Deborah Pyne, D.O.

Patient Information

Adolescent Intake Forms (12-17 years)

2305 Coit Road, Suite C
Plano, Texas 75075

(972) 733-1955
fax (972) 733-1990

drdebpyne.com
info@drdebpyne.com

Patient Checklist

We are pleased that you have chosen Deborah Pyne, D.O. to consult in your medical care. She will be working with you to help you understand your present condition and help achieve your intentions for improved health.

We ask that you complete and return this packet along with any additional paperwork before you come for your first appointment. You can email the completed forms, fax them to 972-733-1990, upload them here, or drop them off in person.

- [ ] Complete the enclosed forms in their entirety.
- [ ] Collect any relevant test results, x-rays/MRI reports and records. See page 9 for a medical records request form.
- [ ] Make a list of your symptoms and a timeline of these symptoms.
- [ ] Spend a few minutes thinking about your goal for the visit and write down any questions you want answered.
- [ ] Bring your medications and supplements in addition to the written list located on page 11.
- [ ] If you are coming for a musculoskeletal-related problem, wear soft, stretchy clothing like yoga pants or sweat pants.
- [ ] If a guardian is not accompanying you to your appointment, authorization must be provided to allow treatment. See page 10 for a consent for treatment form.
- [ ] Please help us maintain a fragrance free atmosphere for our chemically sensitive patients by avoiding cologne, perfume, and scented body products as much as possible on the day of your appointment.

Policy Statement

Our goal is to be partners in your healthcare. This requires both partners putting energy into the relationship. Our office is set up to facilitate you being in charge of your own health. Our office policies are designed with this in mind.

APPOINTMENTS

We provide Osteopathic Manipulation, Preventive and Wellness Services. We do not provide primary care or treat episodic or acute illnesses. Because of the nature of our practice, we are unable to book appointments on an urgent or emergency basis and are not available for medical care outside of regular office hours. If you do not have a primary care provider for urgent and emergency care, on request, we will provide you with a list of facilities that can be accessed for urgent and emergency medical care.

We encourage patients to arrive at least 5 minutes prior to your scheduled appointment. By being on time, you receive the full appointment time and the attention you deserve. We respect your time and try very hard to stay on schedule.

Create a space for your healing to begin. To facilitate this, bring your attention, bring your intention and have a plan of what you would like to accomplish.

We ask that cell phones are turned off while you are in the exam room so that we will not be distracted from the important partnership we are creating.

CONFIRMATION AND CANCELLATION OF APPOINTMENTS

We do not provide telephone appointment reminders. Courtesy email reminders are sent if you have an email on file. As email delivery cannot be guaranteed, it is your responsibility to keep the scheduled appointment or reschedule.

If you must cancel your appointment, please give 24 business hours. This means that if your appointment is on a Monday, you must cancel by the Thursday before. An office visit fee is charged if an appointment is not changed or cancelled in a timely fashion. **We will not reschedule new patients who are unable to abide by this policy.**

INSURANCE

We do not work for, or participate with any private insurance or managed care companies. You will be provided the appropriate forms and coding so you can file a claim with your insurance company. Insurance policies differ, and it is not possible to determine which medical services will be covered by your policy.

We are not accepting new Medicare part B patients and are unable to offer services to patients who participate in Medicare part B on a cash basis.

PAYMENT OPTIONS

Payment is due on the day of service, unless previous arrangements have been made. For your convenience, cash, Visa, MasterCard, Discover, AMEX or personal checks are accepted.

PHONE CALLS & MESSAGES

Our office hours are Monday to Thursday, 10:00 am to 6:00 pm. We are closed for lunch from 1:00 pm to 2:00 pm. If you call after hours, we will return your call on the next business day. If you have a medical emergency, call 911 or go directly to the nearest emergency room. When leaving a message, please include the following information:

- Full name
- Reason for call
- Best time to be called back
- Phone number(s)
- Email address (if desired)

PRESCRIPTION REFILL REQUESTS

It may take up to 72 hours to process a prescription refill request. Please plan ahead to avoid any interruptions in your medications. Prescription refills can be faxed to our office by your pharmacy. Our fax number is 972-733-1990.

Your signature below indicates that you have read, understand and agree to the policies of Deborah Pyne, D.O. If you have any questions, please make sure they have been answered satisfactorily before you sign.

Patient's Name

Name (parent or legal guardian) Signature Date

Notice of Privacy Practices

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you.

Uses and Disclosures of Protected Health Information

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Operations. We may use or disclose your protected health information as necessary, for our own health care operations in order to facilitate the function of the provider and to provide quality of care to all patients. Health care operations include, but are not limited to: Quality assessment and improvement; Training programs including those in which students, trainees, or practitioners in health care learn under supervision; Review and auditing, including compliance reviews, medical reviews, legal services.

Payment. Your protected health information will be used, as needed, to obtain payment for services that we provide.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

In the event of a serious threat to health or safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

Additional uses of information. Appointment reminders. Your health information will be used by our staff to send you appointment reminders. You may be called for your appointment by your first name while waiting for an appointment.

Individual rights. You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Other uses and disclosures require your authorization. Disclosure of your health information or its use for purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. If protected information needs to be discussed with someone other than the patient or responsible party, we need to have you fill out a form naming who is allowed this privilege.

Office of Deborah E. Pyne, D.O. duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise privacy practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to inspect protected health information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Deborah E. Pyne, D.O. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact. If you would like to request access to your records, submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Deborah E. Pyne, D.O.
2305 Coit Road, Suite C
Plano, Texas 75075

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Effective date. This notice is effective on or after April 15, 2003

I have been informed of my rights to protected health information.

_____

Patient's Name

_____

Name (parent or legal guardian) Signature Date

Electronic Communications Informed Consent

Deborah Pyne, D.O. provides patients the opportunity to communicate with her and her administrative staff using various electronic communication methods, including but not limited to, email, website contact forms, and personal electronic health record (EHR) portals. Transmitting health information using electronic communication methods, however, has a number of risks, both general and specific, that should be considered. Use of electronic communication relies a number of technical factors, many of which are outside the control of the sender or the recipient.

1. General risks include:
    - Most electronic communication forms are instant in nature.
    - Electronic communications can be transmitted anywhere around the world. They may be received and/or forwarded by many intended and unintended recipients without the original senders permission or knowledge.
    - Senders can easily misaddress an electronic communication.
    - Electronic communications are easier to falsify than handwritten or signed documents.
    - Copies of electronic communication may exist on sender or recipients devices, in their back-up data or on their service providers servers even after the sender or the recipient has deleted their original copy.
    - Electronic communication relies on a network of technology all working properly in order for a message to be sent and received.
2. Specific risks include:
    - Electronic communications containing diagnosis and/or treatment information must be included in patients protected personal health information. All individuals who have access to this protected personal health information will have access to these messages.
    - Patients who send or receive messages from their place of employment risk having their employer read their messages.
    - Patients who send or receive messages from a device on an unsecured network (e.g. free wifi) risk having their messages read by unknown persons.
3. We will use reasonable means to protect the security and confidentiality of all electronic communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of all electronic communication. Steps taken by our office to mitigate these risks include:
    - All electronic communications from our office are made using a secured network.
    - All technology service providers are properly vetted to ensure quality, security and reliability.
    - All office electronic devices and patient related softwares are password protected, including all internet or "cloud" based accounts. All passwords are recorded securely and are not accessible by anyone other than Deborah Pyne, D.O. and her administrative staff.
    - All electronic communications which concern diagnosis and/or treatment will be made a part of a patients protected personal health information and will be treated with the same degree of confidentiality as afforded other portions their health record.

- We will never provide patient contact information to a third party that is not authorized to participate in a patients care.

4. Patients must consent to the use of electronic communications after having been informed of the above risks. Consent to the use of electronic communications includes agreement with the following conditions:

    a. All messages to or from patients concerning diagnosis and/or treatment will be made a part of their protected personal health information. As a part of that protected personal health information, any authorization to release medical records will include these communications.

    b. Deborah Pyne, D.O. will endeavor to read messages promptly but can provide no assurance of the receipt of any electronic communications. Therefore, electronic communication must not be used for urgent matters.

    c. Because some medical information is so sensitive that unauthorized discloser can be very damaging, electronic communications should not be used for concerning diagnosis and/or treatment of AIDS/ HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; behavioral health, mental health or developmental disability; or alcohol and drug abuse.

    d. Because of the more public nature of these media, electronic communications concerning diagnosis and/or treatment is not permitted using social media, instant message, or text message (SMS). Patients may receive appointment reminders, event invitation and other general communications via these media as long as no diagnosis and/or treatment information is contained therein.

    e. Deborah Pyne, D.O. cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of these messages. Deborah Pyne, D.O. is not liable for improper disclosure of confidential information not caused by its employees' gross negligence or wanton misconduct.

    f. It is the responsibility of the patient to protect their password or other means of access to messages sent or received from Deborah Pyne, D.O. to protect confidentiality. Deborah Pyne, D.O. is not liable for breaches of confidentiality caused by the patient.

Any further use of electronic communications initiated by the patient that discusses diagnosis and/or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of electronic communications may be withdrawn at any time by written request to Deborah Pyne, D.O.

I have read this form carefully and understand the risks and responsibilities associated with the use of electronic communications. I agree to assume all risks associated with it.

_____

Patient's Name

_____

Name (parent or legal guardian) Signature Date

Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____

I authorize Name/Title: _____

Address: _____

_____

Telephone: _____ Fax: _____

To release my health information to:

Deborah Pyne, D.O.
2305 Coit Road, Suite C
Plano, Texas 75075
T: 972-733-1955 F: 972-733-1990

Type of Information:

- ☐ Complete Medical Records
- ☐ Lab Results Only
- ☐ Progress Notes Only
- ☐ Other _____

Notice: We are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights: This authorization to release health information is voluntary. This authorization may be revoked at anytime. The revocation must be in writing, signed by you or your representative. You are entitled to receive a copy of this authorization.

Expiration of Authorization: Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of you signing the form.

Name (parent or legal guardian) Signature Date

Consent For Treatment

I give permission for my child _____ to be medically evaluated and treated by Deborah Pyne, D.O. in my absence. I understand that it may be necessary to perform diagnostic test in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:

- physician evaluation and consultation
- osteopathic manipulation
- prescriptions and treatment
- laboratory, scoliosis and blood pressure screening
- first aid and emergency care
- referrals to an outside agency for services not provided at the office

If there are any services that you do not consent to in your absence, please list:

_____

_____

☐ My child will be accompanied by:

☐ himself/herself

☐ family member (name): _____

☐ other (name): _____

I give permission for Deborah Pyne, D.O. to share any relevant health information with the person who is accompanying my child.

Unless otherwise revoked, this authorization expires on _____ (insert applicable date) If no date is indicated, the authorization will expire 12 months after the date of you signing the form.

_____

Name (parent or legal guardian) Signature Date

General Information

Who is completing the forms? ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other Relative ☐ Other ☐ Patient			**Name if other than patient:**
Patient Last Name: **First:** **Middle:**			**Preferred Name:**
Birth Date:	**Age:**	**Sex:** ☐ M ☐ F ☐ Other	**Parent or Legal Guardian Mobile Phone:** ✓ if we may leave messages on this line ☐
Address:			**Patient Mobile Phone:** ✓ if we may leave messages on this line ☐
City: **Zip Code:**			**Home Phone:** ✓ if we may leave messages on this line ☐
Name of all Parents or Legal Guardians:			**Parent or Legal Guardian Work Phone:** ✓ if we may leave messages on this line ☐
How did you hear about our office?			**Parent or Legal Guardian Email Address:** ✓ if you have read the informed consent ☐
Pharmacy: **Phone:**			**Patient Email Address:** ✓ if you have read the informed consent ☐
Emergency Contact: **Relationship:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			
Primary Care Physician: **Address:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			
Other Contact: **Relationship:** **Phone:** ✓ to allow us to discuss/release medical information to this person ☐			

Name Signature Date

Health History

Patient Name:	**Birth Date:**

List your desired goals by priority:

List current and ongoing conditions or problems:

Weight:	**Height:**

Previous or Current Illnesses:

☐ ADD/ADHD ☐ Asthma ☐ Autism ☐ Cancer

☐ Chickenpox ☐ Diabetes ☐ Epilepsy

☐ Frequent Ear Infection ☐ Heart Conditions

☐ Hepatitis ☐ Kidney Disease ☐ Malaria ☐ Measles

☐ Mumps ☐ Rheumatic Fever ☐ Rubella ☐ Polio

☐ Scarlet Fever ☐ STD ☐ TB ☐ Reflux

☐_____

Immunizations and most recent dates:

☐ Hepatitis A _____ ☐ Hepatitis B _____

☐ Influenza (Flu) _____

☐ HPV _____

☐ Tdap (Tetanus, Diphtheria, Pertussis) _____

☐ MMR (Measles, Mumps, Rubella) _____

☐ Meningococcal _____

☐ Pneumococcal _____

☐ Varicella (Chickenpox) _____

Allergies (Medications, Food, Environment):

Medication List (include prescribed drugs, over-the-counter medications, vitamins and supplements):

Medication:	**Strength:**	**Dosing:**	**Medication:**	**Strength:**	**Dosing:**

List all family members' significant health problems. Include age the problem first occurred:

Mother:

Father:

Sibling:

Sibling:

List past surgeries and hospitalizations:

Incident:	Date:	Reason:	Comments:

List injuries or physical trauma you have experienced that may be related to pain:

Injury/Trauma:	Date:	Comments:

Have you undergone any of the following diagnostic studies? Include the date:

☐ Allergy Testing _____ ☐ Echocardiogram _____ ☐ EKG _____

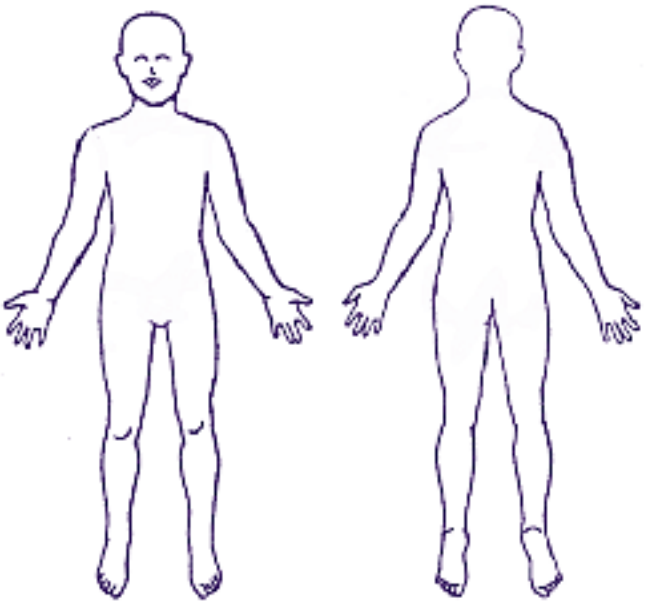
☐ Hearing Screening _____ ☐ Vision Screening _____

☐ CT Scan _____ Part of Body: _____ ☐ X-Ray _____ Part of Body: _____

☐ Ultrasound _____ Part of Body: _____ ☐ MRI _____ Part of Body: _____

Mark specific areas of pain with the following ratings:

1 - mild 2 - moderate 3 - severe



Do you experience numbness or tingling? ☐ Yes ☐ No

Where?

Do you experience any of the following?

☐ Joint Pain ☐ Joint Stiffness ☐ Joint Soreness

☐ Joint Redness ☐ Joint Heat ☐ Joint Swelling

Where?

Do you have any specific joint limitations? ☐ Yes ☐ No

Where?

Do you experience morning stiffness? ☐ Yes ☐ No

Lasts for _____ hour(s)

Do you have any lack of flexibility? ☐ Yes ☐ No

Where?

List any specific activities that cause you pain:

List any treatments you have tried and their outcome:

How do you FEEL about the following areas of your life?

Self: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Family: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Friends: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

School: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Eating Habits: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Activities: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Spirituality ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad Comments:_____

Please rate your daily energy levels:

☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

How many hours do you sleep at night?

Please rate your energy levels after exercise:

☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

Do you fall asleep within 15 minutes?

Please rate your stress levels:

☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

Do you sleep through the night?

Do you feel worse at certain times of year?

☐ Spring ☐ Summer ☐ Fall ☐ Winter

Do you wake feeling rested?

What are your hobbies and leisure activities?

What kind of exercises do you do?
☐ Jogging/Walking ☐ Weight Training ☐ Golf
☐ Cardio Machines ☐ Aerobics ☐ Pilates ☐ Tennis
☐ Yoga ☐ Other:

Do you exercise regularly? ☐ Yes ☐ No

How many times a week? ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Over the past 6 months, have you felt down, depressed or hopeless for more than 2 weeks at a time? ☐ Yes ☐ No

Over the past 6 months, have you felt little interest doing things for more than 2 weeks at a time? ☐ Yes ☐ No

Do you drink caffeine?: ☐ Yes ☐ No
# of cups per day:

Do/did you smoke? ☐ Yes ☐ No
# of years_____ #Packs_____ Year quit_____

Do you drink alcohol? ☐ Yes ☐ No
# of drinks per week_____

Have you ever been exposed to toxic chemicals or metals?

Do you experience any symptoms immediately after eating certain foods, such as belching, bloating, sneezing, or hives?

Do you experience any delayed symptoms after eating, certain foods (24 hours+) such as fatigue, muscle aches, or sinus congestion?

Do you feel worse after eating or drinking any of the following?
☐ High Fat Foods ☐ High Protein Foods ☐ Carbohydrates ☐ Sugar/Junk Foods ☐ Alcohol

Do you ever experience gas?
☐ Often ☐ Occasionally ☐ Rarely

Are you on a special diet?

How often to you typically have a bowel movement?
☐ More than 3 times a day ☐ 1-3 times a day ☐ 4-6 times a week ☐ 2-3 times a week ☐ 1 or less times a week

How would you describe your bowel movements?
☐ Soft and well formed ☐ Often floats ☐ Difficult to pass ☐ Diarrhea ☐ Thin, long and narrow
☐ Small and hard ☐ Loose but not watery ☐ Alternating loose/hard ☐ Greasy or shiny ☐ Brown
☐ Yellow or light brown ☐ Color Varies ☐ Dark or black ☐ Greenish

How often have you taken antibiotics?:
☐ less than 5 times ☐ more than 5 times

How often have you taken oral steroids?:
☐ less than 5 times ☐ more than 5 times

Have you noticed any of the following changes to your hair?
☐ Dryness ☐ Brittle ☐ Change in texture ☐ Thinning ☐ Hair loss ☐ Other_____

Have you noticed any of the following changes to your skin?
☐ Dryness ☐ Redness ☐ Rash ☐ Oily ☐ Acne/Breakouts ☐ Other_____

Women Only

Last OB/GYN exam:

Last mammogram:

Last menstrual period:

Age of first menstrual period:

Length of menstrual periods:

Do you experience any of the following during your cycle?
☐ Heavy Flow ☐ Irregularity ☐ Spotting ☐ Pain ☐ Discharge

Number of pregnancies:

Number of live births:

Method of birth control:

Men Only

Last prostate exam:

Method of birth control: