Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

Dear _____,

Welcome to the Full Circle Center for Integrative Medicine. We are looking forward to working with you and your child. In preparation for your initial visit with us, we would like you to complete some paperwork BEFORE your first appointment. This includes demographic and insurance information with a Consent for Treatment, a Health History Questionnaire, an Acknowledgement of Receipt of HIPAA Privacy Information, and a Consent for Use of the Patient Portal (for secure electronic communication.) If you prefer to type directly onto these forms, they are available on our website at www.fullcirclemed.org on the New Patient page.

The Health History Questionnaire is quite detailed. We understand that completing this form requires a substantial amount of your time, however we feel gathering this detailed information prior to the visit allows us to accomplish more with your time in the office and to provide your child with the level of holistic health care she or he deserves. Thank you for your patience with this. Ideally, please return this to us prior to your visit; that will allow us time to review it and to research your child's condition prior to your visit if needed.

If your child is age12 – 18, we would like them to complete an additional form prior to the visit. In the state of California, certain issues (reproductive health and mental health) may be confidential for adolescents, though we always encourage kids to talk to their parents about these issues.

On the day of your visit, please bring the following items with you:

Your completed paperwork if not already sent in

Your insurance card

Your child's current medications and supplements -- IN THEIR BOTTLES

Pertinent medical records, if you have them

Thank you, and take care,

The Full Circle Center

Acknowledgement of Receipt of Notice of Privacy Practices

Full Circle Center for Integrative Medicine
4641 Valley East Blvd, #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

ٱ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____

Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Full Circle Center
4641 Valley East Blvd., #2
Arcata, CA 95521-4630
707-840-4701
Fax 855-420-6321

New Patient Demographic and Insurance Information

Title: _____ Patient Name:_____ Gender: _____
Address: _____
City: _____ State: _____ Zip code: _____
Cell phone: _____ Home Phone: _____
E-mail address: _____
I prefer to receive notification of confidential results via: ❒Phone ❒E-mail ❒Snail Mail
Marital Status: _____ Employer: _____
Date of Birth: _____ Social Security Number: _____
Preferred Language: _____ Ethnicity and Race (Optional): _____

Responsible Party (Person financially responsible for this account, if other than patient):
Title: _____ Name: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip code: _____
Cell phone: _____ Home Phone: _____
E-mail address: _____
DOB: _____ Social Security #: _____

Insurance information
Primary Insurance Carrier Name: _____
Insurance Address: _____
Insurance Phone Number: _____
Group Name: _____ Group #: _____
Subscriber Name: _____ Subscriber ID with Insurance Company: _____
Subscriber Gender: ___Subscriber DOB: _____Subscriber SSN: _____
Subscriber relationship to patient: _____

If the patient is covered by a secondary insurance policy, please complete the information below for coordination of benefits. This will enable the insurance company to process the claim more quickly.
Secondary Insurance Carrier Name: _____
Insurance Address: _____
Insurance Phone Number: _____
Group Name: _____ Group #: _____
Subscriber Name: _____ Subscriber ID with Insurance Company: _____
Subscriber Gender: ___ Subscriber DOB: _____Subscriber SSN: _____
Subscriber relationship to patient: _____

If covered by Workers' Compensation or insurance related to an accident, please fill out the information below:

Person responsible for payment: _____
Date of Injury: _____
Industrial Claim #: _____
Name of Insurance Company or Program: _____
Address: _____
Policy number: _____
Were you injured on the job? _____

I hereby give authorization for payment of insurance benefits to be made directly to my Healthcare Provider at the Full Circle Center for Integrative Medicine, and any assisting physicians, for services rendered. This authorization shall remain valid until written notice is given by me revoking such authorization.

I understand that I am fully responsible for all charges whether or not they are covered by insurance. A service charge of ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 30 days of treatment date. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees.

I understand that nutritional consultation and herbal consultation are not covered by insurance and that there will be a surcharge for these services.

I hereby authorize the release of any medical information needed to secure the payment of benefits. I further agree that a photocopy of this document shall be as valid as the original. I also authorize discussion of my case among the providers at Full Circle.

_____

Signature of Patient or Responsible Party Date

Full Circle Center for Integrative Medicine
4641 Valley East Blvd, #2
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707-840-4701
Fax 855-420-6321

New Patient History Questionnaire, Child

Name_____ Current Date_____

Date of Birth _____

Welcome to our office. This questionnaire has been designed so that we can both review your child's medical history and factors in her/his life that affect health. It is long and detailed! You may use an additional sheet of paper if needed. Some questions may not apply, depending on the age of your child; you may skip these. All information collected will be kept strictly confidential. Thank you for your patience. If you have a teenager, they will be given an additional form to fill out themselves. Items pertaining to mental health and/or birth control may be confidential, even from you, according to state law.

General Health: ❒ excellent ❒ good ❒ fair ❒ poor

What do you hope to achieve in your care with us?

❒ New primary care doctor ❒ Consultation about a specific problem

_____

If your child is ill, when was the last time your child was well? _____

Did something trigger your child's change in health? _____

Please list current and ongoing problems in order of priority:

Describe problem	Mild	Moderate	Severe	Prior treatment/approach	Good	Fair	Poor
Example: Difficulty maintaining attention		*X*		*Elimination diet*		*X*	

If you had a magic wand and could help your child in 3 ways, what would they be?

1. _____
2. _____
3. _____

Past Medical Illnesses:

(Please list any illnesses that have required hospitalization and any other significant health problems)

❒ problems during pregnancy, birth, or in the newborn period

Difficulty getting pregnant or problems during pregnancy: _____

❒ Vaginal birth ❒ Cesarean section

Antibiotics in labor: ❒ Yes ❒ No

Birth weight: _____ Full term? ❒ Yes ❒ No # weeks early_____

Breast fed? ❒ No ❒ Yes - For how long? _____

Colic? ❒ Yes ❒ No

Number of earaches or other infections in fhe first two years of life: _____ (first at ___ months)

Number of times he/she had antibiotics in the first two years of life: _____ (first at ___ months)

❒ accidents, broken bones, other serious injury

❒ allergies(asthma,eczema,hay fever), food allergies

❒ anemia (low blood count) or bleeding problems

❒ bladder/kidney problems: frequent infections, control problems (if unusual for child's age)

❒ growth problems: poor weight gain, etc.

❒ emotional problems: depression, ongoing or past abuse concerns, behavior problems

❒ heart problems, murmur, etc.

❒ gastrointestinal problems: frequent upset stomach, diarrhea

❒ lung problems: pneumonia, asthma, etc

❒ neurologic: seizures, developmental or learning disabilities, cerebral palsy, headaches

❒ skin problems

❒ sleep problems: insomnia, night terrors, etc.

❒ tuberculosis (or positive skin test)

❒ Hospitalizations

❒ **OTHER** _____

Dates and details on items checked above):

_____

_____

When was his/her last dental visit?_____

Past Surgery(include approximate date and type of procedure, why it was done):

_____

_____

Developmental history: Please indicate the approximate age in months for the following milestones:

Sitting up	___ months	❒ not yet	Dry at night	___ months	❒ not yet
Crawling	___ months	❒ not yet	First words ("dada" etc.)	___ months	❒ not yet
Pulled to stand	___ months	❒ not yet	Spoke clearly	___ months	❒ not yet
Potty trained	___ months	❒ not yet	Lost language	___ months	❒ never
Walked alone	___ months	❒ not yet	Lost eye contact	___ months	❒ never

Immunizations:

Are his/her immunizations up to date? ❒ yes ❒ no If not, please explain: _____

_____

Please bring immunization record to first appointment.

Current medications(include over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, etc. and indicate dose and frequency):

_____

_____

Allergies to any Medication: (list medication and reaction): _____

_____

Has your child had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ❒ yes ❒ no

Has your child had prolonged or regular use of Tylenol? ❒ yes ❒ no

Has your child had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ❒ yes ❒ no

Frequent antibiotics (>3 times per year?) ❒ yes ❒ no

Use of steroids in the past? ❒ yes ❒ no

Allergies to any Food: (list food and reaction): _____

_____

Family History:

Is your child adopted or from a donor insemination? . . . . . ❒ yes ❒ no

Please list medical history for biological relatives:

Relationship	Name	Age	Living/Deceased	Medical Problems
Mother	_____	___	_____	_____
Father	_____	___	_____	_____
Brothers/Sisters	_____	___	_____	_____
	_____	___	_____	_____
	_____	___	_____	_____

Is there any history in the family of the following illnesses?

(Include mother(M), father(F), sister(S), brother(B), grandmother (GM), grandfather(GF), aunts(A), uncles(U), cousins(C).)

	YES	NO	UNSURE	WHO?
Alcoholism or drug abuse	_____	_____	_____	_____
Allergies, severe	_____	_____	_____	_____
Attention deficit/learning disorders	_____	_____	_____	_____
Bleeding problems	_____	_____	_____	_____
Blood clots in legs or chest	_____	_____	_____	_____
Depression or mental illness	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
				(What organ(s)?)
Heart problems before age 50	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____
Liver disease	_____	_____	_____	_____
Lung disease	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Other (seizures. Etc.):	_____	_____	_____	_____

Social History:

Please list everyone who lives in the home with this child and note relationship:

Full Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Brothers/sisters and parents not living in the home:

Full Name:	Age:	Relationship:
_____	_____	_____

_____ _____ _____

Who are the main people that care for your child? _____

Pets: Do you have any pets? . . . . . ❒ yes ❒ no

Names, species:_____

Living situation:

Are you now or have you recently been homeless?. . . . . ❒ yes ❒ no

If not, do you currently live in an ❒ apartment ❒ house ❒ other

Do you have electricity and running water in your home? . . . . . ❒ yes ❒ no

Is food ever in short supply in your home? . . . . . ❒ yes ❒ no

Stress/coping:

Does your child get along well with her/his siblings? . . . . . ❒ yes ❒ no

Are you currently providing care for a disabled or elderly family member? . . . . . ❒ yes ❒ no

Has your child experienced any major life changes that may have impacted his/her health?. . . . . ❒ yes ❒ no

Has your child ever experienced any major losses? . . . . . ❒ yes ❒ no

Have you ever sought counseling for your child? . . . . . ❒ yes ❒ no

Is your child or family currently in therapy? . . . . . ❒ yes ❒ no

Does your child practice stress release methods? ❒ no ❒ yes – If yes, then check all that apply:

❒ Yoga ❒ Meditation ❒ Imagery ❒ Breathing ❒ Prayer ❒ Other:_____

Spiritual Life:

Is there a particular spiritual practice/belief system that is meaningful to your family? . . . . . ❒ yes ❒ no

Name or Description, if this is comfortable for you: _____

Do you practice this singly and/or with a group? ❒ alone ❒ with a group

School history

Is your child currently in school?. . . . . ❒ yes ❒ no

❒ Home school ❒ Public school ❒ Private school

What grade level? _____

Has she or he had any difficulty in school and, if so, what was the problem? _____

_____

What action was taken? _____

Does your child play well with other children?. . . . . ❒ yes ❒ no

How many hours of television/videos/videogames does your child watch/play every day? _____

Discipline

What is your method of discipline? _____

Are discipline or behavior problems a problem for you? _____

How do adults in the home deal with conflict? _____

Abuse

Has your child ever experienced physical or sexual abuse?. . . . . ❒ yes ❒ no

Did she or he receive any counseling? . . . . . ❒yes ❒ no

Travel: Has your child ever been in (or is he/she from): ❒ a foreign country? (where?)

❒ another region of the United States?

Has your child done wilderness camping? ❒yes ❒ no Where?_____

Safety:Does your child ride in a car seat?. . . . . ❒yes ❒ no

If not, does she/he ever ride without wearing a seat belt? . . . . . ❒yes ❒ no

Have you reviewed "child proofing" in your home within the last year?. . . . . ❒yes ❒ no

Do you have a safety plan for your family in the event of a fire or earthquake?. . . . . ❒yes ❒ no

Does your child know the safety plan, if old enough to understand?. . . . . ❒yes ❒ no

Have you done a "drill" of the safety plan with your family?. . . . . ❒yes ❒ no

Are there any weapons in your house?. . . . . ❒yes ❒ no

If there are weapons in the house, are they kept where the child might find them?. . . . . ❒yes ❒ no

Are the weapons stored without ammunition or with safety locks?. . . . . ❒yes ❒ no

Are you afraid of your own temper or that of anyone else in your family? . . . . . ❒yes ❒ no
Does your child know about safety with strangers? . . . . . ❒ yes ❒ no
Does your child know street safety rules? . . . . . ❒ yes ❒ no
Does your child have problems with "bullies"?. . . . . ❒ yes ❒ no

Toxic exposures:

Is your child exposed to secondhand smoke? ❒ no ❒ yes – Where? ❒ at home ❒ elsewhere _____
Does your child have dental fillings**?** ❒ no ❒ yes – What kind? _____

Other possible exposures:

Past	Current	**Exposures**	Past	Current	
		Mold in bathroom			Mold in cellar, crawlspace, or basement
		Damp cellar or had water in basement			Heavily wooded or damp surroundings
		Pest extermination – inside			Well water
		Pest extermination – outside			Old or crumbling paint (when was house built?_____)
		Forced hot air heat			New carpet or other remodeling
		Farm close to house (non-organic)			Feather or down bedding
		Power plant or lines close to house			Landfill/dump
		Industrial plant close to house			Gas or propane stove or heating

Diet: Who does the shopping in your family? _____

Who does the cooking in your family? _____

Does your child follow a special diet?(vegetarian, low salt, low fat, gluten-free etc) ❒ no ❒ yes:

_____

How many meals does your child eat out per week? ❒ 0-1 ❒ 1-3 ❒ 3-5 ❒ more than 5 meals per week

How many times a week does your family eat red meat? _____

How many servings of fruit or vegetables does your child eat every day? _____

What percentage of your family's foods are organic for: fruits and vegetables _____ animal products: _____

What do you give your child for snacks? _____

How many sweetened drinks (Coke, Pepsi, fruit juice, etc.) does your child drink every day? _____

How many servings of chips, candy does your child eat every day? _____

Does your child eat a limited variety of foods (<5 per day) . . . . . ❒ yes ❒ no
Has weight ever been a problem for your child?. . . . . ❒ yes ❒ no
Are you concerned about your child undereating or being preoccupied with weight? . . . . . ❒ yes ❒ no
Has weight ever been a problem for the parents or other adults in the home?. . . . . ❒ yes ❒ no
Has your child ever had to limit certain foods because of a bad reaction to those foods?. . . . . ❒ yes ❒ no
Which foods, what reaction, and do they still avoid those foods:_____

_____

Please list what your child ate yesterday, with approximate amounts:

Breakfast	lunch	supper	snacks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Exercise: Does your child exercise daily? . . . . . ❒ yes ❒ no
What kind of exercise/play does he/she enjoy? _____
Does she/he have safety equipment for bicycles, roller skates, etc.? . . . . . ❒ yes ❒ no
Are helmets/wrist pads used every time your child is on a bike/skateboard/etc.? . . . . . ❒ yes ❒ no

Hobbies, other activities(church groups, sports, musical instruments, etc.):

_____

What is the best thing about your child? _____

_____

Current symptoms:

Mark symptoms or problems your child has now or occasionally, and write details below:

Constitutional: ❒ chills ❒ fatigue ❒ fever ❒ night sweats ❒ weight gain ❒ weight loss

Eyes: ❒ blurry vision ❒ double vision ❒ dry eyes ❒ headache ❒ changes in vision

Ears, nose, throat: ❒ change in sense of smell ❒ dry mouth ❒ ear pain/pressure ❒ hearing loss ❒ mouth pain ❒ sore throat ❒ ringing in ears ❒ trouble swallowing

Heart and circulation: ❒ chest pain ❒ palpitations ❒ fainting spells ❒ Cold hands/feet ❒ difficulty exercising

Lung problems: ❒ shortness of breath ❒ cough ❒ wheezing ❒ hoarseness

Stomach problems: ❒ abdominal pain ❒ constipation ❒ diarrhea ❒ difficulty swallowing ❒ blood in stools ❒ loss of control of bowels (if already potty trained) ❒ indigestion/heartburn ❒ pain with bowel movements

Bladder/kidney problems: ❒ frequent urinary tract infections ❒ problems with foreskin or circumcision ❒ loss of control of urine(accidents) (inappropriate for age) ❒ blood in urine

Muscles/bones: ❒ Joint problems ❒ back pain ❒ hypermobility ("double jointed") ❒ muscle weakness or pain

Skin: ❒ rash ❒ changing mole(s) ❒ itching ❒ dry skin ❒ warts

Nervous system problems: ❒ dizziness ❒ trouble walking ❒ seizures ❒ numbness ❒ headache

Hormones: ❒ change in hair growth ❒ blood sugar problems ❒ excessive hunger/thirst ❒ lump in neck ❒ intolerance to hot or cold ❒ Growth problems (not enough or too much) ❒ Body hair, breast development, other changes happening too early or too late

Blood: ❒ anemia ❒ bleeding tendency ❒ swollen or tender lymph nodes

Allergies: ❒ eye discharge ❒ hives ❒ itching ❒ sinus congestion ❒ skin rashes ❒ wheezing

Psychological: ❒ Anxiety ❒ Depression ❒ Behavior problems ❒ learning problems ❒ development problems

Sleep problems: ❒ insomnia ❒ daytime sleepiness ❒ snoring

Does your child wear glasses? ❒ yes ❒ no Contact lenses? ❒ yes ❒ no Braces? ❒ yes ❒ no

Please provide details of problems circled above. If there are other issues that you want to discuss with your child's provider, please record them below or use another piece of paper.

New Patient History Questionnaire, Adolescent Supplement

Name_____ Current Date_____

Date of Birth _____

Welcome to our office. This questionnaire has been designed so that we can both review your medical history and factors in your life that affect health. We have asked you and/or your parents to fill out a questionnaire on child health, but we would like to know if you have any concerns of your own that may not have been addressed there.

We encourage teens to talk with their parents about everything going on in their lives, but there are also some topics that teens may want to keep confidential, including items relating to mental health and/or sexual activity or birth control. State law says we can keep these items confidential even from your parents if you are 12 or older. Mark the items you want kept confidential with an asterisk (*).

Be warned that by law we must report any concerns for physical or sexual abuse if there is an ongoing risk to you or anyone else.

General Health: ❒ excellent ❒ good ❒ fair ❒ poor

Medical issues or symptoms you want to be sure are addressed today:

_____

_____

_____

Current medications(in addition to those mentioned on the other questionnaire – i.e. anything your parents may not realize you are using/you do not want them to know you are using, including birth control) _____

Allergies to any Medication or Food: (list substance and reaction): _____

_____

Do you follow any special eating plan for yourself? ❒ no ❒ yes What?_____

Have you done anything to try to gain or lose weight? ❒ no ❒ yes What?_____

Do you feel out of control about your eating or food? ❒ no ❒ yes How?_____

Social Support and Stress: (Please write details of any positive answers on the other side)

Do you feel stress is a problem in your life?..... ❒ yes ❒ no
Do you have problems with getting angry frequently or at little things?..... ❒ yes ❒ no
Are you afraid of your own temper or that of anyone else in your family?..... ❒ yes ❒ no
Do you sometimes feel out of control? ..... ❒ yes ❒ no
Do you sometimes feel you are no good or you can't do anything right? ..... ❒ yes ❒ no
Have you ever thought about or tried to commit suicide? ..... ❒ yes ❒ no
Have you or anyone on your block or in your class been shot or mugged in the last year?..... ❒ yes ❒ no
Is there any history of violence in your family? ..... ❒ yes ❒ no
Has anyone close to you ever physically hit you or hurt you?..... ❒ yes ❒ no
Do you feel unsafe in your home, at school, or in your current relationship?..... ❒ yes ❒ no
Is there a partner from a previous relationship who is making you feel unsafe now?..... ❒ yes ❒ no
Do you frequently feel isolated or alone?..... ❒ yes ❒ no
Do you feel people take advantage of you or try to control you?..... ❒ yes ❒ no
Do you feel threatened or bullied by anyone in your life?❒ yes ❒ no

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things ❒ not at all ❒ several days ❒ more than half the days ❒ nearly every day

Feeling down, depressed, or hopeless ❒ not at all ❒ several days ❒ more than half the days ❒ nearly every day

Who provides you with emotional support(family, close friend, teacher, religious advisor, other)? _____

_____

Sexual History:

Have you ever had sex with another person? (Including using hands, mouths, genitals, anus)..... ❒ yes ❒ no
If so, have you had sex in the last month? ..... ❒ yes ❒ no
3 months? ..... ❒ yes ❒ no
1 year?..... ❒ yes ❒ no
Do you have or have you ever had sex with:.....❒ males ❒ females ❒ both
How many people have you had sex with in the last year?.....❒ 1 ❒ 2-3 ❒ more than 3
What do you use for birth control/safe(r) sex? _____
Do you want to discuss safe sex, AIDS, or other sexual issues with the provider? ..... ❒ yes ❒ no
Has anyone ever sexually abused or raped you, or has anyone ever pressured you into being sexual when you did not want to?..... ❒ yes ❒ no
If so, are you willing to discuss the event(s) to your provider?..... ❒ yes ❒ no
Have you had some counseling or other help with this? ..... ❒ yes ❒ no
Do you feel this still affects you? ..... ❒ yes ❒ no

During the PAST 12 MONTHS, did you:

Drink any alcohol? ..... ❒ yes ❒ no
Smoke any marijuana or hashish?..... ❒ yes ❒ no
Use anything else to get high?..... ❒ yes ❒ no
("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.")

Have you ever:

Ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol/drugs? ❒ yes ❒ no
Used alcohol or drugs to relax, feel better about yourself, or fit in? ..... ❒ yes ❒ no
Used alcohol or drugs while you were by yourself or alone?..... ❒ yes ❒ no
Forgotten things you did while using alcohol or drugs? ..... ❒ yes ❒ no
Gotten into trouble while you were using alcohol or drugs?..... ❒ yes ❒ no
Do your family or friends ever tell you that you should cut down on your drinking or drug use? ..... ❒ yes ❒ no

Please list any other concerns and any details for your answers on this form:

Full Circle Patient Portal Informed Consent

Name: _____ DOB: _____

The Patient Portal is a secure web-based system which allows you to communicate with our office and access portions of your medical record. The Patient Portal will require a username and a password.

The portal is available at any time for non-urgent issues and allows you to bypass the phone system, communicating with our office at your convenience. The portal allows you to:

- View and print selected health information and medication records
- Request or cancel appointments
- View messages and educational materials from your provider
- Pose questions to your provider
- View limited lab test results
- Pay bills with our practice

You will be notified by e-mail if you have a message or results to review on the portal.

By using the Patient Portal, you agree to the following Terms & Conditions:

- Take steps to keep portal communications private and confidential including:
- Update contact information online as soon as it changes, including your e-mail address
- Keep your username and password safe and private
- Avoid communicating per personal e-mails

When posing questions to the practice:

- Use is limited to NON-URGENT communication and requests
- Communication following an appointment to clarify recommendations will be provided at no charge
- Please allow up to 24 hours or the next business day to respond to communications; the portal may not be checked on the weekend
- Virtual visits may be available for some new complaints, at a charge, but if the matter is urgent, a phone call to the office to notify us of your request is recommended

The following agreements and procedures relate to online communications:

- Copies of all medically important Patient Portal communications will be saved in your electronic medical record
- Patient Portal communications will be used only for limited purposes and cannot be used for emergencies, highly sensitive medical information, or time sensitive matters

Risks of using Online Patient Portal Communications

All medical communications carry some level of risk. While the likelihood of risks associated with the Portal is low, it is possible for online communications to be forwarded, intercepted, or even changed without your knowledge. We use a secure network for the patient portal to minimize this risk.

Patient Acknowledgement and Agreement

By using the Patient Portal you acknowledge that you have read and fully understand the Terms & Conditions as described. You understand the procedures and risks associated with online communications with your healthcare team and you consent to the conditions described. If you decide you do not want to use the portal, please notify us to deactivate your account. If you have any portal problems, please notify us.

Signature _____ Date_____

Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata CA 95521
(707)840-4701 fax (855)420-6321

Medical Records Release

I request the release of information regarding _____
Patient's Name

Date of Birth:_____

FROM:
Provider/Group name::_____

Address:_____

City/State/Zip_____

TO:
Provider/Group/Other: Full Circle Center for Integrative Medicine

Address: 4641 Valley East Blvd #2

City/State/Zip: Arcata CA 95521

I specifically need the following information released (INITIAL EACH ITEM):

___ All information regarding the assessment, diagnosis, and treatment of_____
___ All information regarding the care provided from _____ until _____
Date Date

Unless "No is written in and initialed, the records will include the following:
Alcohol and drug use/abuse __ _____ Mental Health Information __ _____ HIV status __ _____
No Initials No Initials No Initials

___ Other _____

_____

Lab Results _____ TB results _____ EKG report _____

Immunizations _____ X-ray results _____ Consults _____

The person receiving this information may only use it for the following purposes:
__ Assessment & Evaluation __ Legal Proceedings of Legal Advice __ Employment
__ Health Insurance Enrollment __ School or Educational Needs __ Personal Use
__Aid or Entitlement __Other (Specify) _____

This consent shall remain valid for one year from date of signature unless otherwise specified.

_____ _____
Date Patient, Parent, Conservator, or Guardian (Circle one)

_____ _____
Date Witness Signature

The patient has the right to receive a copy of this authorization.