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: Yelp [ ] Facebook [ ] Twitter [ ] Ad [ ] _____ (specify publication)
Referred By (Friend, Dr., Midwife, Doula) [ ] _____
BPN [ ] Holistic Parenting Support Group [ ] Other [ ] _____

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

Female Patients:
Age of menses onset: _____

Please check all that apply:

past	current		past	current		past	current	
__	__	PMS	__	__	breast tenderness	__	__	irregular periods
__	__	vaginal infections	__	__	painful periods	__	__	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. _____

_____

_____

_____

Major Hospitalizations/Surgeries – Please list any hospitalization or surgeries your child has undergone including date of occurrence

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

Medicines, Herbs, Supplements (Please check any that the patient is currently taking)

___ aspirin
___ ibuprofen/motrin
___ acetaminophen (Tylenol)
___ allergy medication
___ antacids
___ fiber / laxatives
___ insulin
___ cold medicine (Dimetapp, Sudafed)

other, please list _____

How many times has your child taken Antibiotics? _____
Did you supplement with probiotics (acidophilus)? Yes _____ No _____

Please list any known medication allergies _____

Diet

Is (was) your child breastfed or formula fed? _____ Breastfed only _____ formula only _____ both
Until what age was she/he breastfed? _____
What brand(s) of formula have you used? _____
_____
Was the formula soy, cow milk, or goat milk based? _____

What was solid first introduced? _____

Please describe your child's typical daily diet:

Breakfast _____ Morning Snack _____
Lunch _____ Afternoon Snack _____
Dinner _____ Evening Snack _____

Please describe any restricted diet your child follows now or in the past:

_____
_____
_____

Please list any known food allergies/sensitivities _____
_____

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
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 $35 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	$405	$250
Acupuncture treatment with Cupping	$315	$165
Acupuncture treatment without Cupping	$235	$125
<u>Children</u>:		
New patient consultation, exam & treatment	$405	$250
Follow up consultation, exam & treatment : 30 min.	$215	$120
Follow up, treatment only : 15 min.	$107.50	$60
<u>Telemedicine</u>:		
New patient consultation & treatment plan	$250	$250
Follow up consultation & treatment plan 15-45 min	$120 per 30 minutes, prorated by usage	

6. Herbal Supplements for adults, approximately $20-$40/week

****Please note: A Monthly Payment Plan is available for all patients showing financial need. Please speak to us before your 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
Cancellation Policy Agreement

Whole Family Wellness Center has a strict 24 hour cancellation policy. Your appointment time is reserved specifically for you or your child, and we regularly turn away other patients for those times. Therefore, to protect our business and our time, we charge the ***FULL COST*** of your visit in the following circumstances:

- An appointment is cancelled with less than 24 hours notice
- Missing a scheduled appointment time, or
- A very late arrival to your appointment, where we are unable to see you without impacting our other patients.

We will make every effort to waive the cancellation fee in the following circumstances:

- We are able to fill your time slot with another patient
- We are able to reschedule you for a time on the same day that you missed an appointment
- We have an empty enough schedule in the following 1-2 business days after your missed appointment, that we can comfortably offer you an alternative, without effecting other patients' options for scheduling. Please note this is rare. Our schedule is often booked several weeks in advance. There must be enough available appointment times in the schedule that we feel comfortable we are not turning away other patients for that time, to be able to waive your cancellation fee. To have your fee waived, this option will only be offered directly through our office, and CANNOT be scheduled online. If you miss this alternate appointment for ***ANY*** reason, you will be charged the cancellation fee for your original missed appointment.

Please note the following:

- If we are billing your insurance for your acupuncture visits, please know your insurance ***DOES NOT*** cover missed appointments. You will be charge our *Payment at the time of Service* discounted rate, for your missed visit. These rates are as follows: $125 for adult follow up visits, $120 for 30 minute pediatric follow up visits, and $60 for 15 minute pediatric follow up visits. Please know we will ***NOT*** attempt to bill your insurance for missed visits.

- Please note a signed copy of this agreement will be emailed to you for your records.

Please indicate your acceptance of our Cancellation Policy 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
Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by the acupuncturist at the Whole Family Wellness Center Clinic Medical Staff named below and/ or other acupuncturist(s) of the Clinic Medical Staff. I have discussed the nature and purpose of my treatment with the member of the Clinic Medical Staff named below.

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 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 Clinic Medical Staff members maintain a clean environment and use 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 Clinic Medical Staff.

I will notify the Clinic Medical Staff if I am, anticipate becoming, or become pregnant.

I do not expect the Clinic Medical Staff at the Whole Family Wellness Center to be able to anticipate and explain all risks and complications, and I wish to rely on the Clinic Medical Staff to exercise judgment during the course of the procedure which they feel 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.

Discontinuation of services:
You may discontinue treatment at any time. Although it would be unusual for me to refuse services, I may do so at any time. Reasons for refusal of services include but are not limited to: abusive or disrespectful behavior; unpaid fees; repeated cancellation, non-attendance, or tardiness for appointments; intoxication. In addition, should I determine that the severity of your condition warrants higher levels of care, I may refer you to such care instead of or in addition to psychotherapy with me.

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_____

To be completed by Clinic Medical Staff Member:

NAME_____ SIGNATURE_____ DATE SIGNED_____
(please print

Whole Family Wellness Center
Tel: 808-442-2731 • 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 _____