DR. PEGGY BRANSON, N.D.
1831 Orange Ave, Suite A
Costa Mesa, CA 92627
P: 949.574.4978
F: 949.574.9854

PEDIATRIC PACKET

Welcome to Newport Integrative Health!!

Dr. Branson's goal is to provide you with the highest level of personalized care. She is committed to helping you on your path to health and healing.

It is important to read all the enclosed information carefully. You may mail or fax completed forms prior to your appointment. This will allow Dr. Branson to help solve your problems more efficiently and enhance the quality of your care. Alternatively you may bring the forms in with you to your first appointment.

Consultations
Your initial visit will be a 60-minute consultation with Dr. Branson. Nutritional therapy and laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and Dr. Branson will help you select and find the highest quality products. Follow up visits to review lab report or treatment programs are 30-minute visits.

Payment Options
Cash, checks or credit cards (MasterCard, Visa & American Express) are accepted for services rendered. Payment is due on the day of service.

Insurance Information
Newport Integrative Naturopathic Health, Inc. and Dr. Peggy Branson, N.M.D., Inc. do not bill insurance or Medicare and we cannot assure you that services (office visits, phone consultations or lab tests) will be reimbursed. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. Laboratory tests may or may not be covered; this will depend on the terms of your insurance plan.

We encourage your questions and participation in all aspects of your care. We are looking forward to meeting you and providing you with naturopathic health care.

I look forward to meeting you!!

Dr. Peggy Branson, N.D.

Patient Contact Information

Name of Patient _____ Date of First Visit _____

Name of Parent(s)/Guardian(s) _____

Relationship to patient _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (cell) _____ ☐

(home) _____ ☐

(work) _____ ☐

Please check box by phone number if it is OK to leave a detailed message about your health

☐ Please check this box if you consent to receive text communications

Email address_____

Is it OK to use email to correspond about your health? ___Yes ___No

Age _____ Date of Birth _____ Gender: Female _____ Male _____

Live with: Parents ____ Other _____

School _____ Grade_____ Hours per week _____

Insurance Carrier _____ PPO / HMO (circle one)

Preferred Pharmacy: _____ (Phone)_____(Fax)_____

How did you hear about Dr. Branson? Friend _____ (name)
Doctor/health provider _____ (name)
Internet _____ (website)
Other _____ (please specify)

Next of Kin or other to reach in an emergency _____

Phone _____ Address _____

Welcome to the Patient Portal!!

This is your way of digitally communicating safely and securely with your doctor and our front desk staff.

Please fill in your username and password here (please print clearly):

username: _____

password: _____

In your favorite web browser, visit us at https://npihealth.phiportal.com and enter your username and password. Click on the Message tab to start email communication.

The Patient Portal Website is a convenient way to access your medical information and communicate with your doctor.

Features:
- Private and secure- fully HIPAA compliant messaging.
- View Demographics information and request corrections
- Access to lab results

You will receive a copy of your lab test in the patient portal. It is your responsibility to retrieve the results from your portal and follow up on any recommendations

The patient portal is suitable for brief clarification questions that take the doctor 5 min or less to read and respond. **For any question that takes longer then 5 min to respond to or significantly changes the course of treatment please schedule an appointment**. The patient portal is not suitable nor intended for any sort of emergency communication.. Your doctor will reply to your email within 1-2 business days. Her response may be delayed over weekends, holidays, or due to technical difficulties or high volume of messages.

Please be aware that your communication with your doctor will become part of your medical record..

Important Patient Information

BILLING/ISURANCE

- Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
- You will receive an invoice at the completion of your visit.
- Dr. Branson does not bill insurance or Medicare. You can request a "superbill" that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion. Please note that phone visits may not be reimbursed by your insurance carrier.

APPOINTMENTS

- In fairness to our patients and practitioners there is a 48-hour cancellation policy
- There is a fee ($150 for new patient visits and $75 for return visits) for missed appointments and appointments cancelled within 48 hours of the scheduled appointment time.
- As a courtesy to our patients, we will use our best efforts to confirm appointments prior to the appointed time. It is however, the patient's responsibility to keep the scheduled appointment or reschedule.
- The initial consultation with Dr. Branson is $350 and follow-up appointments to review lab results or treatment programs in person or by phone are $175
- There is no charge for brief e-mails via the portal or phone calls, as determined by Dr. Branson at her sole discretion. For non-urgent matters that would be best attended to during an appointment, Dr. Branson will request you either a) schedule an appointment or b) hold your question until your next appointment (this generally applies to questions that change the course of care or take longer than 5 minutes to respond to either by phone or email).

LAB TESTS

- Primex Laboratory is available to provide phlebotomy services at Newport Integrative Health. Primex is an independent company from Newport Integrative Health. Primex performs its own billing and staffing. Any billing or customer service concerns will need to be addressed with them directly
- After your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered and testing recommendations will be reviewed.
- Fees for standard testing can either be billed to the patients PPO insurance or a discounted price can be paid if remitted at the time of the blood draw. Most specialty testing is either paid at time of the draw directly to the laboratory or there may be co-pay and the remaining balance smutted to your insurance. Insurance coverage will vary and depend on the terms of your plan. To verify insurance coverage for laboratory tests please contact your insurance company.
- Some specialized lab tests take up to 5 weeks to be finalized and sent to the office. Dr. Branson cannot guarantee turn-around time on laboratory testing.
- You will receive a copy of your lab test in the patient portal. It is your responsibility to retrieve the results from your portal and follow up on any recommendations
- Dr. Branson does not mark up or profit in any way from the sale of lab testing kits that she orders for her patients.

PATIENT INITIALS _____

Important Patient Information

SUPPLEMENTS

- Nutritional supplements are available for patient convenience at Newport Integrative Health
- Patients are under no obligation to purchase their supplements at the office, and many of the same and similar products are available at your local health food store and/or online
- Your doctor may receive a commission for products sold for their patients
- Newport Integrative Health will ship supplements to your home at standard shipping fees (commonly $4.80).
- Return policy: All sales are final. We are unable to return supplements

PATIENT AWARENESS AND RESPONSIBILITY

- Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health.
- Dr. Branson will inform you of the therapies most relevant to your condition both conventional and alternative.
- You have the choice to accept, refuse or terminate these therapies at any time.
- By agreeing to make every effort to implement an agreed upon program, you will receive the full benefit of your visits with Dr. Branson.
- You are responsible for seeking professional medical attention from Dr. Branson or another facility for a worsening of your condition.
- You are aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- You are aware that you may be referred to another physician for treatment when needed.

EVENING AND WEEKEND CALLS

- Dr. Branson does not maintain regular call on the evenings and weekends.
- If you have a non-urgent question please call during clinic hours or feel free to use the patient portal to contact Dr. Branson directly or call and leave a message at the office and she will respond to your question during the work week.
- If you have an **urgent** question for Dr. Branson, you may contact the on-call doctor on nights and weekends at 949-743-5770.

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EMERGENCIES

- In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

PATIENT SIGNATURE _____ Date_____
(or Patient Representative)

Indicate relationship if signing for patient_____

Consent for Naturopathic Treatment

Newport Integrative Naturopathic Health, Inc.
Dr. Peggy Branson, NMD, Inc.
1831 Orange Ave, Ste A. Costa Mesa, CA 92627
Tel: (949) 574-4978 Fax: (949) 574-9854

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not (collectively, the "doctor").

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act and may include, but are not limited to, nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended are considered safe when taken as instructed in the practice of naturopathic medicine. I understand and agree it is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses and I agree to use herbs and nutritional supplements only as prescribed for me by the doctor. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, **if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1**.

I have read, or have had read to me, the above information and have had an opportunity to ask questions about this consent and to discuss its contents with my legal counsel, to the extent I have deemed necessary. By voluntarily signing below, I hereby consent to receive naturopathic medical care from the doctor. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME (printed) _____

PATIENT SIGNATURE: _____ Date: _____
(or Patient Representative)

Indicate relationship if signing on behalf of patient _____

Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination: multiple health care providers may be involved in your treatment directly and indirectly
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Newport Integrative Health 1831 Orange Ave, Suite A Costa Mesa, CA 92627 P: 949.574.4978 F: 949.574.9854 E: frontdesk@npihealth.com

Right to Revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact above. Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I _____have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment and healthcare operations

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ Patient Signature _____/_____/_____Date

Telehealth Consent Form

Patient Name _____ DOB _____

"TeleHealth" means that you may be evaluated and treated by a health care provider from a distant location via electronic communication. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following: patient medical records, medical images, live two-way audio and video, and/or output data from medical devices and sound and video files.
Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Provider.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.
- I understand that payment will be collected at the time of service.

Authorizations

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- By signing below, I am granting permission to Dr. Peggy Branson ND to perform and administer care and treatment of the patient via telehealth.
- Grants permission to release to third party payor(s) (such as private insurance companies), their representatives, and/or other physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient. (For example laboratory testing or imaging recommended at the appointment then performed for which the patient is submitting the lab/imaging fee to insurance)
- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Printed Name of Signer_____

Relationship to Patient _____

Signature _____Date _____

HEALTH HISTORY QUESTIONNAIRE

Successful health care and preventive medicine are made possible when Dr. Branson has a comprehensive understanding of her patients. Please complete this questionnaire as thoroughly as possible.

Are you currently receiving healthcare? Y N

If yes, where and from whom?_____

If no, when and where did you last receive medical or health care? _____

What was the reason? _____

WHAT ARE YOUR MOST IMPORTANT HEALTH PROBLEMS?
List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Do you have any known contagious diseases at this time? Y/ N If yes, what?_____

CURRENT MEDICATIONS:
Please list any **prescription** or **over-the-counter medications** you are taking, with dosages.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list any **vitamins** or other **supplements** you are taking, with dosages.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

ALLERGIES: Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

HEIGHT & WEIGHT:

Weight:_____ lbs. Height: _____

IMMUNIZATIONS:

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Hepatitis B	Y N
HIB	Y N	Influenza	Y N

Any adverse reactions to immunizations? Please specify.

_____
_____

HOSPITALIZAION AND SURGERIES:

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

X-RAYS AND SPECIAL STUDIES:

X-rays, CAT scans, or other studies your child has had:

_____
_____
_____

MEDICAL HISTORY:

Please check those that are applicable.

☐ Asthma	☐ Ear infections	☐ Mumps
☐ Bronchitis	☐ Eczema	☐ Pneumonia
☐ Chicken pox	☐ Frequent Colds	☐ Scarlet Fever
☐ Croup	☐ Measles	☐ Tonsillitis
☐ Diphtheria	☐ Rheumatic fever	

Other:_____
_____

Any known exposure to heavy metals (mercury or lead paint) or toxins (pesticides or asbestos)? Y/N

FAMILY HISTORY:

	FATHER	MOTHER	SISTERS	BROTHERS
Age (if living)	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____
Check (√) those applicable				
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____
Anemia	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____

BIRTH HISTORY:

Born at how many weeks gestation? _____ weeks

Length of labor _____Weight at birth _____

Complications, if any _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

☐ Bleeding
☐ Cigarette, alcohol or drug use
☐ Diabetes
☐ Amalgam removal or fish intake
☐ High blood pressure
☐ Thyroid Imbalance
☐ Chemical exposure

Other health concerns _____

As a baby, did your child have any of the following?

☐ Allergies ☐ Blue baby ☐ Diarrhea ☐ Rashes
☐ Birth defects ☐ Colic ☐ Fever ☐ Seizures
☐ Birth injuries ☐ Cerebral palsy ☐ Jaundice ☐ Other _____

Feeding: Breast fed ____ How long? _____ months/years Formula: milk or soy

Age Began:

Sitting _____ months Crawling _____ months Walking _____ months
First tooth _____ months Solid foods _____ months First words _____ months

SYMPTOMS:
Y = YES N=NO P= PAST

Dizzy spells	Y P N	Nose bleeds	Y P N	Cries easily	Y P N
Heart murmur	Y P N	Bad breath	Y P N	Nervous	Y P N
Hair loss	Y P N	Constipation	Y P N	Nightmares	Y P N
Night sweats	Y P N	Diarrhea	Y P N	Unusual fears	Y P N
Headaches	Y P N	Gas	Y P N	Bone/joint pain	Y P N
Hearing loss	Y P N	No appetite	Y P N	Flat feet	Y P N
Sore throats	Y P N	Stomach aches	Y P N	Acne	Y P N
Light Sensitivity	Y P N	Vomiting spells	Y P N	Chronic rash	Y P N
Motion/car sick	Y P N	Canker sores	Y P N	Eczema	Y P N
Sleep problems	Y P N	Anemia	Y P N	Hives	Y P N
Extreme fatigue	Y P N	Frequent colds	Y P N	Bloody urine	Y P N
Bleeding gums	Y P N	High fever	Y P N	Burning urine	Y P N
Easy Bleeding	Y P N	Cough	Y P N	Frequent urine	Y P N
Easy bruising	Y P N	Wheezing	Y P N	Other _____	

DIET:

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Number servings *per week*

Fish_____
Red meat_____
Chicken_____

Number servings *per day*

Vegetables_____
Fruit_____
Water_____ in ounces

Does your child eat refined sugar? Y N
Does your child eat fast food? Y N
Does your child eat food with artificial colors or preservatives? Y N
Does your child eat artificial sweeteners? Y N

Extra Curricular Activities

_____
_____

PLEASE WRITE ANY ADDITIONAL INFORMATION (USE BACK IF NECESSARY)

_____
_____
_____
_____