YAKIMA INTEGRATIVE HEALTH
https://www.yakimaintegrativehealth.com/
307 S 12 Ave, Ste. 9 Yakima, WA 98902
Phone: (509) 469-2483 | Fax: (509) 469-8870

PEDIATRIC PATIENT REGISTRATION

Patient Information

Patient Name (Last, First, M.I.)		
Prefer to be called:	DOB	Legal sex ☐ M ☐ F
Living in home with child (choose all that apply) ○ Parents ○ Siblings ○ Other _____		
Emergency Contact Name:	Emergency Contact Phone:	
Who were you referred to us by? (if applicable)		

Primary Guardian

Guardian Name (Last, First, M.I.)			
Guardian Relationship to Patient	Guardian Email		
Street Address	City	St	Zip
Home Phone	Cell Phone	Work Phone	
Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone			
Do we have consent to send automated phone calls and text alerts? ☐ Phone calls only ☐ Text alerts only ☐ Both			

Secondary Guardian

Guardian Name (Last, First, M.I.)			
Guardian Relationship to Patient	Guardian Email		
Street Address	City	St	Zip
Home Phone	Cell Phone	Work Phone	
Preferred Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone			
Do we have consent to send automated phone calls and text alerts? ☐ Phone calls only ☐ Text alerts only ☐ Both			

Patient Insurance

Primary Insurance

Insurance Company Name		Co-Pay
Subscriber's ID	Group Number	
Subscriber's Name	Subscriber's Employer:	
Subscriber's Date of Birth	Subscriber's Sex ☐ M ☐ F	Patient's Relationship to Subscriber:

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Secondary Insurance

Insurance Company Name		Co-Pay
Subscriber's ID		Group Number
Subscriber's Name		Subscriber's Employer:
Subscriber's Date of Birth	Subscriber's Sex ☐ M ☐ F	Patient's Relationship to Subscriber:

Responsible Party

Who is responsible for charges on this account? (Typically the insurance policy holder) ☐ Parent ☐ Guardian			
Name (Last, First M.I.)			
Street Address	City	St	Zip
Home Phone	Cell Phone	Work Phone	

I, the parent or guardian, certify that this information is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information to process claims. I authorize my insurance claim to be paid directly to the clinic.

Patient or Legally authorized individual signature _____ Date _____ Time _____

Printed Name if signed on behalf of the patient _____ Relationship (parent, legal guardian, representative) _____

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Medical History

What are your current concerns regarding your child's health?

1. _____ 2. _____

3. _____ 4. _____

Current medications and dosage

_____

_____

Known allergies to medications

_____

Current supplements and dosage

_____

_____

Can your child swallow pills? Y N

Do you regularly put sunscreen on your child? Y N

Injuries/Surgeries/Hospitalizations

1. _____

2. _____

3. _____

Has your child had any of the following special studies? (please circle)

MRI	CT scan	X-ray	Hearing assessment	EEG	EKG/ECG
Language	Reading/Writing	Psych eval	Allergy testing	Other _____	

Has your child been immunized to the CDC recommended schedule? Y N

Has your child had any adverse reactions to immunizations? Y N

If you have chosen an alternative vaccination schedule, or have chosen not to vaccinate, please specify here:

_____

General Medical History

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

Baby acne	Y	N	P	Sore throat	Y	N	P	Blood in urine	Y	N	P
Eczema	Y	N	P	Cough	Y	N	P	Bladder infection	Y	N	P
Hives	Y	N	P	Ear infections	Y	N	P	Frequent urination	Y	N	P
Chronic rash	Y	N	P	Frequent colds	Y	N	P	Sleep problems	Y	N	P
Easy bruising	Y	N	P	High fevers	Y	N	P	Nightmares	Y	N	P
Night sweats	Y	N	P	Asthma	Y	N	P	Excessive fatigue	Y	N	P
Stomach aches	Y	N	P	Wheezing	Y	N	P	Nervous	Y	N	P
Decreased appetite	Y	N	P	Hearing loss	Y	N	P	Cries easily	Y	N	P

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Increased appetite	Y	N	P	Frequent headaches	Y	N	P	Unusual fears	Y	N	P
Diarrhea	Y	N	P	Bleeding gums	Y	N	P	Depression	Y	N	P
Constipation	Y	N	P	Nose bleeds	Y	N	P	Motion or car	Y	N	P
Gas	Y	N	P	Mouth sores	Y	N	P	Sensitive to light	Y	N	P
Vomiting spells	Y	N	P	Body or breath odor	Y	N	P	Dizzy spells	Y	N	P
Flat feet	Y	N	P	Hair loss	Y	N	P	Bleeding tendency	Y	N	P
Joint pains	Y	N	P	Heart murmur	Y	N	P	Physical trauma	Y	N	P
"Growing pains"	Y	N	P	Jaundice	Y	N	P	Emotional trauma	Y	N	P
Seizures	Y	N	P	Anemia	Y	N	P	Abuse	Y	N	P

Anything else not mentioned: _____

NEW BORN ONLY

Time of Birth _____ Birth Weight _____

Family Medical History

Please specify:

M = mother, F = father, PA/PU = paternal aunt or uncle, MA/MU = maternal aunt or uncle, MGF/MGM = maternal grandfather or grandmother, PGF/PGM = paternal grandfather or grandmother

Allergies	_____	Hypertension	_____	Diabetes	_____	Thyroid disease	_____
Arthritis	_____	Heart disease	_____	Mental illness	_____	Asthma	_____
Cancer	_____	Eczema	_____	Other	_____		

Mother's Prenatal History (if known)

Gestational age at child's birth _____

Was your child adopted? Y N

Health issues for mother during pregnancy (please circle)

Bleeding	Y	N	Diabetes	Y	N	Alcohol/drugs	Y	N
Nausea	Y	N	Thyroid problems	Y	N	Physical trauma	Y	N
Severe stress	Y	N	Cigarettes	Y	N	Emotional trauma	Y	N
Infections disease	Y	N	Birth complications	Y	N			

On a scale of 1 to 10, how committed are you to working to improve your child's health? _____

On a scale of 1 to 10, how much change are you willing to make to improve your child's health? _____

How does your child's state of health affect his or her daily life?

_____

_____

Guardian's Initials _____

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HEALTH HABITS AND PERSONAL SAFETY		
EXERCISE	In a typical week, how many times does your child do the following kinds of exercise for **more than 15 minutes** during their free time?	
	o Sedentary (no exercise)	
	_____ times per week	Mild exercise (climb stairs, walk 3 blocks, yoga, golf)
	_____ times per week	Moderate exercise (fast walking, tennis, dancing)
	_____ times per week	Vigorous exercise (running, jogging, soccer, long distance bicycling)
DIET	Does your child follow a special diet? Y N	If yes, specify:
	Does your child avoid any foods? Y N	If yes, specify:
	How much water does your child drink per day? _____	Is it filtered water? Y N Sometimes
	Please list the typical foods your child eats for:	
	Breakfast:	
	Lunch:	
	Dinner:	
	Snacks:	
CAFFEINE	o None o Coffee o Tea o Cola/soda	
	Number of cups per day _____	
DRUGS	Does your child currently use recreational or street drugs? Y N	

Active History

What does your child do with his/her free time? _____

What does your child do after school? _____

Does your child participate in any sports? Y N

Does your child participate in summer camp? Y N

Does your child have regular household chores/responsibilities? Y N

How many hours of TV does your child watch every day? _____

How many hours of non-school screen time does your child have each day? _____

School History

Has your teacher identified any special problems? Y N If yes, what? _____

How many hours per day does your child spend doing homework? _____

Does your child get along with other children? Y N Describe _____

Days absent per year _____

Does your child look forward to school? Y N

How does your child do in school? (please circle)

Well Average Needs some help In special education Needs tutoring Needs special counseling

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NOTICE OF PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Yakima Integrative Health respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

We may request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For health care operations:

We use your medical records to assess quality and improve services.

We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.

We may contact you to remind you about appointments and give you information about treatment alternative or other health-related benefits and services.

We may use and disclose your information to conduct or arrange for services including: medical quality review by your health plan, accounting, legal, risk management and insurance services, audit functions including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

Receive, read and ask questions about this Notice; Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted; Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information; Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing; Have us review a denial of access to your health information-except in certain circumstances; Ask us to change your health information. You may give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your Records. When you request, we will give you a list of disclosure of your health information. The list will not include disclosures of third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request information more than once in 12 months. Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing; Cancel Prior authorizations to us or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain Insurance.

Our Responsibilities

We are required to: Keep your protected health information private; Give you this Notice; Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Yakima Integrative Health. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver written complaint to Yakima Integrative Health. You may also file a complaint with the U.S. Secretary of

Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use or disclose your protected health information without your authorization as follows:

With Medical Researchers if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

To funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.

To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store or transplant organs.

To the Food & Drug Administration in relation to problems with food, supplements and products.

To Comply With Workers' Compensation Laws if you make a makes workers' compensation claim.

For Public Health and Safety Purposes as Allowed or Required by Law to prevent or reduce a serious, immediate threat to the health or safety, to public health or legal authorities, to protect health and safety, to prevent or control disease, injury or disability, to report vital statistics such as births or deaths.

To Report suspected Abuse or Neglect to public authorities

To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.

For Law Enforcement Purposes such as when we receive a subpoena, court order or other legal process, or you are the victim of a crime.

For Health & Safety Oversight Activities. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.

To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.

In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.

For Specialized Government Functions. For example, we may share information for national security purposes

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

The Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

Patient or Legally authorized individual signature	Date Time
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, representative)

This form will be retained in your medical record.

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ADDITIONAL CONSENT AND RELEASE FORM

Please list any other parties who can have access to your medical information. (This includes parents, step parents, grandparents, and any caretakers who can have access to your medical records.)

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

I authorize contact from this office to confirm and change my **appointments, treatment, and billing information** via:

- Cell phone confirmation
- Home phone confirmation
- Work phone confirmation
- Text message to cell phone
- Email confirmation
- Any of the above

I authorize **information about my appointments and medical health to be conveyed** via:

- Message on cell phone
- Message on home phone
- Text message
- Email message
- Any of the above

Date: _____

_____ _____
Please print your name Please sign your name

_____ _____
Legal Representative Description of Authority

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FINANCIAL POLICY

At Yakima Integrative Health, we understand that the medical system can result in complicated billing structures that cause stress for our patients, so we try to be completely transparent with our billing process. There are two models for billing that we use: insurance billing and direct pay. Below you will find information about both models.

INSURED PATIENTS

A list of insurances that our office can bill can be found on our website (address can be found in header). Please note that insurance benefits vary from plan to plan, and that your health insurance policy is an agreement between the Health Plan and yourself. We at Yakima Integrative Health make every effort to support billing your health insurance for your benefit, but we have found that as an integrative medical clinic, not all services will be deemed medically necessary by your health insurance carrier.

For insurances that we cannot bill or that do not cover the services provided in your treatment, we provide a transparent pricing structure at a discounted rate for direct-to-patient billing. You can find all the information necessary in the “Direct Pay Patients” section below. To know for sure whether your plan covers the cost of services provided at our clinic, please contact your insurance or visit their website to find out if the specific evaluation and procedure codes for your treatment plan are covered. Please contact the front office with any questions about the coding and billing.

If medical treatment is requested during an annual physical exam, the provider bills the insurance carrier for those services separately from the annual exam charge. Similarly, if the provider is credentialed both as an acupuncturist and naturopath and both modalities are used during the visit, the provider will bill for both services.

The amount of office or preventative visits, as well as the amount of acupuncture, massage therapy or osseous manipulation therapy visits, depends on your insurance plan. If coverage is denied due to overage of visits, you will be responsible for paying the balance. If a referral is needed per your insurance plan for coverage, please ensure the referral is submitted to your insurance before the time of your appointment.

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FEES AT TIME OF SERVICE

For insurance plans that require copay, these copays are due at the time of service. It is the patient's responsibility to know copay as well as what will and will not be covered by their insurance.

Because Yakima Integrative Health provides personalized and comprehensive medicine that does not always fit the typical medical model that insurance companies pay, there is a growing discrepancy between services provided and the reimbursement by insurance companies. As a consequence of this, YIH has instituted a **non-covered service fee for all insured patients**.

This out of pocket per visit fee helps cover the administrative costs, care coordination and other services not covered by your insurance plan. We will continue to bill your insurance for services they will cover and have added the non-covered service fee for services your insurance will not cover.

An example of some of these services not covered by insurance may include:

- Administrative work such as completing medical forms
- Managing labs and medication refills
- Messaging patients in the portal and doing individual research on behalf of the patient
- Managing the vaccine program
- The naturopathic care experience

The non-covered service fee will be $20 per visit, due at time of service.

DIRECT PAY PATIENTS

Visits that are direct-to-patient pay are at a flat-rate that is discounted from the full rate. Visits will be billed in accordance with what is performed at the time of visits; any additional testing or procedure performed at the office will be billed separately. Superbills (invoiced lists of services) can be provided after the visit.

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FINANCIAL POLICY AGREEMENT

I, _____ , a patient or legal representative of a patient of Yakima Integrative Health, do hereby acknowledge that my health insurance policy is an arrangement between the Health Plan and myself.

I understand it will be my responsibility to know my insurance policy and its benefits before arriving to my appointment. I also understand that certain services and tests may be ordered by the doctors located at Yakima Integrative Health which may not be covered by my insurance. I agree to be financially responsible for these services and tests should I consent for them to be performed.

I understand that I am financially responsible for any and all services and procedures that are performed with my consent for treatment, should I be paying directly or my insurance or third party payer deny or provide partial benefits for the services performed.

I understand that should I be a direct pay patient, I am financially responsible for all costs. I understand that payment is due at the time of service.

_____ _____

Signature Date

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OFFICE POLICY

Welcome! Thank you for selecting Yakima Integrative Health for your health care needs. Please take a few moments to familiarize yourself with our policies.

Office Hours
Monday – Thursday, 9:00AM to 5:00PM and Friday, 9:00AM to 3:00PM

Payment Policy
Payment is required at the time of service. For your convenience, we accept exact cash, personal checks, and debit/credit.

Insurance Billing
A list of insurances that our office can bill is on our website (address in header above). Any co-pay is due at time of service. Deductible and co-insurance fees are also the patient's responsibility. We ask that you check with your insurance provider before your first appointment to confirm coverage as naturopathic, acupuncture, massage therapy, and osseopathic services vary among insurances. At this time, Medicare does not cover our services and we cannot bill Medicare or any supplemental Medicare plans.

Late Policy
If you are more than 10 minutes late to your scheduled appointment, you will not be seen and will need to reschedule your appointment. You are subject to the missed appointment fee described below.

Missed Appointments
If you need to reschedule your appointment, please give us 24 hours' notice. We charge $100 for any appointments missed, canceled or rescheduled in less than a 24-hour notice.

Appointment Rates
Appointment rates vary by service and provider. Please inquire with the front desk for specific information

I, a patient of Yakima Integrative Health, have read the above policies and understand them.

Signature _____ Date _____

This form will be retained in your medical record.

Patient Name: _____

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CONSENT FOR TREATMENT: NATUROPATHIC CARE

General Information: Drs. Fuller, Hire, Nauman, and Robel are Naturopathic Physicians. Drs. Fuller and Robel are also licensed Acupuncturists. Due to the diversity of modalities that Yakima Integrative Health offers, your treatment may include any or all of the following general modalities: Acupuncture and Oriental medicine, Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling.
Methods, Procedures and Therapeutic Approaches: Your physician may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, blood lab work, urine lab work, general physical exams, neurological and musculoskeletal assessments)
Psychological Counseling, Lifestyle Counseling, Exercise Prescriptions
Herbs/Natural Medicines (prescribing of various therapeutic substances including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures – may contain alcohol; topical cremes, pastes, plasters, washes, suppositories, or other forms. Homeopathic remedies that often dilute quantities of naturally occurring substances may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment – may include intramuscular vitamin injections)
Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching as well as manipulation of the extremities and spine including traction and craniosacral therapy)

Potential Risks: Allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms.
Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or it progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

Telemedicine: I hereby consent to engaging in telemedicine with a Yakima Integrative Health provider (current or future visit). I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine involves the communication of my medical information, both orally or visually, to my health care practitioners. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand the information disclosed by me during the course of my treatment is confidential.

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I give permission for Yakima Integrative Health (Drs. Fuller, Hire, Nauman, and/or Robel) to give me medical treatment.

I allow Yakima Integrative Health providers to file for insurance benefits to pay for the care I receive.

I understand that

- Yakima Integrative Health will have to send medical information to my insurance company.
- I must pay my share of the cost.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand that

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

I understand that I may ask questions before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Yakima Integrative Health or any of its personnel regarding cure or improvement of my condition. I understand that record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me, or otherwise permitted or required by law.

Date:_____

_____	_____
Patient's printed name	Patient's signature
_____	_____
Guardian/Legal Representative printed name	Guardian/Legal Representative signature
_____	
Relationship/Representative's Authority	

This form will be retained in your medical record.