

Natural Pediatric Medicine

Robin Russell, N.D.

12911-120th Ave NE, Suite E-50 Kirkland, WA 98034

425.820.7700 – Phone • 425.820.7707 – Fax

Pediatric/Adolescent Health History Intake Form

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Today's Date: _____

PRENATAL/BIRTH HISTORY

A. Mother's Pregnancy: Normal Complications: _____

B. Gestation: _____ weeks

C. Birth Location: Hospital Birthing Center Home Other _____

D. Delivery: Vaginal C-Section.....Any Complications: No Yes _____

E. Birth Weight: _____ lbs _____ oz.....Length: _____ inches

PRESENT HEALTH CONCERNS: Please list most important health concerns in their order of significance

1. _____

2. _____

3. _____

4. _____

PAST MEDICAL HISTORY

MEDICATIONS: Please list prescription medications +/- over the counter medications that you are currently taking, with dosages

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications: _____

2. Environment: _____

3. Food: _____

Last Name: _____ First Name: _____ Physician's Signature _____ Date of Birth: _____ Date

Today's Date: _____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age _____	Ear Infections:	No	Yes/How often: _____
ADD:	No	Yes/Age _____	Eating Disorders:	No	Yes/Age and type: _____
ADHD:	No	Yes/Age _____	Eczema:	No	Yes/Age: _____
Alcohol use:	No	Yes/How often: _____	Head lice:	No	Yes/Age: _____
Allergies:	No	Yes/Age _____	Molluscum contagiosum:	No	Yes/Age: _____
Asthma:	No	Yes/Age _____	Mononucleosis:	No	Yes/Age: _____
Bedwetting:	No	Yes/Age _____	Obesity/Overweight:	No	Yes/Age: _____
Behavior problems:	No	Yes/Age _____	Pink eye:	No	Yes/Age: _____
Bronchitis	No	Yes/Age _____	Pneumonia:	No	Yes/Age: _____
Colic:	No	Yes/Age _____	Colds:	No	Yes/How often: _____
Constipation:	No	Yes/How often: _____	Sinus Infection:	No	Yes/How often: _____
Cough:	No	Yes/How often: _____	Thrush:	No	Yes/Age: _____
Croup:	No	Yes/Age _____	Vomiting:	No	Yes/Age: _____
Depression	No	Yes/Age _____	Whooping cough:	No	Yes/Age: _____
Diaper rash:	No	Yes/How often: _____	Other:	Age: _____	Illness: _____
Diarrhea:	No	Yes/How often: _____	Other:	Age: _____	Illness: _____

IMMUNIZATIONS: (Please place an X in either the Yes or No box next to each vaccination that you have been vaccinated against. If Yes, please indicate whether there were any reactions and describe in detail)

	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella			
Varicella (Chickenpox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS/SURGERIES: (Indicate reason and date)

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

Physician's Signature

Date

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PAST MEDICAL HISTORY-Con't

LABS AND EXAM HISTORY: Please indicate date and results.

Date of last well child check: _____ Results: Normal Other _____
 Date of last blood work: _____ Results: Normal Other _____
 Date of last urine test: _____ Results: Normal Other _____

Adolescents:

Date of last PAP and pelvic exam: _____ Results: Normal Other _____

FAMILY HISTORY: Please place a "C" for current or "P" for past in the box next to each condition as it applies to you or your family members.

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism									
Allergies									
Anemia									
Arthritis									
Asthma									
Cancer									
Depression									
Diabetes									
Drug Addiction									
Eczema									
Epilepsy									
Headaches									
Heart Disease									
Hepatitis									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Stroke									
Tuberculosis									

SOCIAL HISTORY

Have you or your parents ever consulted with a Naturopathic Physician before? Yes No

Parent's Marital Status: Single Married Divorced Separated/Not Divorced Widowed Domestic Partnership

Siblings (Indicate names and ages)

1. _____ 4. _____ 7. _____
 2. _____ 5. _____ 8. _____
 3. _____ 6. _____ 9. _____

Mother's Occupation: _____ Father's Occupation: _____

Guardian's Occupation: _____

Daycare Location: _____ Days/Hours per week: _____

Physician's Signature

Date

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SOCIAL HISTORY-Con't

BIRTH CONTROL:

Adolescents:

What form of contraception/birth control are you using (Check all that apply).

- Abstinence Withdrawal Fertility Awareness Method The Sponge Spermicide Condom Diaphragm Cervical Cap
- IUD The Pill The Shot (Depo-Provera) The Ring Implants The Patch Vasectomy None

TRAVEL HISTORY: Identify any domestic or foreign travel and indicate year of travel:

Place: _____ Year: _____ Place: _____ Year: _____

PERSONAL HABITS: Identify any substances you have used and circle whether in the past (P) or are currently using (C)

Adolescents:

Which of the following substances do you use and identify frequency (Ex. 2x/d, 1x/mo, 1x/yr)?

- Tobacco: P C Freq: _____ Recreational Drugs: P C Identify type/Freq: _____
- Alcohol: P C Freq: _____ Other: P C Specify/Freq: _____
- Coffee: P C Freq: _____

EXERCISE:

Toddlers/Adolescents:

Do you exercise regularly? Yes No

If you checked yes to exercising regularly, answer the following questions: What type/activity? _____

How long? _____ How Often? _____

SLEEP:

How many hours of sleep do you get at night on average? _____

Toddlers/Adolescents:

How often do you wake and for what reasons? _____

Do you have any trouble falling asleep? No Yes/Why? _____

Do you have trouble waking up? No Yes/Why? _____

Do you wake rested? Yes No/Why? _____

ENERGY AND STRESS:

Adolescents:

How would you rate your energy on a scale of 1 – 10 with 10 being the most energy? _____

How would you rate your stress on a scale of 1 – 10 with 10 being the most stress? _____

How do you cope with stress? _____

NUTRITIONAL HISTORY

Infant/Toddlers:

Type: Nursing Formula/Specify _____ Both

Frequency: Every hour Every other hour Every 3rd hour

Every 4th hour Every 5th hour Other _____

Duration: <15 min 15-30 min 30-45 min 45-60 min

Amount per feeding: <1oz 1-2oz 2-3oz 3-4oz >4oz

Adolescents:

What is a typical breakfast? _____

What is a typical lunch? _____

What is a typical dinner? _____

What are typical snacks? _____

How many glasses of water do you drink each day on average? _____

Do you have any special dietary restrictions? _____

Physician's Signature

Date

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Robin Russell, N.D.
Naturopathic Physician
12911-120th Ave NE, Suite E-50
Phone: 425-820-7700 Fax: 425-820-7707

Patient Information

Date: _____

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Sex: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

May we leave confidential voice-mail messages for you at any of the above numbers? No Yes
(Specify): Home Work Cell

Email: _____ Emergency Contact/Relation: _____ Contact's Phone: _____

Referral Source: Referred by: _____ Insurance Provider List Telephone Book Newspaper ad
 Internet (AANP or WANP website) Physician's Website Other _____

Employer: _____

Mother's Name (Minor's only): _____ Father's Name (Minor's only): _____

Benefits and Billing Information

I. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy #: _____

Name of Policy Holder: _____ Policy Holder's Date of Birth: _____

Relationship to Policy Holder: _____ Is Your Primary Insurance Policy: POS PPO EPO HMO

II. Does your insurance have alternative medicine benefits? Yes No

Who is your Primary Care Provider? _____ Clinic Phone: (____) _____

Clinic Address: _____ City: _____ State: _____ Zip Code: _____

Does your plan require you to have a referral from your Primary Care Provider to receive coverage? Yes No

If yes, which licensed provider were you referred by to at our clinic? _____

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Naturopathic Medicine
Informed Consent for Treatment

I, _____, hereby authorize Dr. Robin Russell to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

Common diagnostic procedures: venipuncture, Pap smears, radiography, laboratory, x-ray.

Contraception

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Immunization

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Minor office procedures: dressing a wound, ear cleansing.

Psychological Counseling

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

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

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 doctor 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 Dr. Robin Russell 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 Dr. Robin Russell to the best of her ability.

Date

Signature of Patient

Signature of Patient Representative OR Guardian

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Financial Policy and Fees

Thank you for choosing Dr. Robin Russell as your naturopathic physician. Please read the following financial and fee policy thoroughly prior to your visit. It is important to Dr. Russell that you understand the billing and fee policies. 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, unless Dr. Russell is billing insurance. If Dr. Russell bills your insurance company, and you are responsible for a co-payment, it will be due at the time of service. If you do not have insurance or have a plan that is not contracted with Dr. Russell, a prompt payment discount of 15% is available on office visits when payment is received at the time of service. Dr. Russell accepts cash, checks, debit cards, Visa, and MasterCard.

2. Insurance

Insurance benefits vary greatly from policy to policy and it is your responsibility to be aware of the extent and limitations of your coverage for Naturopathic Care. Some of the testing that Dr. Russell recommends may not be covered by your insurance plan. Insurance companies may refuse coverage or only pay a portion or percentage of your fees. You will be responsible for any and all fees not covered by your insurance plan. If Dr. Russell is not contracted with your insurance company, you will be required to bill your own insurance company for reimbursement. Dr. Russell will provide you with the proper forms to assist you in collecting insurance reimbursement. As standard protocol, Dr. Russell will release to your insurance company, or companies, any and all information necessary to process an insurance claim so that payment(s) may be made to Dr. Robin Russell.

3. Non-covered services

Insurance companies do not cover the following services thus it is your responsibility for these fees.

1. Emergency cell/pager fees- \$25. As your child's primary care physician, I am available 24 hours per day for urgent health concerns that cannot wait until the next day. If I am not available, a voicemail will be left instructing you to contact Children's Hospital's 24-hour parent resource line where you can talk with doctors and nurses directly and will not be billed the \$25 fee.
2. Home visits or house calls- \$150.
3. Nutritional supplements- Nutritional supplements recommended by Dr. Russell are not covered by insurance. You are not obligated to purchase them at Dr. Russell's office. Supplements are available at the office as a convenience. If you choose to purchase supplements at Dr. Russell's office, payment in full is due at the time of purchase.
4. Missed appointment charge- \$50.

4. Cancellation and no-show policy

Dr. Russell 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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Naturopathic Medicine
Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Dr. Robin Russell’s Notice of Privacy Practices detailing how my health information may be used and disclosed under federal and state law.

I wish to have the following restrictions to the use or disclosure of my health information:

Patient’s Name

Signature of Patient OR
(Authorized Representative)

Date

FOR OFFICE USE ONLY

- Patient refused to sign Acknowledgement of Receipt of Privacy Practices
- Patient was unable to sign Acknowledgement of Receipt of Privacy Practices due to reasons specified below.

Provider Signature

Date

Robin Russell, N.D.

Naturopathic Physician

12911- 120th Ave. N, Suite E-50

425.820.7700 – Phone • 425.820-7707 – Fax

Physician's Signature

Date

Authorization to Release Confidential Health Information

I hereby authorize:

- Dr. Robin Russell, N.D.
- Facility/Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

To release:

- Complete Chart Record (does not include billing information or radiographic images)
- Chart Notes
 - All Specify: _____
- Labs/Reports
 - All Specify: _____
- Billing Records
 - All Specify: _____
- X-rays/Radiographic Images
 - All Specify: _____
- Other: _____

From the Health Records of:

Name: _____ Date of Birth: _____
 SS#: _____ Daytime Phone: _____ Ext. _____

Are you authorizing the release of your own records? Yes No

If not, what is your relationship to the patient? _____

Release of certain medical information requires a minor's consent. This applies to persons aged 13-17 for information pertaining to substance abuse and mental health information, or persons aged 14-17 for information pertaining to sexually transmitted diseases, HIV and AIDS. Other laws may apply.

To be released to:

- Dr. Robin Russell, N.D.
- Facility/Doctor's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

For the purpose of:

- Adjunctive/Concurrent Care Transfer of Care Other: _____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.

Unless specifically excluded, this authorization includes release of specially protected information requiring my explicit authorization for release. This includes referral, diagnosis and treatment information related to: (check the accompanying box(es) below to EXCLUDE the information from authorization)

- substance abuse mental health conditions/psychotherapy sexually transmitted diseases HIV/AIDS

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law. I also understand that if I authorize a third party that is not required to comply with such regulations to receive my health care information, my information may be re-disclosed by that party and would no longer be protected.

I understand that I do not have to sign this form as a condition for receiving treatment and that I am entitled to a copy of this authorization form at the time of signing. I may call Dr. Robin Russell's office at 425.391.7338 to inquire about revoking authorization.

I understand that if I request records for personal use, to hand-carry to another health provider, or for parties not involved in my health care, there may be a charge. "Non-Emergency" release of records may take up to 15 working days. Emergency requests will be given priority processing. "Emergency" status applies only to release of records directly to another healthcare provider for urgent patient care. There is no charge to release records to another healthcare provider.

Patient's Signature: _____ Date: _____
 Guardian's Signature: _____ Date: _____

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Naturopathic Medicine
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 it's 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 Dr. Robin Russell'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

in an effort to continually improve the quality and effectiveness of the health care and services we provide. be used

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 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 Dr. Robin Russell. 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.

Effective Date: November 1, 2005

Version: I