New Patient Office Policy

Wellness Architecture is a cash office and payment is expected at time of service. Payment methods include check, American Express, Visa, Mastercard, Discover, check or cash. If you have an insurance policy that will reimburse you for naturopathic medicine visits we will provide you with a superbill with appropriate diagnostic and billing codes that you can submit to the insurance company for reimbursement of your visit. We suggest that you make a copy of the superbill prior to submission because of consistent insurance clerical error. Our office will not interact with insurance companies on your behalf.

Cancellation Policy

We have a **48 hour cancellation/reschedule** policy. If you do not call our offices 48 hours prior to your scheduled appointment, you will be charged a **100% of missed appointment fee**.

We require a credit card number for our records to schedule your first appointment. Your credit card will not be charged unless you do not provide adequate cancellation notice and will be kept on file for missed appointments or appointments with inadequate cancellation notice.

By signing below, I agree that I have read and understood the policy. I guarantee payment of all charges incurred as a patient of Wellness Architecture.

Signed:_____Date: _____

Printed Name: _____Date: _____

Parent or Guardian (minor): _____Date: _____

Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.

5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family member and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Wellness Architecture, 841 El Camino Real, Menlo Park, CA 94025.

   Note: We must respond to this request within 30 days.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Wellness Architecture, 841 El Camino Real, Menlo Park, CA 94025.

Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. McCully at Wellness Architecture. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or out health information privacy policies, please contact Dr. McCully at Wellness Architecture.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 Wellness Architecture 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 or complaints I may contact:

Dr. Samia McCully
650-233-7327

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

_____ _____

Signature Relationship to Patient, if signed by someone other than patient.

_____

Date

THIS SECTION IS TO BE COMPLETED BY WELLNESS ARCHITECTURE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____

Name and title of employee Date

INFORMED CONSENT FOR TREATMENT

I,_____, hereby authorize Dr. Samia McCully Naturopathic Doctor of Wellness Architecture Naturopathic Services INC. to preform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to Methylcobalamin, side effects such as pain at injection site, swelling at injection site, rash, hot sensation, sweating, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, improved sleep, improved energy, aide in relief of neuralgias and neurological disorders, and prevention of disease or its progression.

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

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees has been given to me by Wellness Architecture Naturopathic Services Inc. or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to other unless so directed by my representative or myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit.

Patient Signature:

_____

Date:____/____/____

Signature of Patient Representative or Guardian:

_____

Pediatric Health History Form

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them in the comments section. The completed form will greatly assist us in providing a thorough evaluation of your health.

Confidential Patient Profile

Name:_____ Age:_____ Date of Birth: _____Sex:_____

Address: _____ City:_____State: _____Zip Code:_____

Mother's Name:_____ Cell: _____ Work: _____ Home: _____

Father's Name: _____ Cell: _____ Work: _____ Home: _____

Mother's E-mail:_____Father's E-mail:_____

How did you hear about us? _____

Chief Complaint: In this section please list in order of importance your health concerns. Chief Complaint: In this section please list in order of importance your health concerns.

1._____ 5._____

2._____ 6._____

3._____7._____

4._____ 8._____

Current Medication List: In this section please list all pharmaceutical medication(s) that you are currently taking along withdosage and frequency

1._____ 5._____

2._____ 6._____

3._____7._____

4._____ 8._____

Are you allergic to any medications? YES ! ☐ NO ! ☐

If "Yes", please list:_____

What happens when you have an allergic attack to medication? _____

Have you ever been treated with antibiotics? YES ! NO ! How many times: _____

Hospitalizations: Include reason, year and duration:

_____

Current Supplement List: In this section please include all homeopathic, herbs, vitamins, minerals you are current taking with dosage.

1._____ 5._____

2._____ 6._____

3._____7._____

4._____ 8._____

School Grade: _____ **School Name:** _____

Previous or referring doctor:		**Date of last physical exam:**	

Mom's Pregnancy

☐ Uncomplicated
☐ Early Labor
☐ Bleeding
☐ Diabetes
☐ Thyroid Problems
☐ Pre-eclampsia

Medications During Pregnancy/Birth (besides prenatal vitamins):
☐ None
☐ Other – Please name:

Post Natal Complications

☐ None
☐ Jaundice
☐ Respiratory
☐ Cardiac
☐ Infections
☐ Gastrointestinal
☐ Hospitalized. How long and why?

Birth History:
Weight (Lbs): _____ Weeks:_____ ☐ Full Term ☐ Preterm

☐ Vaginal ☐ C-Section ☐ Reason for C- Section _____

Development History: Rolled Over at (age) _____ Walked at _____ Sat at _____ Talked at _____

☐ Nursed? If yes until what age? _____

Immunizations ***(check and cirlce how far in the series)***				
	☐ Diptheria ☐ Pertussis ☐ Tetanus	2mo 4mo 6mo 16-18mo 4-6 yrs 11yrs (tetanus only)	☐ Pneumococcal	2mo 4mo 6mo 12-15mo
	☐ Hepatitis B	Birth-2mo 1-4mo 6-18mo	☐ Chickenpox	12mo
	☐ HIB	2mo 4mo 6mo 12-15mo	☐ Measles ☐ Mumps ☐ Rubella	12-14 mo 4-6 yrs
	☐ Polio OPV or IPV	2mo 4mo 6-18mo 4-6yrs	Other?	
	Any reactions to immunizations? Please Describe:			

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Has your child ever had a blood transfusion?

☐ Yes ☐ No

HEALTH HABITS AND PERSONAL SAFETY

On a scale of 1-10, how would you rate your energy (10 being the highest)?

Sleep Pattern: ☐ Normal ☐ Difficulty falling asleep ☐ Frequent waking ☐ Nightmares ☐ Night terrors ☐Other
Sleep Position: _____
During Sleep do you: ☐ Grind Teeth ☐ Perspire ☐ Talk ☐ Snore ☐ Walk

Are you exposed to any hazardous substances? (Yes / No) If yes what?

Academic Performance: ☐ Excellent ☐ Average ☐ Difficult

Physical activity is performed ? (Yes / No), if yes, what kind, how much & how often?

Interaction with other children: ☐ Very well ☐ Average ☐Poor

Current weight? _____ Height _____

Excessive Fears: ☐ Water ☐ Being alone ☐ Thunder ☐ Dark ☐ Flying ☐ Strangers

☐ Animals: Which ones? _____ ☐ Other: _____

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Siblings**	☐ M ☐ F	
Mother				☐ M ☐ F	
Grandmother *Maternal*				☐ M ☐ F	
Grandfather *Maternal*				☐ M ☐ F	
Grandmother *Paternal*				☐ M ☐ F	
Grandfather *Paternal*				☐ M ☐ F	

Do you have any blood relative, aunt, uncle, or grandparent who has had any of the following (check any that apply):

☐ Autism	☐ Anemia	☐ Stroke	☐ Syphilis
☐ Arthritis	☐ Depression	☐ High blood pressure	☐ Seizures
☐ Asthma	☐ Tuberculosis	☐ Brain Tumors	☐ Sickle cells
☐ Bipolar Disorder	☐ Heart disease	☐ Schizophrenia	☐ OCD
☐ Tics	☐ Gonorrhea	☐ Cancer	☐ Aneurysm

Check conditions YOU have or ever had in the past:

- ☐ Aggressiveness
- ☐ Allergies
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Biting
- ☐ Bronchitis
- ☐ Chicken -Pox
- ☐ Colic
- ☐ Ear infections
- ☐ Eczema
- ☐ Encephalitis
- ☐ Head Banging
- ☐ Head injuries
- ☐ Headaches
- ☐ Hitting
- ☐ Meningitis
- ☐ Passing out
- ☐ Pulling own hair
- ☐ Seizures
- ☐ Stuterring
- ☐ Teeth grinding
- ☐ Whooping cough

Sensitivity to:

- ☐ Sound
- ☐ Tough
- ☐ Smell

REVIEW OF SYSTEMS
CIRCLE symptoms that your child currently has or has had in the last YEAR

	General: **Chills, Fever, weight loss, fatigue, cravings, weight gain, changes in appetite, trouble sleeping, cold hands/feet, night sweats, Poor memory, other:**		Cardiovascular: **Chest pain, high blood pressure, irregular heart beat, low blood pressure, poor circulation, swelling of ankles, varicose veins, difficulty breathing, other:**
	Skin: Bruise easily, eczema, psoriasis, hives, rash, itching, changes in moles, ulcerations, change in hair/skin texture, other:		**Musculoskeletal:** muscle weakness, muscle pain, back/neck pain, joint pain or swelling, injuries, numbness, other:
	Eye, Ear, Nose, Throat: Bleeding gums, blurred vision, double vision, earache, ear discharge, hay-fever, hoarseness, loss of hearing, nosebleeds, ringing in ears, sinus problems, difficulty swallowing, cold sores, other:		**Gastrointestinal:** Poor appetite, bloating, constipation, diarrhea, bowel changes, vomiting, gas, hemorrhoids, indigestion, nausea, rectal bleeding, stomach pain, bad breath, belching, black stools, vomiting, vomiting blood, other:
	Neurological: headache, dizziness, tremors, fainting, seizures, forgetfulness, nervousness or anxiety, numbness, other:		**Endocrine:** excessive thirst, excessive hunger, hormonal imbalances, heat/cold intolerance, other:
	Genito-urinary: frequent urination, pain on urination, poor bladder control, kidney stones, wake up to urinate, blood in urine, other:		**Respiratory:** Persistent cough, shortness of breath, wheezing, coughing up blood, production of phlegm, difficulty breathing when lying down, tight chest, asthma, bronchitis, other:

LIFESTYLE HABITS:

What behaviors or habits does your child engage in regularly that support his/her health?

What behaviors or habits does your child engage in regularly that poorly affect his/her health?

What are your expectations for today's visit?

Any additional information you would like to add:

Thank you for your time and effort. We look forward to your visit.