Welcome to Aspire Natural Health.

Thank you for choosing to work with us, we look forward to meeting you and your child.

Your first appointment will be 90 minutes in length.

Please bring to your First Visit:

1. Completed paperwork
2. Any medical records you have
3. Any supplements or medications your child is taking or thinking about taking (please bring the bottles or full label)
4. Any questions you have
5. Notepad or paper to take notes

To Save Trees – Only pages 2, 3, 4, 5, 6 and 13 need to be printed out to give to us. We are legally required to ask you to look at the privacy policies (pages 8-12). And it's best if you look at our prices on page 7, so you're not surprised by anything.

We will give you a reminder call the day before your visit. We respect your time, please respect ours by giving us at least 24 hours notice if you need to cancel or reschedule your appointment. If you don't, we may charge you (see the Prices & Payment policies sheet for more info).

We are located at: 16455 NE 85th St Suite 102, Redmond, WA 98052. For directions and an electronic map click on the directions link at our website: www.aspirenaturalhealth.com or call our office at: (425) 202-7849.

Please feel free to call or email if you have any questions prior to your appointment. We look forward to starting your healing together.

Sincerely,

The Doctors and Staff of Aspire Natural Health

Children's Health Overview for 6-12 years

Please complete and return

This form helps us get a more complete understanding of your child. Please fill it out as completely as possible, we appreciate the time you spend on it. Mark anything that you do not understand with a question mark. Thank you.

Patient's name: ____

Age: _________ Date of Birth: _____/_____/_____ Gender: female / male

Mother's name:___________________________ Father's name: _________________________________

Parent's relationship: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Address: ______________________________________ City: _______________ State: _____ Zip: ____________

Contact parent: ____________________________

Parents Phone # (home): (_____)________________ (work): (_____)_______________ (cell): (_____)________________

May we leave confidential voice-mail messages for you at any of the above numbers? No / Yes (specify): **Home / Work / Cell**

Parents e-mail address: ____

May we leave confidential E-mail messages for you at the above address? No / Yes

______ (initials) I understand that it is possible if my child's personal health information is sent over email that it may be viewed by others. I recognize and accept this possibility and authorize my doctor to communicate my child's personal health information with me over email.

How did you hear about our clinic? ____

What are your child's most important health concerns? List as many as you can in order of importance:

1. ____

2. ____

3. ____

4. ____

5. ____

What expectations would you like us to meet?____

____

Does your child have a contagious disease at this time? Y / N

If yes, what? ____

MEDICAL HISTORY

_______ Chicken pox _______Tonsillitis, approx. no. ______________________
_______ Measles _______ Pneumonia Ear infections, no. __________________________
_______ Mumps _______ Frequent colds Other (please list) __________________________
_______ Rubella

Has your child been vaccinated? Y / N / Selective (partial) vaccination
Any adverse reactions? Y / N What ? ______________________________________

Injuries/Surgeries/Hospitalizations (please list): ____
____
____
____
____

FAMILY HISTORY

Member	Age	Important diseases	Living?	Cause of death
Mother				
Father				
Siblings				
Siblings				
*MGM				
*MGF				
*PGM				
*PGF				

M = Maternal (Mother) P = Paternal (Father) GM = Grandmother GF = Grandfather

Any other important family history? ____
____

What is your child's ethnic background? ____
____

PRENATAL HISTORY

Previous pregnancies by birth mother, miscarriages, or other complications ________________________________
____

Mother's age when child was conceived / born? _______

Mother's health during pregnancy?

_____ Threatened miscarriage _____ Physical or emotional trauma

_____ Nausea
_____ Depression/Anxiety
_____ High blood pressure
_____ Diabetes
_____ Yeast infections / Thrush
_____ Cigarettes, alcohol, other drug consumption
_____ Medications
_____ Thyroid problems
_____ Antibiotic use

Other health issues: ____

BIRTH HISTORY

Term: _____Full _____Premature _____Late Weight at birth _____________________

Length of labor ______________ Complications? ____

_____Hospital birth _____Birth center _____Home birth

Did your child have any of the following problems shortly after birth?

_______ Birth defects _______ Birth injuries _______ Blue baby

_______ Seizures _______ Jaundice _______ Colic

_______ Fever(s) _______ Rashes

Other (explain) ____

EARLY HISTORY

Child's sleep (first year) ____

Food intolerances (if any) ____

Feeding: Breast fed? _____ how long? ___________ Formula? ___ milk / soy / other ___________

Age began solids ___________________________ Which foods? _____________________________________

Age began: Sitting _____________ Crawling ____________ Walking ______________ Talking __________________

Allergies

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods? ____

Any environmental substances (pollen, dog dander, etc.)?____

Typical Day's Food

Breakfast:____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking. Please include dosage:

1) ____________________ 5) ____________________

2) ____________________ 6) ____________________

3) ____________________ 7) ____________________

4)____________________ 8)____________________

HEAD TO TOE REVIEW

Y = a condition now **P** = significant problem in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y P N	Anxiety/nervousness	Y P N
Irritability	Y P N	Cries easily	Y P N
Hyperactivity	Y P N	Poor concentration	Y P N
Unusual fears	Y P N	Nightmares	Y P N
Introvert / extrovert			

HORMONAL

Heat / cold intolerance	Y P N	Fatigue	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Hypoglycemia (low blood sugar)	Y P N	Diabetes	Y N

SKIN

Rashes	Y P N	Eczema / Hives	Y P N
Acne	Y P N	Itching	Y P N
Skin ☐ Normal ☐ Dry ☐ Oily			

HEAD

Headaches	Y P N	Head Injury	Y P N
Dizziness	Y P N	High fevers	Y P N

EYES

Glasses or contacts	Y P N	Excessive tearing or dryness	Y P N
Eye pain	Y P N		

EARS

ASPIRE
NATURAL HEALTH
Work better. Play better. Live better.

Ear infections	Y	P	N	Problems hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus infections	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N	Cavities	Y	P	N
Braces	Y	P	N	Teeth grinding	Y	P	N

LUNGS

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

HEART & BLOOD

Heart murmurs	Y	P	N	Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N				

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N
Urinary tract infections	Y	P	N				

DIGESTIVE

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N

Bowel Movements How often ____

MUSCLES & BONES

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N				

Is there any information about your child's health that you would like to add?

Prices and Payment Policies

Please read & keep

Our goal is to provide you exceptional value by giving the best care we can. This page explains our prices and payment policies. If you have any questions or need any clarification please let us know, we are happy to help.

Payment for your visit and any supplements or medications you purchase is due at the end of your visit. We do not accept insurance coverage for the services and goods we provide. If you ask, we will give you the codes and paperwork to submit to your insurance company for reimbursement. The amount you get back depends on your insurance company and the policy you have. We highly recommend you call them and ask what they reimburse for 'Out of Network' doctor visits.

Rates for office visits:	
New Client visit (90 minute)	$225
Return Client visit (45 minute)	$110
Acute &/or Brief visit (20 minute)	$50
Extended visits (per 15 minutes / 30 minutes)	$40/$75

Phone calls & Email

We are happy to answer questions and do brief follow-ups for on-going treatments or treatments received within the past 30 days, by phone or email, as a free service to our patients. Extended phone calls or emails, or calls or emails on new issues may be charged at the rate of $150 per 60 minutes, based on the amount of time used.

Canceled and missed appointment charges

When you set an appointment with us, we set aside a significant amount of time for you.. Please give us 24 hours notice if you need to cancel or reschedule your appointment. There is no charge for visits canceled with 24 hours or more notice. There is a $25 fee for visits canceled with less than 24 hours notice. If you don't show up for your visit and don't give us any notice, there is a $50 charge. If you have an emergency, let us know, we want to help, and can waive the charges.

Pharmacy

We keep a pharmacy of high quality supplements for your convenience. All pharmacy items need to be paid for before you take them home. We take pride in the supplements we sell, and want you to be happy with your purchase. If you have a problem of any kind with them, let us know and we'll fix it for you.

Methods of payment

We accept payment by cash, Mastercard, Visa or check.

Notice of Privacy Practices

Please keep for your records

We respect your privacy and understand that your medical information is personal and sensitive. We are required by the 1996 Health Insurance Portability and Accountability Act (HIPAA) to make sure that medical information that identifies you is kept private. This *Notice of Privacy Practices* describes how we may use or disclose your protected health information at our clinic. We are required to give you this notice of our legal duties and abide by the terms of this notice; however, we may change our notice at any time. **Please note that any new notice adopted will be effective for all protected health information maintained at the time of change.** You will not be notified individually if a change is made to our notice, however, upon request, we will provide you with a copy of our current notice. You may always obtain a copy of our current notice by any of the following means:

1. Accessing our website at **www.aspirenaturalhealth.com**
2. Contacting our office by mail or by phone at the listed address and phone number
3. Asking for a copy at the time of your next visit.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include sharing information obtained by another healthcare practitioner used to help decide what care may be right for you.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment which may include your diagnoses, procedures performed or recommended care.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, employee reviews, auditing functions, licensing, cost-management analysis, marketing and fundraising activities and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our clinic and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

Your Health Information Rights

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request and receive from us a paper copy of our most current Notice of Privacy Practices.
- The right to ask us to restrict uses and disclosures of your protected health information. You must deliver this request in writing to us. We are not required to agree to those restrictions, but will review your request and inform you of any action taken. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. You must make this request in writing to the Office Manager. We may charge you a fee for the cost of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request in certain limited circumstances in which case you may have another health care provider of the same specialty review your records—except in certain circumstances.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information. You must make this request in writing to the Office Manager and may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in a 12 month period.
- The right to cancel prior authorizations to use or disclose health information. You must make this request in writing to the Office Manager. Your revocation does not affect information that has already been released nor any action taken before we received your revocation.

Our Responsibilities

We are required by law to:

- Keep your protected health information private
- Provide you with this notice of our legal duties and privacy practices
- Abide by the terms of the Notice of Privacy Practices

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

Other Uses and Disclosures of Your Protected Health Information

To Others Involved in Your Healthcare: Unless you object, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person you identify, to the

extent the information directly relates to that person's involvement in your health care. We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

In Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your physician or another physician in the practice must treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Legally Permitted/No Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization:

- **When Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law(s) and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures only if required by law.
- **For Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **For Health Oversight/Compliance Monitoring:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **To the FDA:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may disclose protected health information for law enforcement purposes, so long as applicable legal requirements are met. Such purposes generally include: 1) those required by law; 2) limited information requests for identification and location purposes; 3) those pertaining to victims of a crime; 4) suspicion that death has occurred as a result of criminal conduct; 5) those where a crime occurs on the premises of the practice; and 6) medical emergencies where it is likely that a crime has occurred.
- **Research:** We may disclose your protected health information to researchers when an institutional review board has approved their research. The institutional review board will have reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel to authorized authorities; such as for determinations of your eligibility for benefits. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President, foreign heads of state or others legally authorized.
- **Workers' Compensation:** We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose your medical information to a coroner, medical examiner or funeral director, if necessary, for them to carry out their duties should you die.
- **Correctional Institutions:** If you are in jail or prison, we may disclose your information as necessary for your health and the health and safety of others.

Specially-Protected Information

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is released.

To Ask for Help or Make a Complaint

If you have questions about this notice, want more information, want to request forms for submitting written requests, or want to report a problem about the handling of your protected health information, you may contact:

Aspire Natural Health
16455 NE 85th St. Suite 102
Redmond, WA 98052
(425) 202-7849

If you feel that your privacy protections have been violated, you have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We respect your right to file a complaint and will not retaliate against you for doing so.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Acknowledgment of Receipt of Privacy Practices

Please sign & return

Aspire Natural Health keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to have corrections made to 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. This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I ___________________________________ hereby acknowledge that Aspire Natural Health has provided me with a copy of its **Notice of Privacy Practices** that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions of complaints I may contact:

Tim Gerstmar, ND (425) 202-7849

I also understand that I am entitled to receive updates upon request if Aspire Natural Health amends or changes its Notice of Privacy Practices in a material way.

____________________________ ________________________________

Signature Relationship to patient

If signed by someone other than patient

____

Date