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

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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_____

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

Chart No. _____

ANDRUS/CLINI-REC® HEALTH HISTORY QUESTIONNAIRE – FEMALE

Identification Information

Today's Date _____

Name _____ Date of Birth _____

Occupation _____ Marital Status _____

PART A – PRESENT HEALTH HISTORY

I. CURRENT MEDICAL PROBLEMS

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

Problems	Date Began

What concerns you most about these problems?

_____

_____

If you are being treated for any other illnesses 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

II. MEDICATIONS

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

_____ _____ _____

_____ _____ _____

III. 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 affects you.

Allergic To:	Effect	Allergic To:	Effect

IV. CURRENT GENERAL HEALTH, ATTITUDE AND HABITS

How is your overall health now?	Health now:	Poor____ Fair____ Good____ Excellent____
How has it been most of your life?	Health has been	Poor____ Fair____ Good____ Excellent____
In the past year:		
Has your appetite changed?	Appetite:	Decreased____ Increasad____ 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____
Do you usually have trouble sleeping?	Trouble sleeping:	No____ Yes____
How much do you exercise?	Exercise:	Little or none____ Less than I need____ All I need____
Do you smoke?	Smokes:	No____ Yes____ If yes, how many years?____
How many each day?		____Cigarettes ____Cigars ____Pipesfull
Have you ever smoked?	Smoked	No____ Yes____ If yes, how many years?____
How many each day?		____Cigarettes ____Cigars ____Pipesfull
Do you drink alcoholic beverages?	Alcohol:	No____ Yes____ I drink____ Beers____ Glasses of Wine ____ Drinks of hard liquor - per day
Have you ever had a problem with alcohol?	Prior problem:	No____ Yes____
How much coffee or tea do you usually drink?	Coffee/Tea:	____ cups of coffee or tea a day.
Do you regularly wear seatbelts?	Seatbelts:	No____ Yes____

DO YOU:	Rarely/ Never	Occasionally	Frequently	DO YOU:	Rarely/ Never	Occasionally	Frequently
Feel nervous?				Ever feel like committing suicide?			
Feel depressed?				Feel bored with your life?			
Find it hard to make decisions?				Use marijuana?			
Lose your temper?				Use "hard drugs"?			
Worry a lot?							
Tire easily?							
Have trouble relaxing?							
Have any sexual problems?							

Do you want to talk to the doctor about a personal matter? No____ Yes____

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PART A–
PRESENT HEALTH HISTORY (continued)

IV. CURRENT GENERAL HEALTH, ATTITUDE AND HABITS (continued)

Have you recently had any changes in your:			If yes, please explain
Marital status?	No ___	Yes ___	
Job or work?	No ___	Yes ___	
Residence?	No ___	Yes ___	
Financial status?	No ___	Yes ___	
Are you having any legal problems or trouble with the law?	No ___	Yes ___	

PART B – PAST HISTORY

I. 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			
Spouse			
Children			

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

Illness	Family Members
Asthma	
Diabetes	
Cancer	
Blood Disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Tuberculosis	
Gout	
High Blood Pressure	
Heart Disease	
Mental Problems	
Suicide	
Stroke	
Alcoholism	
Rheumatic Fever	

II. HOSPITALIZATIONS, SURGERIES, INJURIES

Please list all times you have been hospitalized, operated on, or seriously injured.

Year	Operation, Illness, Injury	Hospital and City

III. ILLNESSES AND MEDICAL PROBLEMS

Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year.

Illness	(X)	(Year)
Eye or eye lid infection		
Glaucoma		
Other eye problems		
Ear Trouble		
Deafness or decreased hearing		
Thyroid trouble		
Strep throat		
Bronchitis		
Emphysema		
Pneumonia		
Allergies, asthma or hay fever		
Tuberculosis		
Other lung problems		
High blood pressure		
Heart attack		
High cholesterol		
Arteriosclerosis (Hardening of arteries)		
Heart murmur		
Other heart condition		
Stomach/duodenal ulcer		
Diverticulosis		
Colitis		
Other bowel problem		
Hepatitis		
Liver trouble		
Gallbladder trouble		

Illness	(X)	(Year)
Hernia		
Hemorrhoids		
Kidney or bladder disease		
Mental problems		
Headaches		
Head injury		
Stroke		
Convulsions, seizures		
Arthritis		
Gout		
Cancer or tumor		
Bleeding tendency		
Diabetes		
Measles/Rubeola		
German measles/Rubella		
Polio		
Mumps		
Scarlet fever		
Chicken pox		
Mononucleosis		
Eczema		
Psoriasis		
Venereal disease		
Genital Herpes		
HIV test		
AIDS		

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STOCK NO. 19-751-1 5/83

Please answer all of the following questions. Circle any questions you find difficult to answer.

PART C. — FEMALE BODY SYSTEMS QUESTIONS

	Rarely/ Never	Occasionally	Frequently
1. How often, if ever:			
a. Are you nauseated (sick to your stomach)?			
b. Do you have stomach pains?			
c. Do you burp a lot after eating?			
d. Do you have heartburn?			
e. Do you have trouble swallowing your food?			
f. Have you vomited blood?			
g. Are you constipated?			
h. Do you have diarrhea? (watery stools)			
i. Are your bowel movements painful?			
j. Are your bowel movements bloody?			
k. Are your bowel movements dark or black?			

2. Have you ever had a sigmoidoscopy? No ____ Yes ____ Date ____

	Rarely/ Never	Occasionally	Frequently
3. Is it sometimes hard to start your urine flow?			
4. Is urination ever painful?			
5. Do you have to urinate more than 5 times a day?			
6. Do you get up at night to urinate?			
7. Has your urine ever been bloody or dark colored?			
8. Do you ever lose urine when you strain, laugh, cough or sneeze?			
9. Do you ever lose urine during sleep?			

10. What was your age at start of menstruation? ____ Age
11. Date of last menstruation period? ____ Date
12. How long did your period last? ____ Days
13. How long is your menstrual cycle (days between day starting)? ____ Days
14. Are your menstrual periods irregular? No ____ Yes ____
15. Do you use pads or tampons? ☐ Pads ☐ Tampons
16. How many do you use on heaviest days? ____

	Rarely/ Never	Occasionally	Frequently
17. Do you:			
a. Have any menstrual problems?			
b. Feel rather tense just before your period?			
c. Have heavy menstrual bleeding?			
d. Have painful menstrual periods?			
e. Have bleeding between periods?			

18. Do you have tender breasts? ____
19. Do you have any discharge from your nipples? ____
20. Have your breasts recently changed in size? No ____ Yes ____
21. Do you examine your breasts monthly for lumps? Yes ____ No ____
22. Have you ever had a mammogram? No ____ Yes ____ Date ____
23. Did you breast feed your babies? No ____ Yes ____
24. Do you have any unusual vaginal burning, itching or discharge? No ____ Yes ____
25. What was the date of your last pap test? ____ Date
26. Do you have any problems with or questions about venereal disease? No ____ Yes ____
27. Do you have any hot flashes? No ____ Yes ____

Check here if you wish to discuss any special problems with the doctor. ☐

	Rarely/ Never	Occasionally	Frequently
28. In the past year have you had any:			
a. Severe shoulder pain?			
b. Severe back pain?			
c. Muscle or joint stiffness or pain due to sports, exercise or injury?			
d. Pain or swelling in any joints not due to sports, exercise or injury?			

29. Do you have dry skin or brittle fingernails? No ____ Yes ____
30. Do you bruise easily? No ____ Yes ____
31. Do you have any moles that have changed in color in size? No ____ Yes ____
32. Do you have any other skin problems? No ____ Yes ____
33. Have you ever fainted or felt like fainting? No ____ Yes ____
34. Does any part of your body get numb? No ____ Yes ____
35. Do you ever have fits or convulsions? No ____ Yes ____
36. Do you ever shake or tremble? No ____ Yes ____
37. Do you ever have any problem with coordination? No ____ Yes ____

Please Turn Page and Continue

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				GENERAL
				In last 3 months:
38. In the last 3 months have you had:				
a. A fever that lasted more than one day?	No	Yes		Fever over 24 hours
b. Sores or cuts that were hard to heal?	No	Yes		Sores/cuts hard to heal
c. Any cold sores (fever blisters)?	No	Yes		Herpes simplex
d. Any lumps in your neck, armpits or groin?	No	Yes		Lumps in neck/armpits/groin
e. Do you ever have chills or sweat at night?	No			
39. Have you traveled out of the country in the last 2 years?	No	Yes		Has chills/sweat at night
40. Write in the approx. dates or year for the shots you have had:		Yes, Traveled in:		
		Measles	Tetanus	Has had
		Mumps	Typhoid	these shots
		Polio		
41. Have you had a tuberculin (TB) skin test?	No	Yes	Date	Date of last TB skin test
If so, was it negative or positive?	Neg	Pos		Positive TB test
Have you had an HIV test (AIDS)?	No	Yes		
If so, was it negative or positive?	Neg	Pos		
	Rarely/ Never	Occasionally	Frequently	**HEAD AND NECK**
42. Do you have headaches?				Experiences headaches
43. Do you have pain in your neck?				Experiences neck pain
44. Do you have problems with your:				MOUTH
a. Teeth?				Has teeth problem
b. Gums, jaws or roof of mouth?				Gum, jaw or mouth problem
c. Tongue, or taste sense?				Tongue or taste sense problem
				VISION/HEARING
45. Do you wear eyeglasses?	No	Yes		Wears eyeglasses
46. Do you wear contact lenses?	No	Yes		Wears contacts
47. Has your vision changed in the last year?	No	Yes		Vision changed in last year
	Rarely/ Never	Occasionally	Frequently	
48. How often do you have:				
a. Double vision?				Double vision
b. Blurry vision?				Blurred vision
c. Watery or itchy eyes?				Watery/itchy eyes
49. Do you ever see colored rings around lights?				Sees halos
50. Do others tell you you have a hearing problem?				Hearing problem
51. Do you have trouble keeping your balance?				Loses balance
52. Do you have any discharge from your ears?				Discharge from ears
53. Do you ever feel dizzy or have motion sickness?				Dizzy/motion sickness
54. Do you have any problems with your hearing?	No	Yes		Hearing problems
55. Do you ever have ringing in your ears?	No	Yes		Ringing in ears
	Rarely/ Never	Occasionally	Frequently	**NOSE/THROAT/RESPIRATORY**
56. How often do you have:				
a. Head colds?				Head colds
b. Chest colds?				Chest colds
c. Runny nose?				Runny nose
d. Stuffed up nose?				Head congestion
e. Sore/hoarse throat?				Sore/hoarse throat
f. Bad coughing spells?				Coughing spells
g. Sneezing spells?				Sneezing spells
h. Trouble breathing?				Trouble breathing
i. Nose bleeds?				Nose bleeds
j. Cough blood?				Cough blood
57. Have you ever worked or spent time:				
a. On a farm?	No	Yes		Worked on a farm
b. In a mine?	No	Yes		Worked in a mine
c. In a laundry or mill?	No	Yes		Worked in a laundry/mill
d. In very dusty places?	No	Yes		Worked in high dust concentrations
e. With or near toxic chemicals?	No	Yes		Exposed to toxic chemicals
f. With or near radioactive materials?	No	Yes		Exposed to radioactive materials
g. With or near asbestos?	No	Yes		Exposed to asbestos
	Rarely/ Never	Occasionally	Frequently	**CARDIOVASCULAR**
58. Do you get out of breath easily when you are active (Like climbing stairs?)				Out of breath quickly when exercising
59. Do you ever feel light-headed or dizzy?				Dizziness
60. Have you ever fainted or passed out?				Fainted
61. Do you sometimes feel your heart is racing or beating too fast?				Rapid heartbeat
62. When you exercise do you ever get pains in your chest or shoulders?				Chest/shoulder pains in exercise
63. Do you have any leg cramps or pain in your thighs or legs when walking?				Pain in thighs or legs when walking
64. Do you ever have to sit up at night to breathe easier?				Sits up at night to breathe easier
65. Do you use two pillows at night to help you breathe better?				Breathing problems during sleep
66. Would you say you are a restless sleeper?				Restless sleeper
67. Are you bothered by leg cramps at night?				Leg cramps at night
68. Do you sometimes have swollen ankles or feet?				Swollen ankles/feet

FAMILY PLANNING AND PREGNANCY HISTORY

1. Do you use Birth Control?
   Currently: ☐ No ☐ Not needed
   ☐ Not applicable, I have had:
   ☐ Tubal ligation ☐ Hysterectomy ☐ Other _____
   ☐ IUD ☐ Diaphragm ☐ Foam ☐ Condoms ☐ Pill (Name: _____) ☐ Other _____
   Previously: ☐ No ☐ Not needed
   ☐ IUD ☐ Diaphragm ☐ Foam ☐ Condoms ☐ Pill (Name: _____) ☐ Other _____
2. Do you have any questions about birth control? ☐ No ☐ Yes
3. Do you have any questions or problems concerning sex? ☐ No ☐ Yes
4. Do you have any pain or discomfort with sexual intercourse? ☐ No ☐ Yes
5. Times pregnant: _____ Living children: _____ Miscarriages: _____ Abortions: _____ Premature Births: _____
6. How old were you during your first pregnancy? _____ Years old

Please complete information below concering your pregnancies:

No.	Born Month/Year	Weight at Birth	Sex	Length of Pregnancy	Delivery Type	Complications — Describe if any
1						
2						
3						
4						

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NUTRITION AND DIET

1. How many meals do you eat each day? . . . . . _____ Meals each day
2. Do you usually eat breakfast? . . . . . ☐ No ☐ Yes Breakfast
3. Do you diet frequently 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: _____

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: _____

To order, call or write:
Bibbero Systems, Inc.
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
(Page 1 of 2)

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 must 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. Such authorization must be separate from an authorization to release other medical records.
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. **<u>Chronic</u> 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.

Date	Any Health Changes on This Visit??	Initials