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

SCHAEFER/CLINI-REC® PEDIATRIC HEALTH HISTORY QUESTIONNAIRE - 6 YEARS TO 13 YEARS

Identification Information:

Child's Name_____ Male_____ Female_____ Date of Birth_____ Age:_____ Yrs. _____ Mos.

Parent or Guardian's Name _____

Address: _____ Telephone:_____

Current Doctor: _____ Prior Doctor: _____ Today's Date _____

A. CURRENT MEDICAL PROBLEMS:

1. Please list the medical problems for which you brought your child. About when did they begin? What concerns you most about these problems?
Reason for Visit: Comprehensive Periodic Examination ☐ Yes ☐ No
Medical Problems(s):

2. If your child is 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 him/her.

Illness or Medical Problem	Physician or Medical Facility	City

B. CHILD'S CURRENT HEALTH:

1. Circle the terms you feel generally discribe your child's current health..... CURRENT HEALTH
Healthy Energetic Alert
Unhealthy Tired Slow

2. Does your child have:			**Eyes, Ears, Nose, Throat**
a. Trouble with his eyes?	___no	___yes	Eye problem
b. Trouble reading or watching TV?	___no	___yes	Trouble seeing
c. Crossed or wandering eyes?	___no	___yes	Crossed or wandering eyes
d. Frequent headaches?	___no	___yes	Headaches
e. Problems with his ears?	___no	___yes	Ear problem
f. Difficulty hearing, understanding or speaking clearly?	___no	___yes	Hearing problem
g. Ear infection or draining from ears?	___no	___yes	Ear infection
h. Trouble breathing through his nose?	___no	___yes	Breathes through mouth
i. Frequent colds?	___no	___yes	Colds
j. Frequent sore throats?	___no	___yes	Sore throats
k. Tonsil infections?	___no	___yes	Tonsil infection
l. Nose Bleeds?	___no	___yes	Nose Bleeds
Has your child been to a dentist?	___no	___yes	Dentist _____ Date of last visit
3. Does your child have:			**Chest**
a. A coughing problem?	___no	___yes	Coughing problem
b. Shortness of breath while playing?	___no	___yes	Shortness of breath
c. Wheezing or other problem with breathing?	___no	___yes	Wheezes or breathing problem
d. Chest pain?	___no	___yes	Chest pain
			Digestive
4. Is your child eating properly?	___no	___yes	Eating properly
5. Has your child been losing weight?	___no	___yes	Weight loss
6. Does your child frequently experience:			
a. Diarrhea?	___no	___yes	Diarrhea
b. Constipation?	___no	___yes	Constipation
c. Nausea?	___no	___yes	Nausea
d. Vomiting?	___no	___yes	Vomiting
e. Abdominal Pain?	___no	___yes	Abdominal pain
7. Has your child ever had an anal problem?	___no	___yes	Anal problem
8. Has your child ever had any signs of worms?	___no	___yes	Worms
9. Are your child's bowel movements bloody or very dark?	___no	___yes	Blood in bowel movement
10. Does your child have:			**Urinary/Genital**
a. Difficulty with urination?	___no	___yes	Problem with urination
b. A burning sensation during urination?	___no	___yes	Burning on urination
c. A discharge from vagina or penis?	___no	___yes	Discharge from vagina or penis
d. Unusual or strong smelling urine?	___no	___yes	Urine Odor
e. A bed-wetting problem?	___no	___yes	Wets bed
f. History of urinary tract infection?	___no	___yes	Urinary tract infection
11. a. Any skin rashes, birth marks, or other skin problems?	___no	___yes	**Skin** Skin rashes or problems
12. Does your child have:			**Musculoskeletal**
a. Limb pain	___no	___yes	Limb pain
b. Painful or swollen joints?	___no	___yes	Joint problems
c. Problems with muscle coordination or strength?	___no	___yes	Muscle problems
d. Posture problems?	___no	___yes	Posture problem
e. Foot or ankle problems?	___no	___yes	Foot/ankle problems
13. Does your child have:			**Neurological**
a. Any fatigue or listlessness?	___no	___yes	Fatigue or listlessness
b. Any dizziness?	___no	___yes	Dizziness
c. Any shaking?	___no	___yes	Trembles/shakes
d. Has your child ever had a convulsion, seizure or a fit?	___no	___yes	Convulsions
14. Is your child:			**Developmental**
Too short?	___no	___yes	Too short
Too tall?	___no	___yes	Too tall
Too fat?	___no	___yes	Too fat
Too thin?	___no	___yes	Too thin
15. Puberty - Boys (If applicable)			
Voice change	___no	___yes	Voice change
Muscular growth	___no	___yes	Muscular growth
Pubic hair present	___no	___yes	Pubic hair
Testes growing	___no	___yes	Testes growing
Penis growing	___no	___yes	Penis growing
16. Puberty - Girls (If applicable)			
Breasts developing	___no	___yes	Breast developing
Menstrual periods present	___no	___yes	Menstrual periods
Age and date of first menstrual period			Age___ Yrs.___ Mos.___ Date_____
Periods regular	___no	___yes	Periods regular
Pain or discomfort with period	___no	___yes	Pain or discomfort with period
Flow Heavy	___no	___yes	Heavy flow
Scant	___no	___yes	Scant flow
Use Tampons or Pads			___Tampons ___Pads ___Both

Child's Name _____ Date_____
DOB_____ Place:_____Home _____Hospital _____Birthing Center _____Other_____
Mother's Age at Birth of Child _____ Father's Age At Birth of Child _____

C. FAMILY MEDICAL HISTORY:
Please write in the relationship of the mother's or father's relatives (such as children, brothers, sisters, grandparents, aunts, uncles) who have had any of the conditions listed. Include conditons that baby's mother and father have had.

(X)	CONDITION	RELATIONSHIP	MAT (♂)	PAT (♂)
	Birth Defects			
	Chromosomal Abnormality (Genetics Disease)			
	Obesity / Overweight			
	DES Exposure			
	Congenital Hearing Loss			
	Mental Retardation / Nervous Disorders			
	Migraine Headaches			
	Food Allergies			
	Hay Fever			
	Asthma / Emphysema			
	High Blood Pressure			
	Heart / Valve Trouble			
	Coronary Artery Disease (Note age at death)			
	Stroke			
	Rheumatoid Arthritis / Gout			
	Rheumatic Fever			
	Cancer or Malignancy			

(X)	CONDITION	RELATIONSHIP	MAT (♂)	PAT (♂)
	Metaboic Disease / Thyroid Problem			
	Alcoholism			
	Diabetes			
	Muscular Dystropy			
	Eye Disease			
	Cystic Fibrosis / Lung Disease			
	Tuberculosis			
	Anemia / Blood Disorders			
	Bleeders / Hemophilia			
	Convulsive Disease (Epilepsy)			
	Hepatitis / Gall Bladder Disease			
	Peptic Ulcer / Colitis / Irritable Bowel			
	Venereal Disease			
	Kidney Problems (1) Infections			
	(2) Malformations			
	Eye Disease / Glaucoma			
	AIDS			

D. PRENATAL - PREGNANCY

1. During the pregnancy with this child, did the mother have:
   a. High blood pressure?..... ___no ___yes
   b. Protein in the urine?..... ___no ___yes
   c. Edema (swelling)..... ___no ___yes
   d. Diabetes (sugar in urine)?..... ___no ___yes
   e. Urinary tract infection?..... ___no ___yes
   f. Venereal disease?..... ___no ___yes
      If yes, please list_____
   g. Hepatitis?..... ___no ___yes
   h. Other infections?..... ___no ___yes
      If yes, please list_____
   i. Anemia?..... ___no ___yes
   j. Illnesses not listed above?..... ___no ___yes
      If yes, please list_____
2. During the pregnancy with this child did mother use:
   a. Alcoholic beverages?.... ___no ___yes
   b. Tobacco (smoke)..... ___no ___yes
   c. Controlled drugs?..... ___no ___yes
      If yes, please list_____
   d. Prescription drugs?..... ___no ___yes
      If yes, please list_____
   e. Hormones or DES prescribed?
      ___no ___yes
   f. Non-prescription drugs?
      ___no ___yes
      If yes, please list_____

E. LABOR AND DELIVERY RECORD

1. Was baby born on time or prematurely?
   ___On time ___Prematurely: ___wk. ___mo.
2. Was labor normal, induced or prolonged?
   ___Normal ___Induced
   ___Prolonged: ___Hours
3. Was delivery normal?..... ___no ___yes
   If abnormal, please check appropriate box:
   ☐ Precipitous ☐ Forceps used
   ☐ Vacuum cup ☐ C-Section
4. Was baby born head first?..... ___no ___yes
5. Was baby born breech?..... ___no ___yes
6. What was birth weight, length and head circumference?
   _____Weight _____Length _____Head Circumference
7. What were mother's and baby's blood group and Rh factor?

	Group (ABO)	Rh (+/-)
Mother		
Baby		

F. CONDITION OF BABY AT BIRTH AND DURING FIRST WEEK:

1. How was baby's health during its first week?
   ___Excellent ___Good ___Fair ___Poor
2. If baby's health was other than excellent, check terms used to describe its condition:
   ___blue ___yellow jaundice
   ___breathing problem ___needed oxygen
   ___infection ___birth defect
   ___transfusion (other):_____
3. Did baby stay in hospital longer than mother?
   ___no ___yes _____Days Longer
4. Was baby breast or formula fed?
   ___ Breast Formula Fed _____

G. NEWBORN SCREENING RESULTS

1. Phenylketonuria..... ___pos. ___neg.
2. Galactosemia..... ___pos. ___neg.
3. Congenital Primary Hypothyroidism..... ___pos. ___neg.

H. DEVELOPMENTAL MILESTONES: (Recall to the best of your ability)
How old was your child in months and years, when first able to:

___wks.	Lifts head (2-3)	___mos.	Spoon feeds (18)
___mos.	Rolled over (3-4)	___mos.	First word (12)
___mos.	Sat up (6-8)	___mos.	Two word phrase (24)
___mos.	Stood up (6-8)	___mos.	Toilet trained (24-30)
___mos.	Walked (12-15)	___ yrs.	Remembered full name (3-4)
___mos.	Drank from cup (12-18)	___ yrs.	Rode tricycle (3-4)
___mos.	Finger feeds (9-1)	___ yrs.	Dressed alone (4-5)

I. SAFETY AND ACCIDENT PREVENTION

1. Does your child always use a car seat or safety belt?	___no	___yes	Car Restraint
2. Are medicines, cleansing agents and other dangerous substances kept locked up or out of the way?	___no	___yes	Medicines Etc. accessible
3. Do you have Ipecac Syrup in the home?	___no	___yes	Ipecac Syrup
4. Do you have the telephone number of the poison control center?	___no	___yes	Phone No. or 911
5. Does your child know how to swim?	___no	___yes	Swimmer
6. Is your hot water heater temperature set low (below 120F)?	___no	___yes	Water set low
7. Is your home equipped with an adequate number of smoke alarms?	___no	___yes	Smoke Alarm
8. Do you have a safety gate if you have stairs?	___no	___yes	Safety gate
9. Do you have safety plugs in unused wall sockets?	___no	___yes	Safety plugs
10. Do you have any questions about childproofing your house?	___no	___yes	Safety Questions

CHILD'S NAME_____ DATE_____

J. EDUCATIONAL & SOCIAL HISTORY

In this section, your physician is keenly aware of your fears and concerns and sincerely respects and understands your need for confidentiality. Please feel free to discuss any of these worries with the doctor at anytime.

1. Name of school now attending _____ School
2. Grade now attending _____ Grade
3. Does your child have any problems at school? ____no ____yes Problems at school
4. Has your child failed a grade? ____no ____yes Failed a grade
   If yes, which grade? _____ Grade failed
5. Are the parents satisfied with child's school performance or behavior? ____no ____yes Satisfied with school performance
6. If no, please check areas of concern
   - Dislikes or hates school ____no ____yes Dislikes school
   - Learning problems in reading ____no ____yes Learning problems in reading
   - Learning problems in writing ____no ____yes Learning problems in writing
   - Learning problems in mathematics ____no ____yes Learning problems in mathematics
   - Learning problems in spelling ____no ____yes Learning problems in spelling
7. How would you describe your child's learning ability? ____fast ____slow ____Average learning ability
8. Check the characteristics that you feel best describe your child ____Good Child ____Happy ____Unhappy ____Stubborn
9. Is your child hyperactive? ____no ____yes Hyperactive
10. Can your child sit still for suitable period of time? ____no ____yes Sit still for suitable period
11. Does your child have a short attention span? ____no ____yes Short attention span
12. Does your child often act before thinking? ____no ____yes Acts before thinking
13. Does your child have difficulty organizing work? ____no ____yes Difficulty organizing work
14. Is your child frequently absent from school? ____no ____yes Frequent absences from school
    - if yes: due to behavior problems ____no ____yes Due to behavior problems
    - due to illness ____no ____yes Due to illness
15. Does your child relate well with sibs or peers ____no ____yes Relates well with sibs or peers
16. Does your child lie, steal, fight a lot? ____no ____yes Lie, steal, fight
17. Other concerns regarding your child? ____no ____yes Other concerns
    If yes, please list _____
18. Does your child have problems with homework? ____no ____yes Problems with homework
19. **After school:** **After School**
    - Does your child go home to parent or adult? ____no ____yes Goes home to parent or adult
    - Does your child go home to be alone for awhile? ____no ____yes Alone
    - Does your child go to a daycare center or sitter? ____no ____yes Goes to daycare or sitter
20. How many hours each day does your child watch television? _____ Hours watches TV
21. Does your child have problems with bladder or bowel control? ____no ____yes Bladder/Bowel training problem
22. Do you have concerns about your child's sexual development or experiences? ____no ____yes Sexual development or experiences

Abuse

23. Has your child ever been abused? ____no ____yes Child abuse
    - If Yes: physical abuse? ____no ____yes Physical
    - child neglect? ____no ____yes Neglect
    - Sexual abuse or exploitation? ____no ____yes Sexual
    - Excessive verbal abuse? ____no ____yes Verbal
24. Has your child witnessed spouse or adult-to-adult abuse? ____no ____yes Adult to Adult
25. Do you suspect or does your child have exposure to or involvement with illicit drugs, alchohol, tobacco? ____no ____yes ☐Illicit drugs ☐Alchohol ☐Tobacco

Listed below are a few of the signs or observations which might indicate or make you suspect drug abuse by your child:

- a) Change in attitude at school, home or neighborhood ____no ____yes
- b) Mood swings, increased irritability, angry outbursts ____no ____yes
- c) Neglect of home chores and homework ____no ____yes
- d) Change in appearance ____no ____yes
- e) "Skipping School", stealing, encounters with the law ____no ____yes
- f) Lack of communication with other family members ____no ____yes
- g) You discover a "stash" of drugs or alcohol or your own alcohol supply is dwindling ____no ____yes
- h) Other Signs: _____

Signs or Observations indicating Possible Substance Abuse

26. Do you have other concerns or fears you want to discuss with the doctor? ____no ____yes Concerns or fears to be discussed with doctor

K. FAMILY AND FAMILY SOCIAL HISTORY

1. Child lives with: ☐Both Parents ☐Mother ☐Father ☐Other Relative_____ ☐Foster Parents ☐Live-in Adults
2. List all persons living in this child's home

Name	Age	Relationship to Child	Name	Age	Relationship to Child
1.			4.		
2.			5.		
3.			6.		

Do the responsible adults in your family agree about how to raise your child? ____no ____yes Disagree about rearing

What is the last grade in school finished by your child's mother? _____ Mother's educational level

What is the last grade in school finished by your child's father? _____ Father's educational level

Is your child's family experiencing any marital, financial, housing, legal or other problems? ____no ____yes Marital, financial, housing or legal problems

ACUTE &/OR RECURRENT INFECTIONS, ILLNESSES OR MINOR PROBLEMS

(OTITIS MEDIA, TONSILLITIS, PNEUMONIA, SKIN PROBLEMS, VIRUS SYNDROMES, ETC.)

NAME:

DATE	DIAGNOSIS	TREATMENT	DATE	DIAGNOSIS	TREATMENT

IMMUNIZATIONS

NAME: _____

	DIPTHERIA TETANUS PERTUSSIS	TRIVALENT ORAL POLIO	TETANUS DIPTHERIA	MEASLES	MUMPS	RUBELLA	PNEUMOCOCCI VACCINE	HIB	OTHER:
DATE									
DATE									
DATE									
DATE									
DATE									
DATE									

FOREIGN TRAVEL IMMUNIZATIONS

IMMUNIZATION	DATE	IMMUNIZATION	DATE

TINE OR PPD	DATE					
	RESULT					

ALLERGIC REACTIONS:

DRUGS: _____ INSECTS: _____

FOOD: _____ POLLENS: _____

CONTACTANTS: _____ INHALANTS: _____

CHRONIC MAJOR PROBLEMS OR HANDICAPS (see over for acute &/or recurrent minor problems)

DATE	DIAGNOSIS	MEDICATION LIST		
		NAME OF DRUG	STRENGTH	SCHEDULE

HOSPITALIZATIONS

DATE	REASON / DIAGNOSIS

SURGICAL PROCEDURES

DATE	SURGERY

INJURIES - MINOR OR MAJOR

DATE	INJURY

MENTAL HEALTH OR PSYCHOLOGICAL PROBLEMS
(Enuresis, Sleep, Discipline, Learning, Etc.)

DATE	DIAGNOSIS	TREATMENT

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