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

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

CHILD'S NAME:_____ **DATE OF BIRTH:**_____

PERSON COMPLETING FORM/RELATIONSHIP_____

DATE OF FORM COMPLETION_____

MEDICATIONS:

Medication Dose How many times a day

_____

_____

_____

_____

MEDICATION ALLERGIES: □ No □ Yes

If yes, to what medication(s) and what was the reaction_____

IMMUNIZATION HISTORY:

To the best of my knowledge, my child is up to date on his/her immunizations □ No □ Yes

If no, why?_____

BIRTH HISTORY:

Please indicate any medical problems during pregnancy _____

Please list any medications taken during the pregnancy_____

Any drug or alcohol use during the pregnancy □No □ Yes _____

Delivered by □ elective C-section □ emergent C-section □ forceps □ vacuum extraction
□ normal vaginal delivery

If not a normal vaginal delivery, why?_____

Number of weeks gestation_____

Birth weight_____ APGAR scores: 1 minute_____ 5 minute_____ Discharge weight_____

Did the baby receive the Hepatitis B vaccine □ No □ Yes If yes, date given _____

Please indicate any medical problems during the newborn period_____

Name of hospital where infant was born_____

PERSONAL MEDICAL HISTORY:

Please check if your child has had any of the following medical problems:

□ ADD/ADHD	□ Chicken pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing problems	□ Recurrent ear infections
□ Anemia	□ Diabetes	□ Heart murmur	□ Seizures
□ Asthma	□ Eczema	□ Congenital heart disease	□ Urinary Tract Infections
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Vesicoureteral reflux
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

HOSPITALIZATIONS:

Has your child every stayed overnight in a hospital? □ No □ Yes

If yes, when and why?_____

SURGICAL HISTORY:

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

_____

_____

GYN HISTORY:

Age of first period_____years First day of last period_____ Has not had menses yet_____

FAMILY HISTORY:

Please indicate if your child has a family history **(parents, siblings, grandparents, aunts, uncles or cousins <u>to the child</u>)** of any of the following:

Diagnosis	**Family Member**	**Diagnosis**	**Family Member**
□ ADD/ADHD		□ Hearing disability	
□ Alcohol/Drug Abuse		□ High cholesterol	
□ Allergies		□ High blood pressure	
□ Asthma		□ HIV/AIDS	
□ Birth defects		□ Learning disability	
□ Blood disorders		□ Mental illness	
□ Cancer, type		□ Mental retardation	
□ Heart disease (heart attack, bypass, stents)		□ Migraines	
□ Deafness/Hearing problems		□ Scoliosis	
□ Depression		□ Seizure disorder	
□ Developmental delay		□ Speech problems	
□ Diabetes		□ TB/Lung disease	
□ Genetic disorder		□ Stroke	
□ Hepatitis/Liver disease		□ Thyroid disease	
		□ Other	

SOCIAL HISTORY:

Who lives at home?

Name	**Relationship**	**DOB**

Is the child cared for by any one other than the parents? □No □ Yes

If yes, by whom and how frequently?_____

Does anyone in your home smoke? □ No □ Yes

_____

Provider_____ Date_____

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