Northwestern
Health Sciences University

NURSE PRACTITIONER INFORMED CONSENT FORM

Patient Name	File #	Date

Authorization

I hereby authorize the performance of diagnostic tests, procedures and treatment deemed necessary by my primary care provider. I understand that information about my case may be used in case presentations (my name and other personal information is kept confidential).

I understand that I may stop treatment at any time.

Printed Name _____

Signature _____ Date _____

2501 West 84th Street * Bloomington, MN 55431-1599 · 952.888.4777 · FAX:952.886.7592

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Authorization to Treat a Minor

Patient Name	File #	Date

Authorization

I hereby request and authorize the performance of diagnostic tests, procedures and treatment for my minor child.

As of this date, I have legal right to select and authorize health care services for the minor child named above.

(if applicable) Under the terms and conditions of my divorce, separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify NWHSU.

Printed Name_____ Relationship to Minor Patient

Signature _____Date_____

Witness_____ Date_____

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PEDIATRIC PATIENT INTAKE FORM

FOR OFFICE USE ONLY:

__ Bloomington Natural Care Center **__ Burnsville Natural Care Center** **__ Edith Davis Teaching Clinic** **__ Natural Care Center at Woodwinds** **__ University Health Services**	**Date: _____** **Account Number: _____**

Child's Name: _____
(Last, First, Middle Initial)

Mother's Name: _____
(Last, First, Middle Initial)
Address: _____

Phone: _____ Occupation: _____

Father's Name: _____
(Last, First, Middle Initial)
Address: _____

Phone: _____ Occupation: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Primary Healthcare Provider and/or Clinic: _____

Address: _____

Phone: _____

Your answers to the following questions will help us learn more about your child's health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your child's chief complaint today? _____

_____

Check all that apply.

☐ 1 .....Neck / Back / Joint pain

☐ 2 .....Headaches

☐ 3 .....Depression / Anxiety

☐ 4 .....Respiratory Problems (e.g., asthma, allergies, sinus congestion)

☐ 5 .....Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)

☐6 …..Urinary Problems (e.g., difficult or painful urination, kidney stones)

☐7 …..Fatigue or low energy

☐8 …..Female reproductive health

☐9 …..Male reproductive health

☐10…..Stress management

☐11…..General wellness

☐12 ….Other: _____

2. Health History

Please list any health problems your child currently has or has had. Answer to the best of your knowledge.

☐ Cancer (malignant or metastatic):

_____

☐ Diabetes (Type I or II):

_____

☐ Infectious Diseases (e.g. hepatitis, HIV):

_____

☐ Heart, Lungs and Circulation (e.g. asthma, heart murmur):

_____

☐ Digestive System (e.g. poor appetite, heartburn, constipation, diarrhea):

_____

☐ Psychosocial Health (e.g. depression, anxiety, violence toward self or others):

_____

☐ Skeleton and joints (e.g. arthritis, back or neck pain):

_____

☐ Genitourinary System (e.g. difficult or painful urination, kidney stones, sexually transmitted diseases, painful menses):

_____

☐ Nervous System (e.g. headache, dizziness):

_____

☐ Eyes, ears, nose, and throat (e.g. loss of vision or hearing, ear infections, severe dental problems):

_____

☐ Skin (e.g. rashes, sores, moles that have changed):

_____

☐ Chronic Immune System deficiencies (e.g. colds, sinusitis, bronchitis):

_____

☐ Other:

_____

Family Health History

Do/did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

☐ No

☐ Yes →Please describe your relation to this individual and their condition

_____

_____

3. PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

_____ Complications
_____ Medications
_____ Recreational drugs
_____ Smoking
_____ Alcohol
_____ Caffeine: Cola
_____ Caffeine: Coffee
_____ Caffeine: Tea
_____ Caffeine: Chocolate
_____ Caffeine: Other

_____ Vitamins/Minerals
_____ Any diagnosed Illnesses
_____ Hospitalization
_____ Immunization
_____ Bleeding
_____ Premature Contractions
_____ Back Pain
_____ Other Pain
_____ Excessive Weight Loss
_____ Excessive Weight Gain

_____ Toxic Exposures
_____ Allergic Reactions
_____ Mental Trauma
_____ Physical Injury
_____ Prenatal Classes
_____ Chiropractic Care
_____ Prenatal Care
_____ Carried to Full Term
_____ Attitude – Mostly Happy
_____ Attitude – Mostly Depressed

4. LABOR AND DELIVERY

_____ Greater than 12 Hours
_____ Complications
_____ Fetal Monitor Used
_____ Medications
_____ Forceps

_____ Caesarian
_____ Hospital
_____ Home Birth
_____ Premature Delivery
_____ Vacuum Extraction

Other_____

5. PERINATAL HISTORY – *If known please indicate*

The duration of the pregnancy was _____ weeks.
The apgar score at birth was _____
The apgar score at five minutes was _____
The length at birth was _____
The birth weight was _____

Please check any problems the patient had at birth:

_____ Breathing
_____ Coloring
_____ Crying
_____ Choking

_____ Nursing
_____ Sleeping
_____ Jaundice

_____Other_____ (Please Explain)

Please check if any item(s) applied to the patient at birth:

_____ Medication
_____ Artificial Feeding
_____ Vitamin K

_____ Surgery
_____ Erythromyocin
_____ Circumcision

_____Other_____ (Please Explain)

Please list your child's allergies: _____

_____

Please list any surgeries your child has had in the past, and their date: _____

_____

Please list any traumas or injuries:_____

_____

Please list current medications: _____

_____

6. NUTRITION

Please check if the patient has received any of the following items:

_____	Breast Milk	_____	Sweets
_____	Commercial Formula	_____	Juice: Fruit
_____	Cow's Milk	_____	Juice: Vegetable
_____	Goat's Milk	_____	Vitamins
_____	Solid Foods	_____	Medications
_____	Other _____		(Please Explain)

7. IMMUNIZATION

Please list any immunizations the patient has received along with the date it was received and any reactions observed: _____

_____

_____

_____

Note foreign travel: _____

_____

_____

_____

8. **Please identify your race, as defined by the federal government. (Please check <u>one</u>)**

☐1 ……Asian or Pacific Islander

☐2 ……Black/African American

☐3 ……Hispanic

☐4 ……American Indian or Alaskan Native

☐5 ……White

☐6 ……Other _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PERSONAL HEATLH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

OUR PRIVACY PLEDGE: The NWHSU-Clinic System is committed to full compliance with federal and state laws and regulations ensuring the privacy and confidentiality of our patients' and clients' personal health information; the clinicians and staff will make every effort to respect your privacy and keep confidential the health information entrusted to us.

Our Duties: We are required by law to maintain the privacy of your health information, to provide you with this notice of our legal duties and our privacy practices, and to abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices in accordance with federal or state law; any such change will apply to all of your information in our files.

University Clinic patients and clients will be asked to consent to the use or disclosure of your protected health information by agreeing to allow University clinicians or support staff members to:

- Use your health information within the University Clinic System, or disclose your health information to another health care provider or facility for the purpose of diagnosis, assessment or treatment of your condition.
- Use your health information within the University Clinic System, or disclose your examination, treatment and billing records to another party, such as an insurance carrier, an HMO or your employer for the purpose of receiving payment for services rendered to you.
- Use your health information, examination, treatment and billing records for quality control or other administrative purposes to efficiently and effectively operate the practice.
- Disclose your health information to business associates that perform services for the University's or your benefit and bill for it. All University business associates are contractually required by us to similarly safeguard the privacy and confidentiality of any personal health information disclosed to them.
- Use that information for research purposes, and then only after the University's Institutional Review Board (IRB) has reviewed and approved the research proposal, and established procedures to ensure maintenance of privacy and confidentiality.
- Use your personal health information to contact you by telephone, mail or e-mail with appointment reminders, NWHSU-Clinic System newsletters, information about treatment alternatives or other health related information that may be of interest to you. If not at home to receive an appointment reminder, a message may be left on your answering machine. We may also contact you for the purpose of providing University fundraising information.

Required or Permitted Uses and Disclosures Without Your Consent: Use or disclosure of your health information without your consent may be required or permitted in some circumstances, including but not limited to: 1) The extent that we are required or permitted to do so by applicable federal or state laws; 2) A public health authority for a wide range of public health activities when authorized to collect or receive your health information under federal or state law; 3) An appropriate government authority if there is reason to believe you are the victim of abuse, neglect or domestic violence; 4) Federal or state health care system and government benefit program oversight activities; 5) A response to a court order, or in response to a subpoena, discovery request or other lawful purpose; 6) Law enforcement officials when required to report certain types of wounds or physical injuries, or to comply with court orders, a grand jury subpoena or administrative requests; 7) An appropriate law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the person or the public; 8) A correctional institution if we provide health care services to you as a inmate; 9) Emergent care situations; and 10) Providing care to you that is related to a work-place injury to the extent necessary to comply with Minnesota's worker's compensation laws.

The Health Care Information Rights of Our Patients and Clients Include:

Your Right to Revoke Consent: You may revoke your consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your Right to Limit Uses or Disclosures: You have a right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services we provide at a place other than your home or if you would like the information in a different form.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, the University is not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without your consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purposes; 7) Were made to correctional or law enforcement officers; or 8) Were made prior to April 14, 2003.

We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time or access this notice on the Northwestern Health Sciences University website at www.nwhealth.edu.

Your Right to Complain: You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact the University Compliance/Privacy Officer at:

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR PRIVACY PLEDGE: The Northwestern Health Sciences University (NWHSU) Clinic System is concerned with and committed to the protection of our patients' and clients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the University may use or disclose your health care information include, but are not limited to:

- Another health care provider within the University Clinic System, or to another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- Business associates that we contract with to perform a service for your benefit.
- Research, when the University review board has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, lab or imaging results, information about our clinic facilities, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic facility, on the University web site at www.nwhealth.edu, and will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial here

[ ] I acknowledge receipt of the NWHSU-Notice of Privacy Practices

By signing below, I give consent to the NWHSU-clinicians or staff to disclose my personal health information as noted above.

Printed Name	**Authorized Provider Representative**
Signature	**Date**
Date	