

Four Directions Healing Tools
Bek Wiltbank, MOTR/L
12911 120th Avenue NE, Ste E-50
Kirkland, WA 98034
206.391.6721
425.820.7707 - Fax

Name _____ Birthdate _____ Age _____ Today's Date _____

Street Address _____ City _____ State _____ Zip _____

Caregiver's Names and Relationships: _____

Home Phone _____ Cell Phone _____ Referred by: _____

Email: _____

Reason for bringing your child in for Craniosacral Therapy? (Please include any physical, mental, emotional symptoms your child is having, and any diagnoses your child has been given:)

Any accidents, injuries, or surgeries? No _____ Yes _____

If yes: _____

Birth and Infancy History:

____ Caesarian delivery ____ Forceps or vacuum suction delivery?
____ Labor difficulties _____
____ Anesthesia/epidural _____
____ Breast fed or ____ Bottle fed ____ Vaccinations _____
____ Severe colic or sucking problems _____
____ Pacifier use How long? _____
____ Ear inflammations/infections _____
____ Frequent illnesses _____

Health History:

____ recent dental work ____ sleeps through the night
____ orthodontia/braces ____ wets bed
____ TMJ problems ____ asthma or respiratory problems
____ headaches ____ specific medical condition? _____
____ mouth breathing ____ day ____ night
____ snores ____ childhood illnesses _____
____ allergies _____

Pediatrician/Primary Care Provider:

Name: _____ Phone: _____

Is your child receiving other medical care or therapies? yes _____ no _____

If so, please list type and contact information of provider:

School situation : Please describe your child's experience at school. Able to focus? Fidgety? Has friends?, etc.

Personal habits: Television? Hours/week _____ Computer/Video Games? Hours/week _____

Movies/videos? Hours/week _____ Bedtime at ____pm Wakes up at ____am Hours of sleep _____

Does your child exercise regularly? _____

Nutritional habits: # vegetables per day _____ # fruits per day _____ whole grains _____

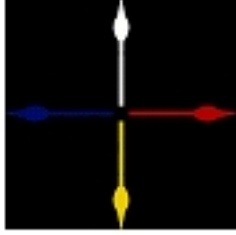
Meat & chicken? _____ fish? _____ Water: :oz. per day? _____ supplements? _____

Has your child had CranioSacral Therapy? _____ Any other treatments? _____

As the parent/guardian of a minor child, your signature below signifies your authorization for his/her treatment:

Signature: _____ Date: _____

Relationship to child: _____



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Informed Consent for Treatment
Craniosacral Therapy

I, _____, hereby authorize Bek Wiltbank, MOTR/L to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Craniosacral Therapy

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

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

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

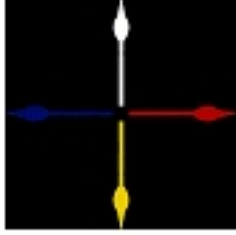
With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Bek Wiltbank, MOTR/L regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Bek Wiltbank, MOTR/L to the best of her ability.

Date

Signature of Patient

Signature of Patient Representative OR Guardian



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Please read the following financial and fee policy prior to your visit. If you have any questions or need clarification, please feel free to ask.

1. Payment policy

Payment in full is required at the time of service. The therapy rate is \$100- 1 hour

The therapy hour, as is industry standard, is 50 minutes.

Four Directions Healing Tools accepts cash or checks.

Please make checks out to Bek Wiltbank.

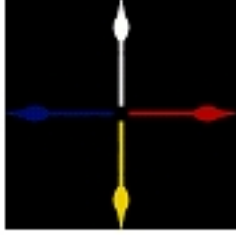
2. Cancellation and no-show policy

Bek Wiltbank, MOTR/L requires a minimum of 24-hours notice if canceling an appointment. If it is not an emergency situation, and you cancel less than 24-hours before your scheduled appointment, you may be charged for the missed appointment.

I acknowledge that I have read and fully understand this financial and fee policy. I agree to the above stated fees and charges. All of my questions have been answered.

Date

Signature of Patient or responsible party



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Craniosacral Therapy
Notice of Privacy Practices

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.

Understanding your Health Information

Each time you visit your healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health or medical professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Understanding of what is in your record and how your health information is used to help you to: ensure its accuracy; better understand who, what, when, where, and why others may access your health information; and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health information is the physical property of your healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the "Notice of Privacy Practices" upon request
- Inspect and copy your health records
- Request an amendment of your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

The physicians and staff at Bek Wiltbank's Office are required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate health information by alternative locations

How We Use your Health Information

- We will use your health information for TREATMENT

Example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding

- We will use your health information for PAYMENT

Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

- We will use your health information for HEALTH CARE OPERATIONS

Example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

Other Ways That We May Use your Health Information

- Business Associates: There are some services provided in our organization through contracts with Business Associates, including: diagnostic services and laboratory tests. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.
- Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

To Report a Problem

If you believe your privacy rights have been violated, you can file a complaint with Bek Wiltbank, MOTR/L. We will investigate all complaints and there will be no retaliation for filing a complaint. You may also file a written complaint with the Secretary of Health and Human Services.