Integrative Pediatrics

Safe passage in a changing world.

Preferred Language: ________________________________

Patient Information

Name: Last	First	Middle	Date of Birth	Identity
			____/____/______	M / F / Other___
			____/____/______	M / F / Other___
			____/____/______	M / F / Other___
			____/____/______	M / F / Other___

Parent/Guardian Information

Name: ______________________________________ DOB______________ SSN_______________ Identity M / F / Other___

Street Address/ Apt #: ____

City/ State/ Zip ____ Patient's Primary Address? Y/ N

Contact: Primary Phone_______________________________ H/M/W Secondary _________________________ H/M/W

Email Address____

Name: ____ DOB______________ SSN____________ Identity M / F / Other___

Street Address/ Apt #: ____

City/ State/ Zip ____ Patient's Primary Address? Y/ N

Contact: Primary Phone_______________________________ H/M/W Secondary _________________________ H/M/W

Email Address____

Primary Insurance Information

Insurance Company ________________________________

Subscriber (policy holder) ____________________________

ID ____

Group____

Copay Amount_____________________________________

Effective Date _____________________________________

Secondary Insurance Information

Insurance Company _________________________

Subscriber_________________________________

ID_______________________________________

Group_____________________________________

Copay Amount______________________________

Effective Date_______________________________

Emergency Contact Relationship to Patient Phone Number

____

How did you hear about us? ____

By signing below, I agree that I have filled this form out to my best ability and believe this information to be true and accurate. If any of the above information changes, I will notify Integrative Pediatrics in writing.

____

Signature Date

____

Printed Name Relationship to Patient Revised October 2018

Financial Policy

Integrative Pediatrics will gladly submit claims to your insurance carrier. We also offer Secondary and Tertiary billing. Please remember that co-pays and deductibles are due at the time of service. If unable to pay at time of service, there will be a $10 fee applied to your account for non-payment. In the event of a Motor Vehicle Accident, we will submit your claim(s) to the motor vehicle carrier.

As a courtesy, our Private Pay patients receive a cash allowance rate. We accept cash, debit cards, checks, Visa, MasterCard, and Discover. Although payment is required at the time service; if unable to pay; prior arrangements can be made with the billing specialists. Please call Billing at 971-317-0211. If your account is paid in full at the time of service, we will extend a prompt payment/cash allowance rate. For Private Pay patients, a $100.00 deposit is required, if unable to pay in full at the time services are rendered.

If you have health insurance, please understand that this is an agreement between you and your insurance company; and you are responsible for knowing your benefits. We will be happy to assist you in any way we can, but *you* are ultimately responsible for timely payment of your account.

Integrative Pediatrics takes many steps to avoid collections; however, if your account is placed with a collection agency; you will be assessed a $100.00 collection fee. This will be added to your final balance placed with the collection agency and you will also be responsible for all legal fees and court costs involved.

In the event of a divorce situation; we do understand your difficulties and we hope you understand a divorce decree is a document that involves you, your ex-spouse and the courts. Although a divorce decree may state that an ex-spouse is responsible for medical bills, Integrative Pediatrics has no authority to enforce compliance. Therefore, we will bill the custodial parent.

If you present a check to Integrative Pediatrics that is not honored by your bank, a $40.00 Non-Sufficient Funds charge will be added to your account per occurrence.

No Show / Late Fee: If you are unable to keep your appointment, you must cancel/reschedule at least 24 hours' prior by calling 503-643-2100. We have implemented an appointment/cancellation policy which enables us to better utilize available appointments for our patients in need of care. Failure to cancel your appointment without 24-hour notice is considered a "no show". No shows will be billed $150 for established patients per occurrence and $200 for

a new patient visit. This will not be billed to your insurance and is patients' responsibility. We reserve the right to dismiss patients from our practice after 3 no show appointments.

In the event that you show up to your appointment later than 10 minutes, you may be subjected to a $50.00 late fee as well as your appointment will need to be rescheduled.

Medical Records: We are a medical home; our philosophy of primary care is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. When you transfer care you are no longer our patient. Transfer of records to a new physician will be sent complementary. Subsequent new provider transfers will be charged $75.00; payment is required prior to release of records. If balance is not paid in 30 days, your account will be billed.

For personal copies of medical records: $25.00-$300.00 fee per medical record (depending on size). We will call you upon readiness of records and payment is due at that time. We can mail your records if requested, for an additional charge. If you request to pick them up and have not done so by 30 days, your records will be mailed to the address you provided and shipping and handling will be added to your balance.
Your signature on this policy authorizes Integrative Pediatrics to release health information to insurance carriers when necessary for payment, and directs them to remit payment directly to Integrative Pediatrics (assignment of benefits).

Administrative Fee: As of September 1, 2019 an annual administrative fee of $295.00 will be instituted per family regardless of your family size. Should you need to make payment arrangements please contact our billing department at 971-317-0211.

____
Signature Print Name Date

NOTICE OF PRIVACY PRACTICES

Effective Date: 9.17.13

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.

If you have any questions about this notice, please contact Annette Murray, Privacy Officer for Integrative Pediatrics at 503.643.2100

11790 SW Barnes Rd., Bldg. A, Ste. 140, Portland, OR 97225

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The

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doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our organization may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

For payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and

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safety or the health and safety of the public or another person.

- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

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- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

  In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

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- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to Annette Murray, Privacy Officer in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to Annette Murray, Privacy Officer. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to Annette Murray, Privacy Officer.

  We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment

  - Is not part of the health information that we keep

  - You would not be permitted to inspect and copy

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- Is accurate and complete

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 5 of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request **in writing** to Annette Murray, Privacy Officer. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to Annette Murray, Privacy Officer.

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- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Annette Murray, Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice on our website, www.drpaul.md.

  To obtain such a copy, contact Annette Murray, Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region
U.S. Department of Health & Human Services
Linda Yuu Connor, Regional Manager
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Voice Phone (800) 368-1019
FAX (206) 615-2297
TDD (800) 537-7697

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To file a complaint with our office contact Annette Murray, Privacy Officer at 503.643.2100.
You will not be penalized for filing a complaint.

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Integrative Pediatrics

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received a copy of the

Integrative Pediatrics

Notice of Privacy Practices.

By signing below, I agree that I have received a copy of the Notice of Privacy Practices.

______________________________________ ____________

Patient Signature (must be at least 15 years old) **Date**

____

Print Patient Name

-OR-

______________________________________ ____________

Parent, Guardian, Responsible Party, Legal Representative Signature **Date**

____

Description of Representative's Authority

Revised 10/2013

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PATIENT HEALTH HISTORY

Todays's Date ____________

______________________________ ________ ____________

Patient's Last **First** **MI** **Age** **Date of Birth**

Pregnancy, Birth, and Newborn

1. Did you have an illness during your pregnancy? NO □ YES □
2. Did the baby come on time? NO □ YES □
3. How old were you when the baby was born? ________Years
4. How many times have you been pregnant? ____________
5. How many hours did the labor last? ________ Hours
6. What was the birth weight? _____ lbs. _____ ozs.
7. Did your baby have any trouble starting to breath? NO □ YES □
8. Did your baby have any trouble in the hospital? NO □ YES □

Medical History

1. Was there severe colic or any unusual feeding problem in the first three months? NO □ YES □
2. Is your child's appetite usually good? NO □ YES □
3. Do any foods disagree with your child? NO □ YES □
4. Does your child often have diarrhea? NO □ YES □
5. Has constipation ever been much of a problem? NO □ YES □
6. Does your child take any medicine? NO □ YES □
7. Has he/she had any allergies or reactions to any medicines or injections? NO □ YES □
8. Has he/she ever had eczema or hives? NO □ YES □
9. Has he/she ever had wheezing or asthma? NO □ YES □
10. Does he/she tend to have a stuffy nose or "constant cold"? NO □ YES □
11. Has your child had as many as three bouts of ear trouble? NO □ YES □
12. Does he/she have more than three colds or throat infections a year with fever? NO □ YES □
13. Does he/she hear well? NO □ YES □
14. Does he/she have any trouble passing urine? NO □ YES □
15. Has he/she ever had a convulsion or fit? NO □ YES □
16. Has he/she had any trouble with his/her eyes? NO □ YES □
17. Has he/she had any trouble with his/her teeth? NO □ YES □
18. Is there anything wrong with the way he or she walks? NO □ YES □
19. Check any of the following that your child has had:

☐ "Red or Hard" Measles ☐ Whooping Cough

☐ German or "3-Day" Measles ☐ Serious Accidents

☐ Broken Bones ☐ Pneumonia

☐ Removal of Adenoids and Tonsils

Other Operations:

Other Diseases (Explain):

Hospitalizations (Purpose)

Developmental History

1. At what age did he/she sit alone? __________
2. At what age did he/she walk alone? __________
3. Did he/she say any words by the time he/she was eighteen months old? NO □ YES □
4. If you did not know your child's age, how old would you guess him/her to be by the way he/she acts? __________
5. Is he/she doing well in school? NO □ YES □
6. Doe he/she get along well with other children? NO □ YES □
7. Check any of the following problems which your child has:

□ Wets Bed □ Nightmares □ Speech Problems
□ Won't Toilet Train □ Breath-Holding □ Destructive
□ Wetting During the Day □ Temper Tantrums □ Mean to Animals
□ Nervous Habits of Any Kind

Family History

1. List first name, age, general health, and years of education of the child's parents:

Mother

Father

2. List names, age, sex, and general health of child's brothers and sisters:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

3. Have any of your children died? NO □ YES □
4. Check any of the following diseases that this child's parents, brothers, sisters, grandparents, aunts, uncles, or first cousins have had:

□ Mental Retardation □ Diabetes □ Early Death
□ Mental Illness □ Heart Disease □ Inherited Diseases
□ Deformities □ High Blood Pressure □ Asthma
□ Seizures

5. What doctors have taken care of your child in the past?

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Authorization to Release Medical Records

All sections of this form ***MUST*** be completed or the authorization will not be valid

Send Records / Record Requests / Revocation Requests to → **Integrative Pediatrics Medical Records**
11790 SW Barnes Road • Portland, OR 97225 • P 503-643-2100 • F 503-643-7300 • drpaul.md

Patient Name: ____________________________Date of Birth: ______/_______/_______ Phone: (_______)____________________

Address: ____
Street City State Zip Code

I Authorize My Health Information to Be:

❑ Sent to: ❑ Verbally exchanged with:

❑ Requested from: ❑ **I *do not* authorize release of records. Cell phone (___)-_______-________**

Name #1: ____

Name #2: ____

Address: ____

City/State/Zip: ____

Phone: (_______) ______________________ Fax: (_______) ______________________ (Fax number must be included)

Email: ____

My health information: ❑ **MAY** or ❑ **MAY NOT** be faxed.

❑ **MAY** or ❑ **MAY NOT** be securely emailed.

Purpose of Release:

❑ Permanently Changing Physician/Clinic

❑ Personal Use**

❑ Legal

❑ Parent/Guardian Use: ___________________________

❑ Consult/Sharing With Other Provider

**There is a charge for any personal request for medical records. Your request will be processed within 30 days.

Indicate Type of Information to Be Released Below:

❑ **General Medical Records**

Excluding protected records. Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports, and immunizations.

–OR–

Specific Information Only:

❑ Medical Records for Specific Date(s): _________
❑ Medications
❑ Lab, Pathology, EKG, Titers (MMR,varicella,etc)
❑ X-ray, MRI, CT, etc.
❑ Immunizations Only
❑ Problem List
❑ Treatment Plans/Progress Notes

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Protected or Sensitive Information:

By **INITIALING**:

I authorize the release of the following protected or sensitive information. **Patients 14+ must provide initial.** I understand that certain information ***cannot*** be released without specific authorization as required by State/Federal law.

_______________ (initial) DRUG & ALCOHOL DIAGNOSIS/TREATMENT

_______________ (initial) ADD/MENTAL HEALTH TREATMENT

_______________ (initial) AIDS/HIV TEST RESULTS
(incl. related high-risk behavior)

_______________ (initial) GENETIC TESTING

_______________ (initial) FAMILY PLANNING OPTIONS
(birth control, tests)

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information. You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan. You have the right to revoke this authorization at any time by providing a written request for revocation to Integrative Pediatrics. If you revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire 2 years from the date signed or will expire on the following date, event, or condition: _________________________.

X____ ______________________________ X_____/_____/_____
Signature of Parent or Legally Responsible Person | Print Name | Relationship | Date

X____ ______________________________ X_____/_____/_____
Signature of Patient 14+ years – REQUIRED | Print Name | Date

Records Fees - If Transferring to someone other than another doctor's office

- $20.00 - For First 25 Pages
- $0.25 - For Each Page Over 25
- $5.00 - Rush Charge If Done Within 7 Days
- Postage - If Being Mailed

INTERNAL USE ONLY

I have verified: ❑ Form is complete ❑ Identity of requester

❑ Relationship (if not patient) ❑ Payment received: _____/_____/_____

Employee Name: ______________________________ Date: _____/_____/_____