Digestion: _____

Skin: _____

Respiratory: _____

Urinary: _____

How much sleep does your child get? From _____ pm to _____ am. Quality? _____

Was your child early or late in rolling over, teething, or talking? _____

Is there anything not covered in this questionnaire that you would like to let your doctor know?

Thank you for your time and effort. We look forward to providing you with the best possible care

**Naturopathic Medicine
Informed Consent for Treatment**

I, _____, hereby authorize Dr. Jesse I Buttler or other licensed doctors of naturopathic medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, UA, Pap smears, radiography, laboratory

Minor office procedures: e.g., ear cleansing

Naturopathic physical medicine: e.g. craniosacral technique, muscle energy stretching, therapeutic massage techniques, heat and cold therapies, electric stimulation, manual therapies and other related treatments

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections, IV therapy

Western Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses

Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities

Psychological counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential risks: allergic reactions to prescribed herbs and supplements; side effects of natural medicines; inconvenience of lifestyle changes; injury from injections, venipuncture, or physical medicine; aggravation of pre-existing conditions.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

Printed Name of Patient

Signature

Date

Printed Name of Legal Guardian

Signature

Date

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on January 2, 2008.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature Below is only an acknowledgment that you have received this Notice of our Privacy Practices:

Printed Name of Patient

Signature

Date

Printed Name of Legal Guardian

Signature

Date

Informed Consent and Request for Classical Chinese Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Gibran K. Ramos, Licensed Acupuncturist, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Classical Chinese Medicine (CCM) and Acupuncture with Gibran K. Ramos, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for him, hereafter called *allied health care provider*.

I understand that I have the right to ask questions and discuss to my satisfaction with Gibran K. Ramos, and/ or with the *allied health care provider* providing backup the following:

- (1) my suspected diagnosis(es) or condition(s)
- (2) the nature, purpose, goals and potential benefits of the proposed care
- (3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
- (4) the probability or likelihood of success
- (5) reasonable available alternatives to the proposed treatment procedure
- (6) potential consequences if treatment or advice is not followed and/ or nothing is done
- (7) any other questions or concerns regarding medical procedures, course of treatment, and/or care.

I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but not be limited to:

- Physical exam (general, including palpation of pulse, observation of the tongue, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (burning of herbal material in the form of a loosely compacted herb or stick directly on the skin or indirectly above the skin)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Tuina (ancient Chinese massage)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements)
- Herbs which may be taken internally or used externally. (use of herbal formulas or single herbs in the form of teas, powders, pills, capsules, tinctures which may contain alcohol, pastes, plasters, washes or suppositories. Formulas or Herbs may include shells, minerals and animal materials)
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)

Potential benefits of care, treatment or procedure provided by Gibran K. Ramos, and/ or with the *allied health care providers*: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks of care, treatment or procedure provided by Gibran K. Ramos, and/ or with the *allied health care providers*: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, spontaneous miscarriage; allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical medicine (cupping, tuina/massage); aggravation of pre-existing symptoms.

Payment Policies

1) Payment is expected in full at the time that services are rendered. Payment is expected in full at the time supplements or other products are purchased. We accept Visa, MasterCard, debit cards, cash and checks. There will be a \$30 fee for every returned check.

2) Insurance: If your insurance policy is qualified and proven to cover our care, we will agree to bill your insurance company directly. This is with the understanding that your insurance policy is a contract between you and your insurance company - we cannot guarantee payment of your claims. If your insurance company pays only a portion of your bill or rejects your claim, you are still financially responsible for the remainder of the claim unless we are contracted with your insurance plan.

3) Appointments by phone must be paid at the time of the visit. You will be asked for your credit/debit card number prior to the visit and will be charged for the visit as well as any supplements and shipping costs at that time.

Office Policies

1) Please call 24 hours in advance to cancel or change an appointment. A missed appointment fee of \$50 will be assessed for appointments cancelled with less than 24 hours notice.

2) I give permission to the physicians and staff of Northwest Natural Medicine, LCC to contact me via telephone and email given the contact information that I provided on my intake forms. I understand if I am not available, a message with information about my appointment or my medical condition will be left.

3) Return Policy on Supplements: Unopened and unused pre-packaged supplements can be returned for their full value. Individualized supplements that are formulated by Northwest Natural Medicine, LLC cannot be returned.

4) Please refrain from using your cell phone in the clinic unless it is an emergency. Thank you.

I have read and understand the above-stated policies of Northwest Natural Medicine, LLC and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Printed Name of Patient

Signature

Date

Printed Name of Legal Guardian

Signature

Date