Essential Family Medicine

Holistic Primary Care

1110 SE Alder St
Suite 201
Portland, OR 97214
503-477-5051

Dr. Shawnte Yates ND, LAc ~ Dr. Molly Thelisdort ND, LAc ~ Sandy Musclow ND, LAc

PEDIATRIC INTAKE FORM (6-12 years)

Patient's name ________________________________ Date of visit _________________

Age _______ Date of Birth ________________ Gender: female _________ male ____________

Parent 1 name___________________________ Parent 2 name __________________________

Address ________________________________City __________________Zip______ State ____

Phone # (home) (_________) ______________________ Parents work # (_______) ___________________

How did you hear about our clinic? ____

Health insurance: Company ____

Policy/I.D. No. __________________________ Group/code No ________________________

Name policy is in ____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept ___________________

____

What are your child's most important health problems? List as many as you can in order of importance.

1)____

2)____

3)____

4)____

Does your child have a contagious disease at this time? Y N

If yes, what? ____

PREVIOUS ILLNESSES

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number ______________	
Ear infections	Y N	approx. number ______________	
Other	Y N	list ______________________________	

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram	....	....	....
Psychological evaluation	....	....	....
Hearing	....	....	....
Speech/Language	....	....	....

Injuries/Surgeries/Hospitalizations (please list): ____________________________________

____

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? ____________	

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods? ____

Any environmentals?____

MEDICATIONS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking along with dose and frequency.

1) ________________________________ 4) _______________________________

2) ________________________________ 5) _______________________________

3) ________________________________ 6) _______________________________

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects _____ Hypertension _____ Arthritis
_____ Tuberculosis _____ Cancer _____ Allergies _____ Mental illness _____ Asthma

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother's age at child's birth? __________

Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full ________ Premature __________ Late ___________ Weight at birth________________
Length of labor ________________ Complications? ______________________________________
Did your child have any of the following problems shortly after birth?
______ Birth defects ______ Birth injuries ______ Blue baby___ Cerebral palsy ______ Seizures
______ Jaundice____ Colic ______ Fever ______ Rashes

Other (explain) ____

Child's sleep patterns (first year) ____

Food intolerances (if any) ____

Feeding: Breast-fed? ________ how long? _____________ Formula? _ milk / soy ________

Age began solids ____________________ Which foods? _________________________________

Age began: Sitting _________ Crawling _________ Walking __________ Talking _____________

TYPICAL DIET

Please list any food allergies or intolerances, along with the reaction they provoke.

What food does your child crave/insist upon?

Does your child have any dietary restrictions (religious, vegetarian/vegan etc.)?

Breakfast:____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

ENVIRONMENT

Describe your child's sleep pattern:

How would you describe your child's temperament?

Is your child in: school (grade_________), daycare/homecare, or other _________

How would you describe your child's behavior and performance at school?

What are your child's favorite activities?

Does your child exercise regularly? How much, how often?

____

How much television does your child watch? __________ hrs a day/ week

How often does your child read (not for school)/How often does someone read to your child?

Does anyone in the child's household smoke, even just outside? Y N

Are there animals in the home? Y N

Type: ____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N

Bowel Movements How often ______________________________________

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N				

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N

Is there any information about your child's health that you would like to add? ________________________

____

____

Welcome! We're glad to be of service for you and your child!

Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Essential Family Medicine and you may obtain one at any time.

Uses and Disclosures

We may use and disclose your health information for different reasons.

• Treatment: To assist in your diagnosis and treatment.

• Payment: In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.

• Health Care Operations: For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes. We must disclose, when required by law, for the following examples:

• Avoid threat to health or safety. To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.

• Coroners, Funeral Directors, Organ Donation. To said professionals such that they can carry out their duties.

• Health oversight activities. To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.

• Health-related benefits or services. For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.

• Law Enforcement, judicial and administrative proceedings. In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.

• National security and intelligence. As required by military officials for security and military purposes.

• Public health activities. To public health agencies for reasons such as preventing or controlling disease, injury or disability.

• Research. For medical research – Such circumstances include taking steps to protect your privacy.

• Victims of abuse, neglect or domestic violence. To government agencies and law enforcement personnel as required by law.

• Workers' compensation. In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made only with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Essential Family Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make. Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via email than by regular mail. To verify or modify where or how you would like communication sent, contact Essential Family Medicine. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record. Right to inspect and copy: Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Essential Family Medicine and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Essential Family Medicine. We will respond within 60 days of receipt of your written request.

We may deny your request in writing if your information is

1) not correct and complete,
2) not created by us,
3) not allowed to be disclosed, or
4) not part of our records.

Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information. Right to receive an accounting of disclosures: This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before January 19, 2012). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

Right to get a paper copy of this Notice: At any time even if you previously agreed to receive an electronic copy.

Right to file a complaint: If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us, contact Essential Family Medicine. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I _______________________________(Legal Guardian), herby declare that I have received a copy of my privacy rights as determined by HIPPA, Health Insurance Portability and Accountability Act of 1996.

___________________________	________________________________	__________________
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Dr. Elise Wong, ND, LAc ~ Dr. Shawnte Yates, ND, LAc ~ Dr. Molly Thelisdort ~ Dr. Sandy Musclow, ND, LAc

Informed Consent for Naturopathic Treatment

I, __________________________(Legal Guardian), do voluntarily, knowingly and willingly give my consent to treatment by Naturopathic Medical Care. A number of different approaches are used. Diet and nutritional supplements, botanical medicine, homeopathy, hydrotherapy, physical medicine and lifestyle counseling are the mainstays of naturopathic medicine. Pharmaceutical medicines may be employed if absolutely necessary. Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being. We will take a thorough case history, do pertinent physical examinations, and may take blood and urine samples. If your case requires, the physical may include more specific examinations. Even the gentlest therapies may have complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies should be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. Please inform your Naturopathic Doctor immediately of any disease that you are suffering from, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your Naturopathic Doctor immediately.
There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture
- Risks and Side Effects associated with pharmaceutical medicines

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I state that my child does not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or is currently taking anticoagulants. If my child has any of the above conditions, I have listed them here:

By voluntarily signing below I, ____________________________(Legal Guardian), hereby certify that I have read this entire form, have been told about the risks and benefits of naturopathic and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of
treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

________________________ ________________________________ ________________

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Informed Consent for Chinese Medicine Treatment

I ________________________(Legal Guardian) hereby agree and consent to the performance of Chinese Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, direct or indirect moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, Shiatsu and Sotai (Japanese Massage), Chinese herbal medicine, and nutritional counseling based on classical Chinese medical theory. Acupuncture is a technique utilizing fine sterilized stainless steel needles inserted at specific points in the body to correct various ailments. I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, collapsed lung, minor swelling, bleeding, bruising may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if my child experiences any symptoms or problems. I understand that my child should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

Cupping utilizes round suction cups over a large muscular (such as the back) to enhance blood circulation to the designated area. Potential risks include bruising, mild skin irritation or rarely a skin burn.

Moxibustion is the use of a form of compressed herb (mugwort) that is lit and placed either, directly or indirectly over acupuncture points. Potential Risks include skin irritation or burn.

Shiatsu and Sotai are different forms of Japanese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.

• I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

• I am relying on the practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that Chinese Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I state that my child does not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or is currently taking anticoagulants. If my child has any of the above conditions, I have listed them here:

By voluntarily signing below I, ____________________________(Legal Guardian), hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

______________________________	______________________________	________________
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STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

• Financial options extended to me are based on the personal identification information and documentation I have provided.

• I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.

• I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amounts owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees.

• I hereby authorize Dr. Shawnte Yates, ND, LAc - Dr. Elise Wong, ND, LAc - Dr. Molly Thelisdort, ND, LAc - Dr. Sandy Musclow, ND, LAc and Essential Family Medicine to release information necessary to secure payment.

• I understand that there will be a minimum $60 fee for any appointment not cancelled or rescheduled within 48-business hours of the scheduled appointment. Business hours are Monday – Friday, 9am – 6pm.

• Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

I understand and agree to the following with regards to current and/or future insurance billing:

• The verification of my health, motor vehicle accident, or worker's compensation insurance is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier. I am fully responsible for being aware of any coverage exclusions.

• I am responsible for providing in a timely manner all accurate and thorough documentation required to verify my insurance coverage and/or bill my insurance carrier, including all relevant Coordination of Benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.

• I understand that Dr. Shawnte Yates – Dr. Elise Wong – Dr. Sandy Musclow – Dr. Molly Thelisdort and Essential Family Medicine can require presentation of proof of insurance at any time, and that my insurance may need to be re-verified for specific coverage details as often as every six months.

• I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified, or not provided in a timely manner and has resulted in Dr. Shawnte Yates – Dr. Elise Wong – Dr. Molly Thelisdort – Dr. Sandy Musclow or Essential Family Medicine inability to directly bill for and/or receive reimbursement from my insurance carrier.

• I am responsible for full and timely payment of all insurance co-pays, deductibles, and coinsurance balances due, including any and all services not covered or paid by my insurance carrier (subject to individual provider insurance contract provisions).

• I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.

• I authorize release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to Dr. Shawnte Yates – Dr. Elise Wong – Dr. Molly Thelisdort – Dr. Sandy Musclow. This release applies to support the insurance billing process only.

• I have fully read and understand the above agreements and authorizations.

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Health Insurance Disclaimer

Essential Family Medicine, Dr. Yates, Dr. Wong, Dr. Musclow and Dr. Thelisdort will be following protocols for verifying your insurance coverage. Insurance information given to us by your insurance company is not a guarantee of payment. This includes information provided about covered services, copays, coinsurance, deductibles and pre-authorizations. Any charges that are not covered by the given insurance company will be billed to you. It is your responsibility to read your policy, to know your coverage and to review explanation of benefits statements regarding payments.
I have fully read and understand the above disclaimer.

______________________	______________________	______________
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HIPAA – Notice of Privacy Practices & Consent

I hereby consent to the use and disclosure of my protected health information by Dr. Shawnte Yates, ND, LAc - Dr. Elise Wong, ND, LAc – Dr. Molly Thelisdort ND, LAc – Dr. Sandy Musclow, ND, LAc and Essential Family Medicine (EFM) for the purposes of treatment, payment and healthcare operations, and as otherwise required by law.

- I acknowledge that Dr. Shawnte Yates – Dr. Elise Wong – Dr. Sandy Musclow – Dr. Molly Thelisdort and EFM has provided me with a copy of the Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I have a right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed copy of the Notice of Privacy Practices.
- I have the right to request restrictions to the usage and disclosure of my health information.
- I have the right to request an alternative to the standard method of communication of my protected health information.
- I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while Dr. Shawnte Yates – Dr. Elise Wong – Dr. Molly Thelisdort – Dr. Sandy Musclow and EFM may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by EFM at the following address: 1110 SE Alder St, Suite 201 - Portland, OR 97214
- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact EFM by phone at 503-477-5051.
- I am aware that Dr. Shawnte Yates – Dr. Elise Wong – Dr. Molly Thelisdort – Dr. Sandy Musclow and EFM reserves the right to change the terms of their Notice of Privacy Practices and to make new Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, EFM will
make available a revised Notice of Privacy Practices for my review.

______________________	______________________	______________
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E-Mail Authorization and Consent Agreement

Between Essential Family Medicine: Dr. Elise Wong, ND, LAc ~ Dr. Shawnte Yates, ND, LAc ~ Dr. Molly Thelisdort ~ Dr. Sandy Musclow, ND, LAc and Patient

Notice of Email Usage Policy and Consent

My practitioner will only initiate email communication for scheduling or other uses not involving medical information. I understand that I have the option to send emails to my practitioner if s/he agrees. If I choose to initiate a conversation about my health concerns via email, my practitioner will NOT respond via email and will contact me via the phone number I provide with information related to my health concerns. There is no guarantee of when a response will be given. I have been advised that Email is never, ever appropriate for urgent or emergency problems. Email is NOT confidential. Employers have a legal right to monitor email if they choose; system operators for most email systems have access to all email that passes through their systems. Email communications travel across the public Internet. It is not always possible to verify that email is actually received, opened and read by the addressee. There is not a way to assure the privacy of the email on a shared computer or email account. All email correspondence may become part of my medical record.

IT IS EXTREMELY IMPORTANT THAT YOU PUT YOUR PRACTITIONER'S NAME ON

EACH AND EVERY EMAIL YOU SEND TO YOUR PRACTITIONER.

Since email may not be monitored while my practitioner is not in the office, I will follow up by telephone or in person if I do not receive a response within a week. I understand that there are many potential issues with putting sensitive, personal health information in the public communication space, including but not limited to potentially waiving my physician-client privilege in the event of any legal proceeding. I understand that I may revoke my consent to use email communication for health information at any time, whether I have previously sent emails regarding my health information, by contacting my practitioner directly and providing such revocation in writing.

Name: ____ DOB: ____________________
(Patient Name and date of birth)

Signature: _______________________________________ Date: ____________________
(Guardian Signature)

Practitioner(s): _______________________________________

____