Mona Bhalla, ND, LLC
NATUROPATHIC PHYSICIAN

Mona Bhalla, ND, LLC
1221 SE Madison St.
Portland, Oregon 97214
503-445-7767
FAX: 503-459-4221

Pediatric patient health history questionnaire

Name ____ **Today's date** _________ **Age** _____
Last *First* *MI*

Parent or guardian ____________________ ____________________ ____________________
Father *Mother* *Guardian*

Parent or guardian SSN ______________________________ **Child DOB** ___________________

Sex ☐ Female ☐ Male **Email** ______________________

Address ____
Street/POB *City* *State* *Zip code*

Email ____

Telephone number Home ______________ Work _______________ Cell ________________

Name and address of doctor's office/hospital/clinic where your child's health records are kept

_________________________ ______________________ ___________ ______ ________
Office/hospital/clinic name ***Street/POB*** *City* *State* *Zip code*

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems?

1

2

3

4

MEDICATIONS

Now = medication currently being taken

Past = medication taken at one time or another

	Now	***Past***		***Now***	***Past***
Aspirin	____	____	*Asthma medication*	____	____
Tylenol	____	____	*Decongestant*	____	____
Inhalers	____	____	*Ibuprofen*	____	____
Antibiotics	____	____	*Topical steroids*	____	____
Antihistamine	____	____	*Other*	____	____

Does your child have any allergies to foods, drugs, or other allergens in your environment (cats, mold, dust)? ☐ Yes ☐ No If yes, list and explain ____

____

MEDICAL HISTORY (check all that are applicable)

- ☐ *Chicken pox*
- ☐ *Scarlet fever*
- ☐ *Bronchitis*
- ☐ *Asthma*
- ☐ *Measles*
- ☐ *Pneumonia*
- ☐ *Rubella*
- ☐ *Mumps*
- ☐ *Frequent colds*
- ☐ *Eczema*
- ☐ *Croup*
- ☐ *Other*
- ☐ *Tonsillitis: how many times?* _____
- ☐ *Ear infections: how many times?* _____

X-RAYS AND SPECIAL STUDIES

	When	***Where***	***Results***
☐ *Electroencephalogram*			
☐ *Psychological evaluation*			
☐ *Hearing*			
☐ *Speech/language*			

INJURIES, SURGERIES, AND HOSPITALIZATIONS

____

____

____

IMMUNIZATIONS

- ☐ *Measles*
- ☐ *Polio*
- ☐ *MMR*
- ☐ *Small pox*
- ☐ *Diphtheria*
- ☐ *Mumps*
- ☐ *DPT*
- ☐ *Tetanus*
- ☐ *Influenza*
- ☐ *Other*

Any adverse reactions to immunizations (please specify)?

____

____

FAMILY HISTORY

- ☐ *Heart disease*
- ☐ *Diabetes*
- ☐ *Birth defects*
- ☐ *Cancer*
- ☐ *Mental illness*
- ☐ *Hypertension*
- ☐ *Arthritis*
- ☐ *Tuberculosis*
- ☐ *Allergies*
- ☐ *Hay fever*
- ☐ *Eczema*
- ☐ *Other*

Previous pregnancies by natural mother, miscarriages, or complications: ______________

____

____

Mother's age at child's birth ____

Mother's health during pregnancy

- ☐ *Bleeding*
- ☐ *Hypertension*
- ☐ *Illness*
- ☐ *Cigarettes*
- ☐ *Nausea*
- ☐ *Diabetes*
- ☐ *Thyroid problems*
- ☐ *Alcohol, drugs*
- ☐ *Physical or emotional trauma*

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BIRTH HISTORY/Term

☐ *Full* ☐ *Premature* ☐ *Late* *Weight at birth* ________

Length of labor ________ *Complications?* ☐ *Yes* ☐ *No* *Explain* ______________________________

As a baby, did your child have any of the following?

☐ *Jaundice*	☐ *Diarrhea*	☐ *Birth defects*	☐ *Rashes*
☐ *Colic*	☐ *Fever*	☐ *Cerebral palsy*	☐ *Allergies*
☐ *Blue baby*	☐ *Seizures*	☐ *Birth injuries*	☐ *Other*

Feeding ☐ *Breast fed* *How long?* ___________ ☐ *Milk* ☐ *Soy*

Age began *Solid foods* ___________ *Sitting* _______________ *Crawling* ____________
Walking _____________ *First words* ___________

Child's sleep patterns during first year? ____

____

SYMPTOMS

Please circle: Y = a condition your child has now P = a condition your child had in the past N = a condition your child has never had

Hives	*Y*	*P*	*N*	*Burning of urine*	*Y*	*P*	*N*	*Bloody urine*	*Y*	*P*	*N*
Eczema	*Y*	*P*	*N*	*Frequent urination*	*Y*	*P*	*N*	*Cries easily*	*Y*	*P*	*N*
Bleeding gums	*Y*	*P*	*N*	*Heart murmur*	*Y*	*P*	*N*	*Nervous*	*Y*	*P*	*N*
Nose bleeds	*Y*	*P*	*N*	*Vomiting spells*	*Y*	*P*	*N*	*Sleep problems*	*Y*	*P*	*N*
Acne	*Y*	*P*	*N*	*Anemia*	*Y*	*P*	*N*	*Night sweats*	*Y*	*P*	*N*
High fever	*Y*	*P*	*N*	*Stomach aches*	*Y*	*P*	*N*	*Sensitive to light*	*Y*	*P*	*N*
Chronic rash	*Y*	*P*	*N*	*Jaundice*	*Y*	*P*	*N*	*Body/breath odor*	*Y*	*P*	*N*
Hearing loss	*Y*	*P*	*N*	*Easy bruising*	*Y*	*P*	*N*	*Motion/car sickness*	*Y*	*P*	*N*
Diarrhea	*Y*	*P*	*N*	*Flat feet*	*Y*	*P*	*N*	*No appetite*	*Y*	*P*	*N*
Sore throats	*Y*	*P*	*N*	*Constipation*	*Y*	*P*	*N*	*Nightmares*	*Y*	*P*	*N*
Gas	*Y*	*P*	*N*	*Canker sores*	*Y*	*P*	*N*	*Wheezing*	*Y*	*P*	*N*
Joint pain	*Y*	*P*	*N*	*Cough*	*Y*	*P*	*N*	*Dizzy spells*	*Y*	*P*	*N*
Hair loss	*Y*	*P*	*N*	*Frequent headaches*	*Y*	*P*	*N*	*Frequent colds*	*Y*	*P*	*N*
Unusual fears	*Y*	*P*	*N*	*Bleeding tendency*	*Y*	*P*	*N*	*Excessive fatigue*	*Y*	*P*	*N*

Any condition not mentioned? ____

____

DIET

Describe your child's typical daily diet

____

____

Does your child have any food intolerances you know of? ☐ *Yes* ☐ *No*
If yes, please explain

____

____

Mona Bhalla, ND, LLC
1221 SE Madison St.
Portland, Oregon 97214

Insurance information, consent to treat, and payment policy for patients of Mona Bhalla, ND, LLC

Name ____ Telephone ___________________________

Address ______________________________________ Date of first visit to clinic _______________

______________________________________ SSN _____________________________

Date of birth __________________________________

Insurance coverage

Name of insured _____________________________ SSN of insured _____________________

Date of birth of insured ________________________ Employer __________________________

Address and telephone of employer ____

Insured relationship to patient ☐ self ☐ spouse ☐ child ☐ partner

☐ other __________________ Insured is ☐ male ☐ female

Insurance company ____________________________ Address __________________________

____

____

Telephone _____________ Adjuster _________________

Group or plan number ___________________________ Claim number _____________________
(Workers comp)

Emergency telephone number ____________________

Consent form and agreement

Naturopathic therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of Mona Bhalla, ND, LLC, to inform patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury or bruising, dizziness, or temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform patients of procedures being performed and the risks and alternative treatments available. If your physician does not explain these risks to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

____ ____
Signature of patient *Date*

Agreement to payment policy of Mona Bhalla, ND, LLC

By signing below, I understand that full payment for all services and products I receive from Mona Bhalla, ND, LLC, is required at the time of service. Any failure to make an appointment cancellation with Mona Bhalla, ND, LLC within 24 hours of the scheduled time, unless due to an emergency, is subject to a $60 charge to the patient. Further, I understand that Mona Bhalla, ND, LLC, may submit my bill to my insurance carrier on my behalf, if I so request, and that Mona Bhalla, ND, LLC, cannot be held responsible for either the amount of reimbursement I receive or any delay between the time of submission and the time of reimbursement.

____
Signature of patient

Mona Bhalla, ND, LLC
1221 SE Madison St.
Portland, OR 97214

Consent for Purposes of Treatment and Healthcare Operations for Patients of Mona Bhalla, ND, LLC.

Naturopathic Medical Consent: I consent to the use or disclosure of my protected health information by Mona Bhalla, ND, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Mona Bhalla, ND, LLC. I understand that diagnosis or treatment of me by my physician at Mona Bhalla, ND, LLC may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Mona Bhalla, ND, LLC is not required to agree to the restrictions that I may request. However, if Mona Bhalla, ND, LLC agrees to the restrictions that I request, the restriction is binding on Mona Bhalla, ND, LLC and my physician at Mona Bhalla, ND, LLC.

I have the right to revoke this consent in writing, at any time, except to the extent that my physician at Mona Bhalla, ND or Mona Bhalla, ND, LLC has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Mona Bhalla, ND, LLC’s Notice of Privacy Practices prior to signing this document. Mona Bhalla, ND, LLC’s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Mona Bhalla, ND, LLC. This Notice of Privacy Practices also describes my rights and Mona Bhalla, ND, LLC’s duties with respect to my protected health information.

Mona Bhalla, ND, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent to me by mail or asking for one at the time of my next appointment.

______________________________________ ______________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative’s Authority

Notice of Patient 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your right to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our clinic, you are implying consent to the use and disclosure of your protected health information by your provider, our office staff, and others outside of our clinic that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operations of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

· **<u>Treatment:</u>** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your PHI, as necessary, to another physician who may be treating you. Your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your PHI to another physician or health care provider (e.g. a specialist or laboratory) who, at the request

of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

· **Payment:** Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your healthcare plan may undertake before it approves or pays for the health care services we recommend for you. This may include making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant PHI be disclosed to the health plan to obtain approval for those services.

· **Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities, and training of medical assisting externs and chiropractic students.

For example, we may disclose your protected health information to interns, externs, or students that see patients at our office. In addition, we may use a sign-in sheet at the reception desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or their assistants may be may be recorded to assist in accurately capturing your responses; we may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We do have open therapy/adjusting areas.

We will share your protected health information with third party "business associates" that will perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure, we will have a written contact with that business associate that contains terms that will protect the privacy of your PHI.

We may use your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We many also use and disclose your PHI for other internal marketing activities. We may also send you information about products or services that we believe may be beneficial to you. You may contact either of our Privacy Officers to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made Only With Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below.

· Disclosures of psychotherapy notes
· Uses and disclosures of Protected Health Information for marketing purposes;
· Disclosures that constitute a scale of Protected Health Information;
· Other uses and disclosures not described in the Notice of Privacy Practices will be made only with authorization from the individual.

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your PHI, you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

· **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to this disclosure, we may disclose such information as necessary if we determine that it is in your best interested based on our professional judgment. We may use or disclose PHI to notify or assist in notifying, a family member, personal representative, or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

· **Required By Law:** We may use or disclose your PHI to the extent that the law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

· **Public Health:** We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

· **Communicable Diseases:** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

· **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

· **Abuse or Neglect:** We may disclose your PHI to a public authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

· **Legal Proceedings:** We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful purposes.

· **<u>Law Enforcement:</u>** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as the result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.
· **<u>Workers' Compensation:</u>** We may disclose your PHI, as authorized, to comply with worker's compensation laws and other similar legally-established programs.
· **<u>Required Uses and Disclosures:</u>** Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

The following is a statement of your rights with respect to your PHI and brief description of how you may exercise these rights.
· **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access can be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officers if you have any questions about access to your medical record.
· **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. *You have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the health care delivered by our office.* You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. *You may also opt out of fundraising communications in which our office participates.*

Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor. You may request a restriction by presenting your request, in writing, to the staff members identified as "Privacy Officer" at the top of this form. The Privacy Officers will provide you with a "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

· **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not be requesting an explanation from you as to the basis for the request. Please make this request in writing.

· **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for this amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact either of our Privacy Officers if you have questions about amending your medical record.

· **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003.

· **You have the right to be notified by our office of any breach of your protected health information.**

· **Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic at times, but private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. To file a complaint, you may go to: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf*. Our office can also provide you with a written form in which to file your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 12, 2017.

Consent to Use Protected Health Information

Acknowledgement for Consent and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your protected health information will be used by Dr. Mona Bhalla ND, LLC or may be disclosed to others purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. ___

Requesting a Restriction on the Use or Disclosure of your Protected Health Information
- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Describe and Notify private areas available upon request.

Revocation of Consent
You may revoke this consent of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ______________
Patient or Legally Authorized Individual Signature Date

____ ______________
Print Patient's Full Name Date