Aline Fournier, D.O.

760.746.1133 – phone

760.746.9880 – fax

drafournier@sbcglobal.net

307 South Ivy Street

Escondido, CA 92025

Dear New Patient:

Thank you for choosing Dr. Fournier as your physician. Dr. Fournier is proud to provide the highest quality care possible for her patients. Dr. Fournier acknowledges and respects the inherent dignity of each person as an individual and strives to provide you with the same special attention to your needs as she expects to receive for herself and her loved ones.

Office Hours:

The office is open Monday through Thursday, 1:30 p.m. to 6:00 p.m. If you are unable to keep an appointment, please give the office 24 hours notice so that another patient may make use of your reserved appointment time. We adhere as closely as possible to scheduled appointments. However, Dr. Fournier's schedule is sometimes unpredictable and we recommend that you call the office to verify the timeliness of your scheduled appointment.

Note: Please do not wear perfume or scented lotion. Wear loose clothing – no jeans. If you have cold and/or flu symptoms call to reschedule.

Comprehensive Health History Questionnaire:

Please answer all questions thoroughly and bring any substantiating X-ray, MRI, Ultrasound and/or laboratory reports to your scheduled appointment. We do not recommend that you have your X-ray, MRI and/or Ultrasound films mailed to our office in the event they should get lost in transit.

Directions:

Major freeways and access roads are identified on the enclosed map to guide you to our office without delay.

If you have any questions or wish to reschedule your appointment please contact us by phone at 760.746.1133 or by e-mail at drafournier@sbcglobal.net.

ALINE FOURNIER, D.O.

Patient Financial Policy

1. We accept cash, debit cards (with credit card logo), check, Visa, MasterCard, American Express and Discover.

2. We require that any amount due be paid at the time of service. Please contact the Office Manager to discuss any financial questions or concerns.

3. We do NOT accept Medicare, Medical, Worker's Comp, commercial insurance, auto insurance or contingency cases.

4. The fee for a returned check is $40.00. If you submit a check with insufficient funds, your professional treatment may be suspended until your balance is paid. Checks will no longer be accepted from a patient who has had a returned check.

5. Any patient account balance of 90 days past due, who does not have a financial payment contract, will be turned over to an outside collection agency. This also includes any patient account balances that have defaulted from their financial payment contract.

6. There is a $50.00 fee to copy records.

7. If you are unable to make your scheduled appointment, you must notify us 24 hours in advance. Failure to do so will result in a $135.00 fee.

8. Any treatment administered to a patient whose balance exceeds $400.00 must be paid at time of visit. Said patient must have a written and signed financial payment contract for the outstanding balance.

Dr. Aline Fournier
307 S. Ivy Street
Escondido, Ca 92025
760.746.1133

****

Dr. Fournier's Guidelines

LOW STRESS DIET GUIDELINES

OBJECTIVES: Minimize stress to your system, support detoxification and enhance your overall health.

GENERAL RULES:

1. Eat whole foods as provided by nature: organic vegetables are especially beneficial.
2. Eat raw organic foods with every meal. The best raw foods are salads.
3. Best desserts – fruits except if you're trying to lose weight or reduce inflammation.
4. To improve a poor appetite, normalize excessive appetite or lose weight, eliminate sugar and starches.
5. Drink lots of pure water (free of chlorine and fluorides but not distilled, purified or reverse osmosis): ½ of your body weight in ounces every day. Check with Dr. Fournier to ensure that your specific condition does not preempt you from drinking this much water.
6. No sugar!!! Use only Stevia, Xylitol or Monk Fruit.
7. Eat organic food, grass fed meat (except pork), organic poultry, vegetables, raw nuts, etc. whenever possible.
8. Avoid soy, soy milk, soy products and tofu. Tempe may be used sparingly.
9. Avoid milk and milk products. Use raw organic milk and products (cheese) or unsweetened almond milk or coconut milk.
10. Avoid seafood and fish, except for Alaskan fish, due to mercury toxicity.
11. Eat raw organic nuts for snacks (7-8 nuts eaten slowly).

IMPORTANT! ELIMINATE FOODS THAT CONTAIN:

- Hydrogenated or partially hydrogenated fats
- Preservatives, natural flavors, hydrogenated protein
- Artificial sweeteners
- High fructose corn syrup
- GMO

WE WELCOME YOU...

...and thank you for selecting us for your healthcare needs! We are dedicated to providing you with the best possible healthcare. To help us do this, please fill out this form completely in ink. If you have any questions or need help, please ask us – we will be happy to assist you.

1. Personal Information

Today's Date ______

Name ______

Address ______

City/State/Zip ______

Name you prefer to be called ______

Birthdate ______

Male____ Female____ Minor____ Single____ Married____ Divorced____ Widowed____ Separated____

Social Security Number ______

Employer______ Occupation ______

Referred by ______

2. Contact Information

Home Phone (   )______ Cell Phone (   )______

Work Phone (   )______ Extension______

E-Mail ______

Where do you prefer to be contacted? Home ____ Cell ____ Work ____ E-Mail ____

When is the best time to reach you? (Circle) Mon Tue Wed Thu Fri Sat Sun Time of Day______

In the event of an emergency, who should we contact? Name______

Relationship______ Home or Work Phone (   )______ Cell Phone (   )______

3. Responsible Party

Who is responsible for the account?

Name ______

Address ______

City/State/Zip ______

Relationship to patient ______

Driver's License Number______ Birthdate______

Social Security Number ______

Employer______ Occupation ______

Work Phone (   )______ Ext.______ Home Phone (   )______

Cell Phone (   )______ E-Mail______

ORDER # 58-8427 • © 1996 BIBBERO SYSTEMS, INC. • PETALUMA, CALIFORNIA • TO REORDER CALL TOLL FREE: (800) 242-2376 OR FAX: (800) 242-9330 (Rev. 8/08)

4. Insurance Information

Primary Insurance

Name of Insured_______________

Relationship to Patient_______________

Insured's Birthdate_______________

Social Security Number_______________

Employer_______________

Date Employed_______________

Insurance Company_______________

Group #_______________

Employee/Cert. #_______________

Insurance Company Address_______________

____

Deductible_______________

Maximum Annual Benefits_______________

Secondary Insurance

Name of Insured_______________

Relationship to Patient_______________

Insured's Birthdate_______________

Social Security Number_______________

Employer_______________

Date Employed_______________

Insurance Company_______________

Group #_______________

Employee/Cert. #_______________

Insurance Company Address_______________

____

Deductible_______________

Maximum Annual Benefits_______________

5. Financial Arrangements

For your convenience, we offer the following methods of payment. Please check which you prefer.

Payment in full is due at time of visit.

____ Cash

____ Personal Check

____ Credit Card – MC___ or Visa ___

____ I wish to discuss the office's payment policy.

Late Charges

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

6. Authorization and Release

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

Signature of patient or parent if minor | Date

ORDER # 58-8427 • © 1996 BIBBERO SYSTEMS, INC. • PETALUMA, CALIFORNIA • TO REORDER CALL TOLL FREE: (800) 242-2376 OR FAX: (800) 242-9330

Andrus/Clini-Rec®

ADOLESCENT/YOUNG ADULT HEALTH HISTORY QUESTIONNAIRE

CHART # ________

Identification Information:

Today's Date ____/____/____

Name ______________________ Male ____ Female ____ (check one)

Date of Birth ____/____/____

Address ______________________

Home Telephone (____) ______________ (area code)

CONFIDENTIAL

A. CURRENT MEDICAL PROBLEMS:

1. Please describe the medical problems for which you came to see the doctor. About when did they begin?

Reason for Visit or Medical Problem	Date Began

2. What concerns you most about these problems?

3. If you are being treated for any other illness or medical problems by another physician, please describe the problems and write the name of the physician or medical facility treating you.

Illness or Medical Problem	Physician or Medical Facility	City

B. GENERAL HEALTH HISTORY:

1. MEDICATIONS:

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin or cold tablets).

2. ALLERGIES AND SENSITIVITIES:

List anything that you are allergic to such as certain foods, medications, dust, chemicals or soaps, household items, pollens, bee stings, etc., and indicate how each affect you.

Allergic To	Effect	Allergic To	Effect

3. FAMILY HEALTH:

Please give the following information about your immediate family:

Relationship	Age, If Living	Age At Death	State of Health or Cause of Death
Father			
Mother			
Brothers and Sisters			

Have any blood relatives had any of the following illnesses? If so, indicate relationship (Mother, brother, etc.)

Illness	Family Members
Diabetes	
Cancer	
Blood Disease	
Tuberculosis	
Epilepsy	
High Blood Pressure	
Heart Disease	

4. HOSPITALIZATIONS:

Please list the last three times, if any, that you have been hospitalized.

Year	Operation or Illness	Hospital and City

BIBBERO SYSTEMS, INC.
Copyright ©1980, 1983 Bibbero Systems International, Inc.

5. IMMUNIZATIONS:

Please place an (X) next to each of the following immunizations you have had, and if possible give the approximate age when you received each one.

Immunizations	(X)	Age	Immunizations	(X)	Age
Smallpox	___	___	Measles	___	___
DPT (Diptheria/ Whooping Cough/ Tetanus)	___	___	Rubella	___	___
			Mumps	___	___
			Polio	___	___
Typhoid	___	___	Tine Test (TB)	___	___
			(Result)	___ positive	___ negative

6. MEDICAL PROBLEMS:

Please mark with an (X) any of the following medical problems which you have had within the past twelve months, and how often they occur.

Medical Problems	Not at All	Some-times	Fre-quently	Medical Problems	Not at All	Some-times	Fre-quently
Acne or other skin problems	___	___	___	Unusual lumps or swollen glands	___	___	___
Ear Infections	___	___	___	Stomach aches or cramps	___	___	___
Colds/sore throats	___	___	___	Constipation or Diarrhea	___	___	___
Speech problem or difficulty making yourself understood	___	___	___	Blood in bowels	___	___	___
				Burning sensation when urinating	___	___	___
Hearing problem or difficulty understanding others	___	___	___	Severe back pain	___	___	___
				Unusual bleeding	___	___	___
Vision problems or difficulty recognizing colors	___	___	___	Headaches	___	___	___
				Convulsions or seizures	___	___	___
Coughing/wheezing spells or difficulty breathing	___	___	___	Severe chest pain	___	___	___
				Other (explain) ___	___	___	___
				___	___	___	___

7. CURRENT HEALTH:

a. How is your overall health now? . . . . . Health now: Poor___ Fair___ Good___ Excellent___

b. How has it been most of your life? . . . . . Health has been: Poor___ Fair___ Good___ Excellent___

c. In the past year:

- Has your appetite changed? . . . . . Appetite: Decreased___ Increased___ Stayed same___
- Has your weight changed? . . . . . Weight: Lost___ lbs. Gained___ lbs. No change___
- Are you thirsty much of the time? . . . . . Thirsty: No___ Yes___
- Has your overall 'pep' changed? . . . . . Pep: Decreased___ Increased___ Stayed same___

d. Do you usually have trouble sleeping? . . . . . Trouble sleeping: No___ Yes___

e. How much do you exercise? . . . . . Exercise: Little or none_ Less than I need_ All I need_

f. Do you smoke? How many of each? . . . . . Smoke: Cigarettes___Pipesful/cigars,___ a day, Don't Smoke___

g. Do you drink one or more alcoholic beverages a day? . . . . Alcoholic beverages: No___ Yes___ (one or more/day)

h. How much coffee or tea do you usually drink? . . . . . Coffee/tea: ___ cups of coffee or tea a day.

		Not at All	A Little	A Lot
i. Do you use marijuana?	Use marijuana?	___	___	___
j. Do you use "hard drugs"? (Including cocaine, heroin, etc.)	Use "hard drugs"	___	___	___
	Which one(s)	___		
k. Are you sexually active?	Sexually active:	___	___	___

l. Have you had a venereal disease? ☐ Yes ☐ No

m. HIV test (AIDS)? . . . . . ☐ Yes ☐ No

We all have questions about our health and the way our bodies work. Please tell us below how you feel about yours:

I'm concerned about:	Not At All	A Little	A Lot	I'm concerned about:	Not At All	A Little	A Lot
My General Health	___	___	___	My Stomach or Bowels	___	___	___
My Weight	___	___	___	My Sexual Organs	___	___	___
My Teeth	___	___	___	My Bones or Joints	___	___	___
My Skin	___	___	___	My Muscles	___	___	___
My Nose	___	___	___	My Physical Size	___	___	___
My Hearing	___	___	___	My Appearance	___	___	___
My Heart	___	___	___	My Urination	___	___	___
My Breathing	___	___	___	(Women Only)			
Other (explain) ___				My Menstrual Periods	___	___	___
___				My Breasts	___	___	___

Copyright ©1980, 1983 Bibbero Systems International, Inc. (REV. 6/92)

CONFIDENTIAL

To Order Call:
Toll Free: 800-BIBBERO (800 242-2376)
Or Fax: (800) 242-9330

C. LIFE STYLE DATA BASE: (✓ check the most appropriate item)

FAMILY:

1. How many siblings (brothers/sisters) do you have? . . . . ______(Brothers and Sisters)
2. Among your brothers and sisters, are you the: . . . . Youngest____ About in the middle____ Oldest____ Only child____ (Which one)
3. With whom do you live? . . . . Both parents____ One parent____ ________ Other person____ (Who?)________ (relationship)
4. Are your parents: . . . . Living Together _____ Divorced/ Separated _____ How Long ________
   One is deceased______ Both are deceased______

	Not At All	A Little	A Lot
5. Can you express your opinion and feelings freely at home? . .	______	______	______
6. Are you listened to at home?	______	______	______
7. If your mother is living, can you talk things over with her? . . (Skip if parent deceased)	______	______	______
8. If your father is living, can you talk things over with him? . . (Skip if parent deceased)	______	______	______

9. If you had a personal problem, who in your family would you turn to? . . . . ________________ (relationship) No one ______
10. Is there anyone in your family you feel drinks too much? . . . No_____ Yes_____ Whom____________ (relationship)
11. Do you have a room to yourself? . . . . No_____ Yes_____
12. Do you have a quiet place to do your schoolwork or be by yourself? . . . . No_____ Yes_____
13. What time do you usually go to bed? . . . . about ____________ o'clock
14. What time do you usually get up? . . . . about ____________ o'clock

	Not At All	A Little	A Lot
15. Do you and your parents agree on most things?	______	______	______
16. Do you and your brothers/sisters agree on most things?	______	______	______
17. Do you feel that your family really cares for you?	______	______	______

18. How much time do you spend with family members in sports, hobbies, discussion, etc.? . . . . about________hours per week
19. Check here if you have any problem in your family life you would like to discuss with your doctor . . . . ☐

SCHOOL & SOCIAL:

	Not At All	A Little	A Lot
1. Do you play any team sport(s) at school?	______	______	______
2. Do you take part in any school affairs at school, (i.e., paper, dramatics, band, etc.)?	______	______	______
3. Do you take part in activities outside of school (church, youth groups, etc.)	______	______	______
4. Would you like to spend more time with people your own age than you do now?	______	______	______

over for Physician's Notes)

ht ©1980, 1983 Bibbero Systems International, Inc. Stock No. 19-741-6 ystems International, Inc.

AL

PERSONAL:

Do any of the following statements describe your feelings or concerns?

		Not At All	A Little	A Lot	
1.	I feel lonely	___	___	___	Feels lonely
2.	I am concerned about my future	___	___	___	Concerned/future
3.	I feel tense and "uptight"	___	___	___	Tense & uptight
4.	I feel worried and blue	___	___	___	Worried/blue
5.	I have trouble falling asleep	___	___	___	Problems falling asleep
6.	I feel tired when I wake up in the A.M.	___	___	___	Tired in A.M.
7.	I lose my temper	___	___	___	Loses temper
8.	I have headaches	___	___	___	Has headaches
9.	I am bored with my life	___	___	___	Bored w/life
10.	Other people make too many demands of me	___	___	___	Too many demands made by people
11.	I feel overwhelmed by all the things I have to do	___	___	___	Overwhelmed
12.	I worry about money	___	___	___	Worries about money
13.	I feel like committing suicide	___	___	___	Feels like committing suicide
14.	I worry about my job	___	___	___	Worried about job
15.	I worry about my school grades	___	___	___	Worried about school grades
16.	I feel clumsy and awkward	___	___	___	Feels clumsy & awkward
17.	I worry about not being accepted by my peers	___	___	___	Worries about peer acceptance
18.	I feel worthless and useless	___	___	___	Feels worthless/ useless

SUMMARY:

All in all, how satisfied are you with yourself and your life? Please rate your feelings by putting an "X" on the scale from 1 to 10 ....

Degree of satisfaction with self and life:

One last item: Now that you have answered these questions, if there is anything concerning your health or your life that has not been covered, and that you would like to discuss with your doctor right now, simply place an "X" in this box ....

Would like to discuss a problem with doctor: ☐

Please Turn to Page 4 on Back and Complete

Stock No. 19-741-6 5/83

Patient's signature ____________________

Copyright ©1980, 1983 Bibbero Systems International, Inc.

COI

NUTRITION AND DIET

1. How many meals do you eat each day? ______ Meals each day
2. Do you usually eat breakfast? ☐ Yes ☐ No — Breakfast
3. Do you diet freqently and/or are you now dieting? ☐ No ☐ Yes — Diets
4. Do you consider yourself ☐ Underweight ☐ Overweight ☐ Just right? — Weight
5. Do you snack ☐ More than once a day ☐ Usually daily ☐ Rarely? — Snacks
6. Do you add salt to your food at the table? ☐ Almost always ☐ Sometimes ☐ Rarely — Salts food
7. Check the frequency you eat the following types of foods:

	More than once daily	Daily	3 times weekly	Once weekly	Twice monthly	Less or never
a. Whole grain or enriched bread or cereal						
b. Milk, cheese, or other dairy products						
c. Eggs						
d. Meat, Poultry, Fish						
e. Beans, Peas, or other legumes						
f. Citrus						
g. Dark green or deep yellow vegetables						

List any food supplements or vitamins you take regularly: ______

Additional Patient Comments: ______

CONFIDENTIAL

Thanks for completing this questionnaire. Please review for skipped questions, sign your name on the space to the right and return it to the physician or assistant. If you wish to add any information, please write it on the spaces provided above.

Patient's Signature ______

Physician's Notes: ______

Copyright ©1980, 1983 Bibbero Systems International, Inc.

To order, call or write:
Bibbero Systems, Inc.
1300 N. McDowell Blvd., Petaluma, CA 94954
Toll Free: 800-BIBBERO (800 242-2376)
Or Fax: (800) 242-9330
Stock No. 19-741-6

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. **Client's name**: ______________________________
   First Name Middle Name Last Name

2. **Date of Birth**: ___/___/___ 3. **SSN**: ___-___-____ 4. **Date authorization initiated**: ___/___/___

5. **Authorization initiated by**: ______________________________
   Name (client or provider) (If provider, please specify relationship to client)

6. **Information to be Used or Disclosed**:
   - ☐ My health information relating to the following treatment or condition: ____________
   - ☐ Most recent ___ years of record
   - ☐ My medical records for the following date(s): ____________
   - ☐ Entire medical record
     - ☐ Include ☐ Exclude: My health information related to drug and/or alcohol abuse
     - ☐ Include ☐ Exclude: My health information related to HIV/AIDS
   - ☐ Psychotherapy Notes [**Note: Must be a separate consent]**
   - ☐ Other information to be used or disclose (describe information in detail): ____________

7. **Purpose of Use or Disclosure**:
   - ☐ Treatment, Payment or Health Care Operations
   - ☐ Disclosure to Life Insurer for Coverage Purposes
   - ☐ Disclosure to Employer of results of pre-employment physical or lab tests
   - ☐ Marketing Purposes
   - ☐ To the Following Family Members: ____________
   - ☐ Other (describe each purpose of the requested use and disclosure in detail): ____________

8. **Person(s) Authorized to Make the Disclosure**: ____________

9. **Person(s) Authorized to Receive the Disclosure**: ____________

10. **This Authorization will: ☐ not expire, ☐ expire on ___/___/___ or ☐ upon the happening of the following event:** ____________

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Client: ____________

Signature of Personal Representative: ____________

Relationship to Client if Personal Representative: ____________

Date of signature: ___/___/___

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS
(Page 2 of 2)

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address (insert address of provider):

   ____
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected health information to be used or disclosed under this authorization. You do not have the right of access to the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider my deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.
6. If this office initiated this authorization, you <u>must</u> receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. <u>Such authorization must be separate from an authorization to release other medical records</u>.
8. You have a right to an accounting of the disclosures of your protected health information by provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Screening for Aerosol Transmissible Diseases*

Patient Name:

In compliance with California OSHA Title 8, Section 5199, all healthcare facilities **must** screen patients for aerosol transmissible diseases **at each office visit.** For facilities exempt from the ATD regulation, screening must still occur **AND** treatment is **not** provided to patients suspected or identified as having aerosol transmissible diseases. (Add add'l sheets if needed.)

1. **Do you have (circle all appropriate)?: History of Tuberculosis (TB) or Symptoms of Tuberculosis** (Productive Cough, Bloody Spit, Fever, Fatigue, Night Sweats, Fever Unexplained Weight Loss).

   No ________

2. **Do you have (circle all appropriate)?: Flu or other Airway Illness, including Pertussis (Whooping Cough), Measles, Mumps, Rubella, Chicken Pox, and Meningitis** (Body Aches, Runny Nose, Sore Throat, Nausea, Vomiting, Diarrhea, Fever, Respiratory Symptoms, Coughing Spasms, Swollen Glands, Skin Rash, Blisters, Stiff Neck)

   No ________

3. **Chronic Respiratory Illness (NOT acute, contagious, or infectious illness).**

   Do you have (circle)?: Chronic Upper Airway Cough Syndrome, Postnasal Drip, Gastro-Esophageal Reflux Disease (GERD), Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Emphysema, Allergies, Asthma.

   No ________

_______________________________________ ____________________

Patient Signature **Date**

Date	Any Health Changes on This Visit??	Initials

*This form may be modified as needed for your facility.

© 2013 San Diego Healthcare Compliance

Date	Any Health Changes on This Visit??	Initials