ground floor health

1227 N Allen pl | Seattle WA 98103
P: 206.624.6627 F: 206.525.5933 | groundfloorhealth.com

Pediatric Intake Form

Date: _____

Child's last name: _____ **Child's first name**: _____ **M. I**. _____ **Birth date:** _____

Nickname(s):_____ Sex: _____Gender: _____Pronouns: _____

Caregiver: _____ Caregiver : _____

Sibling (s):_____

A note to our patients: Please complete this two-sided form as thoroughly as possible to aid in your diagnosis and treatment. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you.

Besides caregivers listed above, does anyone else take care of the child? No Yes Who? _____

Has the child received healthcare elsewhere? No Yes Where? _____

Has the child been immunized? No Yes Which ones? _____

When? _____

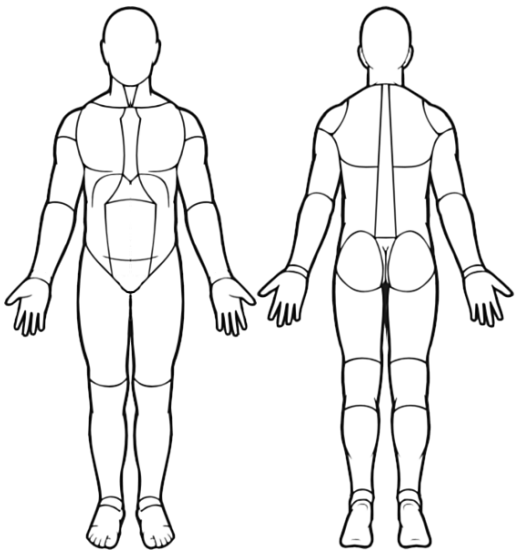
How would you rate this child's health in general? (Circle) Excellent Good Fair Poor

Do you have concerns about the child's behavior or development? No Yes What?_____

Do you have any concerns about the child's nutrition or growth? No Yes What?_____

Date of last physical/annual exam: _____ Date of last blood tests: _____

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		

What goals do you have for your visit at the clinic today? _____

_____

Do you have any questions about our clinic or care? _____

Please list any prescription medications, over the counter drugs, supplements, vitamins, herbs, homeopathic remedies, etc that the child is currently taking with dosages: _____

_____

Please list any allergies to medication or life-threatening allergies and reaction: _____

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Family health habits:

How often does your child use a seatbelt (car seat)? Never Rarely Sometimes Often Always

Does your child ride a bicycle? Yes No

How often does she/he use a helmet? Never Rarely Sometimes Often Always

Does your home have smoke detectors? Yes No Does your home have a fire extinguisher? Yes No

Do you feel that you live in a safe place? Yes No

In the past year, have you felt threatened in your home? Yes No

What kinds of guns are in your house? Handgun Shotgun Rifle Other None

If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No If yes, who? _____

Do you currently smoke cigarettes? Yes No If yes, how many? _____

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Past history: Please circle those that apply to child

- ☐ Frequent Ear Infections
- ☐ Allergies, Hay Fever
- ☐ Eczema, Psoriasis
- ☐ Anemia
- ☐ Heart Murmur
- ☐ Vision Problems
- ☐ Kidney or Bladder Infections
- ☐ Seizures
- ☐ Broken Bones
- ☐ Hearing Problems
- ☐ Bed Wetting
- ☐ Injury or Abuse
- ☐ Asthma
- ☐ Pneumonia, Bronchitis, Persistent Cough

Family Medical History:

Please check the 'yes' box next to each condition that applies to the child's mother, father or other family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C" for current. Indicate who had the condition in the 'Relation' column.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Alcoholism/ Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

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INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the providers of Ground Floor Health, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, Pap smears, radiography, laboratory, x-ray.
Minor office procedures: e.g. cleaning, suturing, and dressing a wound, ear lavage, skin scraping, skin cryotherapy.
Medicinal use of nutrition: e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: e.g. botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
Physical medicine: e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.
Psychological Counseling
Contraception
Vaccination

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 or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. Notify Ground Floor Health clinic if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, 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 Ground Floor Health, or any of its personnel 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 by paying the appropriate fee. 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 my provider(s) to the best of their ability.

_____ _____
Signature of patient Date

_____
Signature of Patient Representative or Guardian

Original: Chart
Copy: To patient (if requested)

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Financial Policy

Thank you for choosing the physicians at Ground Floor Health to be your healthcare providers. We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following financial policy prior to your treatment. Should you have any questions, feel free to ask.

Insurance Billing:
Ground Floor Health is contracted with most major insurance companies. You are welcome to ask for a list or if we are contracted with your specific company. For patients with these insurance plans, we bill insurance directly and accept payment plus any co-payments, co-insurance, deductibles and payments for non-covered services as payment in full. Although we are contracted with your insurance company, it does not guarantee that your plan covers all visits. **Patients are responsible to know the terms of their insurance and whether naturopathic, and/or acupuncture services are covered.**

Office Fees:

- Fees are determined after the visit has taken place and depend on the complexity of the health concern, which procedures were performed, and the amount of time spent with the patient.
- If we are not contracted with your insurance company or you do not have medical insurance, we offer a time-of-service discount. If you are having financial difficulty, we will be happy to work with you. You may want to establish a payment plan. We ask that these payments be made on time monthly and be paid in full within six months.
- Annual Exams and Dual Licensed Providers: If medical treatment is requested during an annual physical exam, I understand that my provider is allowed to bill the insurance carrier for those services separately from the annual exam charge. I also understand that if my provider is credentialed as both an acupuncturist and a naturopath and both modalities are used during the visit, my provider will bill both visits separately.

Payment Policy

- Full payment for visit co-pays, supplements and lab fees must be rendered at time of service and can be made by cash, check, Visa or MasterCard.
- Patients will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 90 days will be billed to the patient.
- A late fee will be assessed beginning with the second billing statement if there is failure to make payment or make contact with us in 30 days. If there is no response to these actions, further action may be taken.
- If you pay for services by check and that check is returned for non-sufficient funds, we will charge an additional $50 to your account. If that happens, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If your account has not cleared by then, we may take further action.
- Showing up for your scheduled appointment is very important. If you are unable to make your appointment, please give our office 24 hours or 1 business day notice so that we may give another patient that time. **Patients that "no show" or do not cancel 24 hours prior to their appointment may be assessed an appointment charge of $75.** This charge is your responsibility. Insurance companies do not pay for missed appointments.

I, _____agree to the above-defined financial policies of Ground Floor Health. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that I'm fully responsible for the total payment of all services and procedures performed in this office. This includes any service that may not be covered by my medical insurance. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs or legal fees incurred to collect on this account.

I, the undersigned, have read, understand, and agree to the information and conditions specified in this document.

_____ _____

Patient/Guardian Name and Signature

Date

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Patient Information Form

Today's Date: _____

Last Name:_____ **First Name:**_____ **M.I.** ___ **Date of Birth:**_____

Nickname(s):_____ Sex: _____Gender: _____Pronouns: _____

Address:_____ Apartment #:_____

City: _____ State: _____ Zip code:_____ Country: _____

Occupation: _____ Employer/School: _____

Phone: (___)_____ Work Phone: (___)_____ Ext: _____

Social Security #: _____ Email:_____

Parent/Guardian Name (minors only) _____ Parent/Guardian Name (minors only) _____

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race (please select):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other

Ethnicity (please select one):

- ☐ Hispanic
- ☐ Not Hispanic or Latino
- ☐ Decline

Preferred Language (please select one):

- ☐ English
- ☐ Bosnian
- ☐ Indian (including Hindi & Tamil)
- ☐ Sign Language
- ☐ Spanish
- ☐ Russian
- ☐ Other

Emergency Contact: _____ Contact's Phone #: (___)_____

Relationship to Person: _____

Are you hearing impaired? Y N Are you visually impaired? Y N Do you need an interpreter or TTY line? Y N

Do you have non-English language needs?: _____ (or) Special needs?: _____

How did you hear about us? _____

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Insurance Information

Please notify us if processing Labor and Industry (L & I) or Personal Injury Protection (PIP) Claims
Please complete this section if we will be billing your insurance.

1. Does your insurance cover naturopathic physicians? Yes No

Who is your primary care provider (PCP)?: Dr. _____ Phone #: (___) _____

Clinic address: _____ City: _____ State: ____ Zip Code: _____

Does your plan require you to have a referral from your PCP to receive coverage? Yes* No

*If yes, to which physician were you referred at our clinic?: _____

2. Primary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ Policy holder's date of birth: _____

Relationship to policy holder: _____Is your primary a: (circle) POS PPO EPO HMO

3. Secondary Insurance Company & Plan Name: _____

ID Number: _____ Group/Policy Number: _____

Name of policy holder: _____ Policy holder's date of birth: _____

Relationship to policy holder: _____Is your secondary insurance a: (circle) POS PPO EPO HMO

I, the undersigned, pledge that the above information is accurate and complete to the best of my knowledge. I understand that payment is due at the time of service for all visits at the clinic unless prior arrangements have been made. I understand that if I am providing insurance billing information, I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize Ground Floor Health, to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.

X_____ _____ X_____ _____

Signature of patient* Date Signature of guardian Date

_____

* Guardian's signature required for minors. Relationship to patient

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NOTICE OF PRIVACY POLICY

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.

Ground Floor Health respects your privacy and understands that your personal health information is very sensitive. We respect our legal obligation to keep health information that identifies you as private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes, which you do when signing the Patient Information Form at your first visit.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

υ For treatment:
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed of your care.
- We may fax your requested medication refill to your pharmacy.

υ For payment:
- Health plans may require information from us about your medical care to determine benefits, pre-existing conditions and any appeals. Information provided to health care plans may include your diagnosis, procedures performed, or recommended care.

υ For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications of our health care providers.
- We may use and disclose your information to conduct or arrange for services, including: medical quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of Ground Floor Health. The protected health information in it, however generally belongs to you. You have the right to:
- Receive, read, and ask questions about this Notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to agree to do this, but if we agree, we must honor the restrictions you want.
- Request and receive from us a copy of the most current Notice of Privacy Policy
- Ask to see or to get photocopies of your health information. A request must be in writing. You need to allow up to 30 days for us to process your request and may have to pay for photocopies in advance.
- Ask us to amend your health information if you think it is incorrect or incomplete. You may give us this request in writing and if we agree, we will amend the information within 60 days of request. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included in any release of your record.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released.

We may use and disclose your protected health information without your authorization as follows:
- With Medical Researchers-if the research has been approved and has policies to protect the privacy of your health information. We may also share information to medical researchers preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.

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- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To Comply With Workers' Compensation Laws-if you make a workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law:
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
        - to protect public health and safety
        - to prevent or control disease, injury, or disability
        - to report vital statistics such as births or deaths.
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To The Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, we may share information for national security purposes.

Appointment Reminders

Unless you inform us in writing otherwise, we may call to remind you of a scheduled appointment. If you are not home we reserve the right to leave a reminder message either on an answering machine or with the person who answers. We will ONLY disclose the day and time of the appointment, not the reason for the appointment. We may send postcards reminding you it is time to make a follow up appointment, this reminder WILL NOT disclose the reason for the appointment. We may send postcards stating normal test results.

Our Responsibilities

- By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we make changes, we will update this Notice and post it in our office. At your request, you may receive a copy of the revised policy.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective Date: This Notice will become effective on July 1, 2005.

We keep a record of your health care services that we have provided. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so for payment from third party payors or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

By my signature below I acknowledge receipt of the Notice of Privacy Policy.

_____	_____
Patient Name	DOB
_____	_____
Patient or legal authorized individual signature	Date
_____	_____
Printed Name if signed on behalf of the patient	Relationship