HALLECK HOLISTIC HEALTH, PS
Dr. Maria L. Putney
208 Halleck Street, Suite 101
Bellingham, WA 98225
Ph: 360.325.8976 Fax: 360.922.7086

HIPPA FORM

Statement of Privacy Practice

We at Dr. Maria Putney's are dedicated to protect the privacy of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

Your Personal health information will never be given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality care, implement payment activities, conduct normal practice operations, and comly with the law. This may include your name, address, telephone number(s), Social Security Number, insurance information, medical history, health record, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As Stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes. We may use and/or disclose your health information to communicate reminders about appointments, this includes voicemail messages, answering machines, and postcards.

Patients Rights

You have the right to request copies of your healthcare information.

We thank you for being a patient here at Dr. Putney's. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

I have read, understood and received a copy of this Statement of Privacy Practices

_____ _____

Signature Date

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Office Policies

Telephone Appointment Policy: *I understand that I may contact the office at any time to request information or assistance. Dr. Putney will call me back in a timely manner. I understand that if a specific time is set aside for a telephone consultation with Dr. Putney regarding medical concerns or questions, that there will be a charge for this consultation, and in some cases my health insurance will be billed accordingly. I understand that scheduling a time for a telephone consultations means that Dr. Putney sets aside time where she is unavailable to see patients.*

Cancellation Policy: *I understand that if I fail to give* ***24 hours notice*** *of cancellation I will be required to pay 100% of the appointment charges. If unforeseen circumstances occur, I will let the office know. I understand that my adequate notice allows other who need care to make appointments.*

Responsibility For Payment of Account: *I am responsible for payment for services rendered and pharmacy items received from this clinic, whether or not my insurance company pays. I will pay a per month finance charge on any balances left unpaid where by myself or my insurance company. Methods of payment available to me include cash, check, money order, Visa or Mastercard. I understand there is a* ***$30.00 charge on NSF (returned) check.***

Insurance Information
Name on Insurance Card_____ **Date of Birth**_____
Primary Insurance_____**ID#**_____**Group#**_____
Employer_____
If No insurance please check ☐

Date:_____
Name:_____ **Social Security Number**_____

_____
Signature

Address_____
City_____**State**_____**Zip**_____
Home Phone_____**Work Phone**_____
E-mail address_____
Relationship to Patient: Self Parent Other

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Non-Covered Service Agreement for Insurance Coverage

I,_____being a patient of ***Dr. Maria L. Putney****, located at* ***208 Halleck Street, Suite 101 Bellingham, WA*** *do hereby acknowledge that it has been explained to me the following services may not be covered by the benefits available to me under the terms of my Health Plan or Insurance Policy:*

Office Visits

Home Visits

Infusions: IV therapy

Injections

Panels for Allergy and Heavy Metal Testing

Comprehensive Stool Analysis Testing

Occult Blood Testing

Ear Irrigation

Massage Therapy

I acknowledge that I have been told, in advance of treatment, that my care might not be covered by my health plan/insurance policy, and I agree to make financial arrangement and or full payment with my practitioner to pay for these services.

Date:_____

Patient's Signature:_____

Patient's Printed Name:_____

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Medical Record Release Form

Patient Name:_____Address:_____

Phone: _____-_____ Date of Birth: ____/_____/_____

As required by the Privacy Regulations, Dr. Maria L Putney may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

From: Clinic/Dr:_____ Address:_____ _____ Phone:_____ Fax:_____	**TO:** **Halleck Holistic Health, PS** Dr. Maria Putney Address: 208 Halleck St., Ste 101 Bellingham, WA 98226-5708 Ph: 360-325-8976 Fax: 360-922-7086

By **initialing** the spaces below, I authorize the release of the following records, if such records exist:

____ Entire medical record ___ Progress notes ___Laboratory report

____ Pathology reports ___ EKG ___X-ray

____ Operative report ___ Other, Please be specific:_____

The following items must be **initialed** to be included in other documents:

___ HIV/AIDS related record ___Mental Health records

___ Drug/Alcohol diagnosis, treatment or referral information ___Genetic testing information

(Federal regulations require a description of how much information and what kind of information is to be disclosed). Describe_____

For the specific purpose of (describe in detail):

_____

This authorization will expire **180 days** from the date of signing. I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.
7. I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature_____ **Date:**_____

Medical Intake Form Today's Date_____

Name:_____ Occupation:_____

Sex: F or M (circle one) Employer:_____

Age:___ Date of Birth:_____ Work Ph:_____

Email:_____ Emergency Contact Ph:_____

Cell Ph:_____ Contact Person:_____

Home Ph:_____ Marital status:_____

Home Address:_____

City:_____ State:_____ Zip code:_____

If patient is under 18 years of age:

Legal Guardian:_____ Relation:_____

Phone:_____

Cancer History:

***It would be of great assistance if you bring copies or original reports of any or all diagnostic tests (ie. MRI, CT scan, Biopsy, X-Ray, etc) that you may have had with you.**

Cancer Type/Stage:_____

Date of Diagnosis:_____

Any Metastasis? Y or N If yes, where_____

Health Priorities: List your main health priorities/concerns in order of importance

1._____

2._____

3._____

For the purposes of integrating your care and communicating with other healthcare practitioners, please list the names of your treatment team. ***We will not contact your doctors without your consent.***

Practitioner	**Name**	**Location and Phone**	**Permission to Contact**	
Primary Physician			Yes	No
Medical Oncologist				
Radiation Oncologist				
Surgeon				
Other:				

Please list dates of cancer surgeries:

Date of Surgery	**Purpose of Surgery**	**Complications**

Please list your radiation therapy:

Site of Radiation	**Start Date/Frequency**	**End Date**	**Complications**

Please list type of chemotherapy received and dates

Type of Chemotherapy	Start Date	End Date	Complications

Other than the cancer diagnosis, please list any medical conditions, illnesses, surgeries, complications, or reasons for past hospitalizations

Other Medical Conditions	Date of Diagnosis	Is the condition still present?	Symptoms/Complications

Please list all current medications/supplements

Medication/Supplement	Dose/Frequency	Prescribing Physician	Length of Use

Please list any allergies and /or Food Sensitivities

Allergy/Food Sensitivity	Symptoms

How many times have you taken antibiotics within the last 5 years_____

Were you frequently given antibiotics as a child?_____

Have you had any adverse reactions from any vaccinations?_____

Personal Medical History

	Current	Previous
General Symptoms		
Loss of consciousness	☐	☐
Numbness/Tingling	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Loss of Sleep	☐	☐
Frequent Cold/Flu	☐	☐
Loss of Weight	☐	☐
Head/Neck		
Headaches	☐	☐
Type:_____		
Vision Problems	☐	☐
TMJ concerns	☐	☐
Earaches	☐	☐
Hearing Loss	☐	☐
Sinus problems	☐	☐
Difficulty Swallowing	☐	☐
Skin		
Rashes/Eczema	☐	☐
Itching	☐	☐
Bruise easily	☐	☐
Dryness	☐	☐
Boils	☐	☐
Hives	☐	☐
Contagious disease	☐	☐
Respiratory		
Chronic Cough	☐	☐
Shortness of Breath	☐	☐
Smoking	☐	☐
If yes, how many Years_____		
If quit, when_____		
Breathing problems	☐	☐
Asthma/Bronchitis	☐	☐

	Current	Previous
Cardiovascular		
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Bleeding disorders	☐	☐
Chest pain	☐	☐
Stroke	☐	☐
Artery Hardening	☐	☐
Varicose veins	☐	☐
Swelling in ankles	☐	☐
Swelling in face	☐	☐
Poor circulation	☐	☐
Angina	☐	☐
Heart disease	☐	☐
Genitourinary		
Trouble urinating	☐	☐
Blood in urine	☐	☐
Kidney infections	☐	☐
Kindey stones	☐	☐
Prostate trouble	☐	☐
Gastrointestinal		
Poor digestion	☐	☐
Indigestion	☐	☐
Excessive hunger	☐	☐
Belching or gas	☐	☐
Nausea/vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Liver concerns	☐	☐
Gall bladder trouble	☐	☐
Ulcer	☐	☐
Endocrinology		
Thyroid problems	☐	☐
Diabetes TypeI	☐	☐
Diabetes Type II	☐	☐

	Current	Previous
Infections/Illnesses		
Herpes circle one	☐	☐
Hepatitis (Type A, B, C)	☐	☐
TB	☐	☐
HIV/AIDS	☐	☐
Cancer	☐	☐
Autoimmune Disease	☐	☐
Allergies	☐	☐
Muscles/Joints		
Stiff neck	☐	☐
Backache	☐	☐
Swollen joints	☐	☐
Painful tail bone	☐	☐
Foot trouble (L/R)	☐	☐
Shoulder pain(L/R)	☐	☐
Elbow pain(L/R)	☐	☐
Wrist pain(L/R)	☐	☐
Hip pain(L/R)	☐	☐
Knee pain(L/R)	☐	☐
Arthritis	☐	☐
Weakness	☐	☐
Loss of strength	☐	☐
Women's Health		
Painful menstruation	☐	☐
Excessive Flow	☐	☐
Hot Flashes	☐	☐
Vaginal Dryness	☐	☐
Irregular cycle	☐	☐
Vaginal discharge	☐	☐
Cramps/backache	☐	☐
Swollen breasts	☐	☐
Lump in breast	☐	☐
Are you pregnant?	Yes☐	No☐
On birth control?	Yes☐	No☐
# of Pregnancies_____		
# of Children_____		

Please list anything not covered above:_____

_____

Do you use any of the following?

Substances	Circle One	How much/How often/form
Alcohol	Yes No	
Tobacco	Yes No	
Cannabis/Marijuana	Yes No	
Recreational Drugs	Yes No	
Caffeine	Yes No	
Aspirin/Ibuprofen/NSAIDS	Yes No	
Antacids	Yes No	
Diet Pills	Yes No	
Laxatives	Yes No	
Birth Control Pills/Implants/Injections	Yes No	

Please indicate which of the following screening tests you have received

Test	Circle One	How Often/Recent Date
Mammogram/Thermography	Yes No Never	
Self Breast Exam	Yes No Never	
Bone Density Scan	Yes No Never	
Pap Smear	Yes No Never	
Digital Rectal Exam: Prostate	Yes No Never	
PSA: prostate surface antigen blood test	Yes No Never	
Cholesterol levels	Yes No Never	
Blood Glucose	Yes No Never	
Diagnostic Imaging: X-ray, CT, MRI, Ultrasound	Yes No Never	
EKG or EEG	Yes No Never	

Family History:

Indicate if any family member has had any of the following

Illness	Circle One	Family Member
Allergies	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Cancer	Yes No	
Depression	Yes No	
Other Mental Illness	Yes No	
Infertility	Yes No	
Other:	Yes No	

Lifestyle:

Do You exercise?_____ How often?_____

Water intake?_____oz/day

Typical Diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Cravings:_____

Have you recently gained or lost weight (circle one) Yes No If yes, over what time period?_____

Weight gained/lost_____lbs.

Hobbies:_____

Traveled outside the US? Please list locations and year_____

_____

Is there anything that you feel is important that has not been covered?_____

_____

_____

Where did you learn about this clinic?

Friend/Family name:_____

Referral from another Medical Healthcare Provider:_____

Internet:

Dr. Putney's Webpage □

Facebook □

Google/other search engines □

Other:_____