

Whole Family Wellness Center
New Patient Information (Pediatric)

Patient Information:

Patient Name _____ Today's Date _____
Street Address _____ Apt # _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Office Phone _____
Mobile Phone (____) _____ Email _____
Birth Date _____ Age _____ Gender _____

Referred by: _____

Emergency Contact _____ Relationship _____
Home Phone (____) _____ Office/cell phone _____
Pediatrician's Name _____ Phone _____
Date of last visit _____

Billing and Insurance

Primary Insurance _____ Phone (____) _____
Primary Insurance Address _____
Policy Holder's Name _____ Relationship _____
Policy # / ID# _____ Group # _____

Missed Appointment Policy

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged the full price of your visit.

_____ I understand cancellation policy.

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Health History

Reason for office visit _____

Has your child been seen by another practitioner for this? ___ Yes ___ No

If yes, what was the outcome? _____

Has your child had acupuncture or other holistic/natural treatment before? If so, for what reason and what type of treatment? _____

Do you wish for Jill Stevens to act as your child's primary care provider? ___ Yes ___ No

Please check off any of the following symptoms that your child has in the past or is currently experiencing:

- | past current | past current | past current |
|---|--|---|
| <input type="checkbox"/> ___ frequent colds | <input type="checkbox"/> ___ jaundice as a baby | <input type="checkbox"/> ___ dry skin |
| <input type="checkbox"/> ___ sinus infection | <input type="checkbox"/> ___ abdominal bloating | <input type="checkbox"/> ___ itching |
| <input type="checkbox"/> ___ production of phlegm | <input type="checkbox"/> ___ abdominal pain | <input type="checkbox"/> ___ cradle cap |
| <input type="checkbox"/> ___ cough | <input type="checkbox"/> ___ decreased appetite | <input type="checkbox"/> ___ rashes, hives, eczema or psoriasis |
| <input type="checkbox"/> ___ cough with blood | <input type="checkbox"/> ___ belching | <input type="checkbox"/> ___ acne |
| <input type="checkbox"/> ___ reoccurring ear infections | <input type="checkbox"/> ___ indigestion | <input type="checkbox"/> ___ edema |
| <input type="checkbox"/> ___ hay fever or allergies | <input type="checkbox"/> ___ heartburn | <input type="checkbox"/> ___ seizures |
| <input type="checkbox"/> ___ nose bleeds | <input type="checkbox"/> ___ bad breath | <input type="checkbox"/> ___ bedwetting |
| <input type="checkbox"/> ___ asthma | <input type="checkbox"/> ___ bleeding gums | <input type="checkbox"/> ___ frequent urination |
| <input type="checkbox"/> ___ bronchitis | <input type="checkbox"/> ___ constipation | <input type="checkbox"/> ___ blood clotting disorders |
| <input type="checkbox"/> ___ pneumonia | <input type="checkbox"/> ___ frequent diarrhea | <input type="checkbox"/> ___ urinary tract infections |
| <input type="checkbox"/> ___ hoarse voice | <input type="checkbox"/> ___ blood in stools/black | <input type="checkbox"/> ___ insomnia / nightmares |
| <input type="checkbox"/> ___ difficulty swallowing | <input type="checkbox"/> ___ pus in stools | <input type="checkbox"/> ___ anxiety |
| <input type="checkbox"/> ___ recurring sore throat | <input type="checkbox"/> ___ hemorrhoids | <input type="checkbox"/> ___ often feel afraid |
| <input type="checkbox"/> ___ frequent swollen glands | <input type="checkbox"/> ___ rectal pain | <input type="checkbox"/> ___ night sweating |
| <input type="checkbox"/> ___ mouth ulcers | <input type="checkbox"/> ___ change in appetite | <input type="checkbox"/> ___ ADD/ADHD |
| <input type="checkbox"/> ___ grinding teeth | <input type="checkbox"/> ___ colic | <input type="checkbox"/> ___ behavioral problems |
| <input type="checkbox"/> ___ eye glasses | <input type="checkbox"/> ___ low energy / fatigue | <input type="checkbox"/> ___ learning problems |
| <input type="checkbox"/> ___ difficulty hearing | <input type="checkbox"/> ___ bed wetting | |

Female Patients:

Age of menses onset: _____

Please check all that apply:

- | past current | past current | past current |
|---|--|--|
| <input type="checkbox"/> ___ PMS | <input type="checkbox"/> ___ breast tenderness | <input type="checkbox"/> ___ irregular periods |
| <input type="checkbox"/> ___ vaginal infections | <input type="checkbox"/> ___ painful periods | <input type="checkbox"/> ___ abnormal bleeding |

Family History (Complete for each family member, placing an X in the appropriate box):

	Child	Mother	Father	Sister	Brother
Allergies					
Blood Disorder / Anemia					
Diabetes					
Cancer or Tumors					
Seizures					
High Blood Pressure					
Kidney or Bladder Disorder					
Stomach or Intestinal Disorder					
Drug / Alcohol Use or Abuse					
Tuberculosis					
Heart Disease					
Stroke					
Depression / Mental Illness					
Suicide Attempt					
Age at Death					

Blood Work: When was the last time your child had blood work? What lab tests were done?

Vaccinations

- MMR: ___ Yes ___ No ___ Some
Hep B: ___ Yes ___ No ___ Some
Chickenpox: ___ Yes ___ No ___ Some
Hib ___ Yes ___ No ___ Some
DTaP: ___ Yes ___ No ___ Some
Influenza: ___ Yes ___ No ___ Some
Pneumococcal: ___ Yes ___ No ___ Some
Polio: ___ Yes ___ No ___ Some

Birth

What type of birth did your child have? (please check all that apply)

- Home ___ Birthing Center ___ Hospital ___ Birthing Doula ___
Midwife ___ Medical Doctor ___ Water birth ___
Other ___ Please describe _____

Please describe any medical procedures, if any, used during the birth _____

Please describe any complications that may have occurred during the birth _____

Please describe the pregnancy of this child. Include any physical complications as well as any emotional issues/stressors that may have arisen during the pregnancy. _____

Please list your health concerns for your child in order of importance:

Please describe an average day of activities for your child:

Please describe the living arrangements for your child. Including circumstances such as joint custody, co-sleeping, siblings, etc.

What are your expectations and/or hopes for the outcome of this treatment?

Please provide any additional information about your child's health not covered by the above questions (if you need additional room please use the back of this paper).

Whole Family Wellness Center Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine at the Whole Family Wellness Center.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, Homeopathy, Flower Essence Therapy, nutritional supplements and nutritional counseling.

I have had the opportunity to discuss with the practitioner at Whole Family Wellness Center the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. Following an acupuncture treatment, there may be dizziness or fainting. Although the practitioner maintains a clean environment and uses disposable needles, in rare cases infection of the needling site may occur. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. Burns and scarring are potential side effects of moxibustion.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastro-intestinal upset, allergic reactions or any other undesirable effect to the herbs, I will inform the above named practitioner.

I will notify Whole Family Wellness Center if I am or anticipate becoming pregnant.

I do not expect the practitioners at Whole Family Wellness Center to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise judgment during the course of the procedure which they feels at the time, based upon the facts then known, is in my best interest.

I understand that clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent, unless required to do so by law.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

PATIENT'S NAME _____
(please print)

PATIENT'S SIGNATURE _____

DATE SIGNED _____

ARE YOU PREGNANT? ___ YES ___ NO

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:

NAME OF PATIENT _____
(please print)

PATIENT'S REPRESENTATIVE _____
(please print)

REPRESENTATIVE'S SIGNATURE _____

AS: _____
Relationship or Authority of Patient's Representative

DATE SIGNED _____

WHOLE FAMILY WELLNESS CENTER

FINANCIAL POLICIES

1. All fees for services are due at the time of visit unless previous arrangements have been made.
2. Most conditions require an average of 4-12 treatments, although some will respond well in fewer visits and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.
3. Your appointment time is reserved specifically for you. In the event of a missed appointment, an appointment cancelled with less than 24 hours notice, or arriving later than 20 minutes after your appointment time, please note you will be charged the full price of your visit.
4. There is a service charge of \$25 for every returned check.
5. Fees for services are as follows. Please note that payments made at the time of service will receive the “payment at the time of service discount” and all other payments will be charged the full fee.

	Full Fee	Payment at the time of service Discount
<u>Adults:</u>		
New patient consultation, exam & treatment	\$190	\$150
Follow up consultation & treatment	\$130	\$85
<u>Children:</u>		
New patient consultation, exam & treatment	\$190	\$150
Follow up consultation, exam & treatment- 30 min.	\$110	\$75
Follow up, treatment only- 15 min.	\$55	\$38

6. Herbal Supplements for adults, approximately \$8-\$25/week

****Please note: Sliding scale is available for all patients showing financial need. Please speak to me before our first appointment if you require consideration for a lower fee.

Please indicate your understanding and acceptance of these policies by signing below.

Signature

Date

Printed Name

Whole Family Wellness Center Privacy Policies

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*

We gather personal information and health information in several ways:

- Information we receive from you;
- Information we receive from other healthcare providers; and
- Information we receive from third party payers.

*This information is used for treatment, payment and healthcare operations.

*You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

*You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$10-20 and with 10 working days to process it.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office.

I have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

If I would like to review the Privacy Policies I may request a copy at the front desk of Whole Family Wellness Center, 1240 Powell St, Ste 2-A, Emeryville, CA 94608.

Patient Signature _____

Date _____

Whole Family Wellness Center
1240 Powell St. Ste 2-A • Emeryville, CA 94608
Tel: 510-851-3006 • Email: wholefamilywellness@gmail.com

WHOLE FAMILY WELLNESS CENTER
Authorization for Release of Medical Records

Patient Name _____ Date _____
Address _____
City _____ State _____ Zip Code _____
Phone _____ Email _____

I, _____, authorize the practitioners of the Whole Family Wellness Center to release my medical records to the following practitioner(s):

The release of my medical records can include but is not limited to health history, lab results, progress notes, & treatment plan.

With my signature below I hereby authorize the release of my medical records:

Patient Signature _____ Date _____