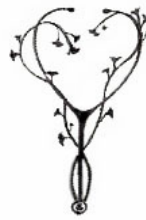


CONFIDENTIAL MINOR PATIENT INFORMATION

- Dr. Bobbi Lutack
- Dr. Paris Preston
- Dr. Jena Peterson
- Dr. Traci Taggart



EVERGREEN CENTER FOR
INTEGRATIVE MEDICINE
2008 NE 65th St
Seattle, WA 98155
(206) 729-0907

Patient Information	First Name:	MI:	Last Name:
Street Address:			
City:	State:	Zip:	
SSN:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Home phone:	
Date of Birth (mm/dd/yyyy): / /	Age:	Alt phone: ()	
Emergency Contact:		Relationship:	
Home phone:	Work phone:	Cell phone:	
Mother's Name:		Birthdate:	
Mother's Employer:	Occupation:	Work Phone:	
Father's Name:		Birthdate:	
Father's Employer:	Occupation:	Work phone:	
Referred by:			

Primary Health Insurance	Insurance Company:	Phone: ()
Claims address:		
Name of Insured:	Insured's Birthdate: / /	
Relationship to patient: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:		
ID # on card:	Group #:	
Employer of insured:		

I understand that I am financially responsible for all charges and agree to pay for services. I understand that if I fail to provide complete and accurate billing information at the time of service I may be billed and held responsible for all charges. I understand that if I fail to cancel an appointment at least 24 business hours in advance, I may be assessed a fee. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Parent/Guardian Signature _____

Date _____

PEDIATRIC HISTORY	Provide general description and dates for the following (to the best of your knowledge)
Born In: <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Home <input type="checkbox"/> Other Method: _____	
List present symptoms. List most important first:	
Vaccinations:	
Operations:	
Serious Illnesses:	
Medicines taken in last 5 years (include date and duration for major medicines - e.g. Amoxicillin, 3 mos., repeated ear infections 2/97):	
Current medications:	
Date of last checkup:	Doctor's Name & Phone:
Birth weight: lbs ounces	Length: inches Chest: Head:
List any chemicals, metals, dusts, smoke or fumes your child is repeatedly exposed to:	
Does your child react to pollens? If so, which ones?	
Does your child react to foods? If so, which ones?	

PEDIATRIC HISTORY	Provide general description and dates for the following (to the best of your knowledge)															
<p>If your child HAS or DID HAVE any of the following, please check:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Attention Deficit Disorder</td> <td><input type="checkbox"/> Excess Fatigue</td> <td><input type="checkbox"/> Hyperactivity</td> </tr> <tr> <td><input type="checkbox"/> Colic</td> <td><input type="checkbox"/> Frequent Cough/Wheezing</td> <td><input type="checkbox"/> Insomnia</td> </tr> <tr> <td><input type="checkbox"/> Eczema</td> <td><input type="checkbox"/> Frequent Infections</td> <td><input type="checkbox"/> Learning Difficulties</td> </tr> <tr> <td colspan="3"> </td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other: _____</td> </tr> </table>		<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Excess Fatigue	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Colic	<input type="checkbox"/> Frequent Cough/Wheezing	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Learning Difficulties	 			<input type="checkbox"/> Other: _____		
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<input type="checkbox"/> Eczema	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Learning Difficulties														
<input type="checkbox"/> Other: _____																

FAMILY HISTORY	If family members have had any of the following, please check:																
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> Blindness</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Nervous or Mental Disorder</td> </tr> <tr> <td><input type="checkbox"/> Alcoholism</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> High Blood Pressure</td> <td><input type="checkbox"/> Obesity</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Hypoglycemia</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Bleeding Tendency</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Kidney Disease</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>		<input type="checkbox"/> Allergies	<input type="checkbox"/> Blindness	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Nervous or Mental Disorder	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Obesity	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other: _____
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<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Obesity														
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Tuberculosis														
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other: _____														
<p>Which of the above does your child have, if any?</p> 																	

HABITS	Circle appropriate answer below
Milk / Formula:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Mother's Milk:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Sugars/Sweets:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Fruit Sweeteners:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Fast Food:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Protein Foods:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Vitamins / Minerals:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Aspirin:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Laxatives:	never rarely frequently weekly daily: once a day twice a day 3x / day 4x / day 5+x / day
Does your child eat a special diet?	
What are your child's favorite foods?	
What is your child's general disposition?	
How much does your child sleep?	
Does your child wear (circle): cloth diapers disposable none	

GENERAL
Are you willing to change your habits to help improve your child's health?
Does your child have any other problems you would like to discuss with the doctor?

CLINIC POLICIES

In order to establish clear communication between the patient and doctors, the following outlines the clinic policies regarding fees, policies and scheduling. Please note that each doctor is a sole proprietor. ECIM is not a group practice and therefore, each doctor sets their own fees, schedules and other policies regarding treatment.

Fees and Payment Fees are set by each practitioner. You have a right to ask what these fees are prior to the visit. If the visit runs over the scheduled time, the practitioner reserves the right to charge for additional time as they see fit. Payment is due at the time of service for office visits and dispensary items that are not covered by insurance. Co-payments, if applicable, are also due at the time of service. Dr. Preston and Dr. Peterson accept cash, check and Visa/Mastercard. Dr. Lutack accepts cash or check only. Sliding fee scales are determined on an individual basis by each practitioner.

Returned Check Fee Returned checks are subject to a \$25 fee.

Insurance Dr. Lutack, Dr. Preston and Dr. Peterson are covered by multiple insurance policies, including most of the major insurance carriers. This does not necessarily reflect the coverage for other practitioners within ECIM. ECIM is not responsible for verifying insurance coverage; it is the patient's responsibility to verify benefits and that the doctors are covered providers on your plan. The patient will be responsible for payment of any services not covered / paid for by insurance.

Appointment Cancellations When you make an appointment, we reserve that time specifically for you. If you must cancel an appointment, we ask that you give us at least 2 business days' notice for New Patient visits, or at least one business day (24 hours) for established patients. Failure to follow the cancellation policy will result in a charge. We do our best to run on time, but as each doctor tries to give every patient the best care possible, it is common for the doctor to be running behind. We suggest calling ahead to find out whether your practitioner is on time.

Phone Consults / Emergency Pager There is no charge for brief questions that can be answered by the staff or doctor. If the call is regarding a more complex issue, the doctor may request that the patient come in for a visit and also reserves the right to charge a fee for the phone consult. The **emergency pager** is to be used by established patients only for truly urgent medical needs that occur outside of regular business hours. The doctor reserves the right to charge a fee of \$65 per page depending on the complexity of the issue.

Returns on Dispensary Items Unopened supplements can be returned within 30 days of purchase for a full refund with the exceptions of: acidophilus products, suppositories, compounded hormones, amino acids, and specialty order items.

Scents ECIM maintains a scent-free environment and we ask that you respect our more sensitive patients by refraining from wearing perfume or cologne on days of your visit, as well as avoiding smoking prior to entering the clinic.

If you have any questions regarding these guidelines, please ask. By signing below you agree to the above policies.

Signature _____ Date _____

CONSENT FOR TREATMENT

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, radiology, blood and urine lab work, general physical exams, neurological and musculoskeletal assessments.

Psychological and Lifestyle Counseling, Exercise Prescriptions

Herbs/Natural Medicine: Prescribing of various therapeutic substances including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, and tinctures (which may contain alcohol) topical creams, pastes, plaster washes, suppositories or other forms. Homeopathic remedies (often highly diluted quantities of a naturally occurring substance) may also be used.

Dietary Advice and Therapeutic Nutrition: The use of foods, diet plans, or nutritional supplements for treatment. This may include intramuscular vitamin injections.

Soft Tissue and Osseous Manipulation: The use of massage, neuro-muscular techniques, muscle-energy stretching or visceral manipulations of the extremities and spine including traction and craniosacral therapy.

Potential Risks: May include pain, discomfort, discolorations, infection, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing symptoms or conditions.

Potential Benefits: Restoration of health and the body's maximum functional capacity, relief of pain, and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

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

Statement of Consent For Treatment:

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participating in these procedures at any given time. With this knowledge, I voluntarily consent to the above procedures, realizing and acknowledging that no guarantees have been given to me by my doctor/practitioner or any of their personnel regarding cure or improvement of my condition(s). I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or as otherwise permitted by law.

Guardian/PatientsName(print)

Guardian/Patients Signature

Date

PATIENT-PRACTITIONER RELATIONSHIP

I understand that I am a patient of _____, who is an independent practitioner at The Evergreen Center for Integrative Medicine. The Evergreen Center is not a group practice, but rather a facility where independent practitioners share office space. I understand that my medical care is the sole responsibility of the individual practitioner, not The Evergreen Center for Integrative Medicine or any of the other practitioners who may practice there.

If I am seeing more than one practitioner at this clinic, I understand that each practitioner is required to keep separate records and will be billing for services separately from any other practitioners at this clinic.

Patient Name (please print)

Date

Patient/Guardian Signature

Relationship to Patient

NOTICE OF PRIVACY PRACTICES

The Evergreen Center for Integrative Medicine (ECIM) is required to provide you with a copy of its "Notice of Privacy Practices" document and to obtain written acknowledgement, if possible, that you have received it. This notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:

- * Provide and coordinate my treatment
- * Obtain payment from third-party payers for my health care services
- * Conduct normal health care operations such as quality assessment and improvement activities

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy.

My signature below acknowledges that I have (please check one):

_____ been offered a copy of the Notice of Privacy Practices document and have accepted that copy.

_____ been offered a copy of the Notice of Privacy Practices document and have declined a copy. I understand that I can request a copy at any time in the future, and be given a current copy.

Patient/Guardian Signature

Relationship to Patient

Date

Office Use Only

I hereby affirm that ECIM has made a good faith effort to provide a copy of the Notice of Privacy Practices to the above named patient and to obtain written acknowledgement of such.

Staff Initials: _____

Staff please check one:

_____ Pt offered but refused to sign _____ Pt. physically unable to sign

_____ Communication barrier / other reason: _____