DR. ANNA EKSTROM
Osteopathic Physician
1 First Street, Suite 3, Los Altos 94022
(510) 505-4775

OFFICE POLICY

Welcome to my office!
Please remember to bring your completed forms as well as a list of any supplements, any recent blood work, and/or medications you are currently taking. To help you get acquainted with my office, please familiarize yourself with my policies and fee schedule as outlined below.

YOUR APPOINTMENT

Your appointment time is set-aside especially for you and your physician. **My office requires 24-hours notice in the event that you must cancel your appointment. Patients who miss their appointment or cancel at the last minute will be charged for the full amount of the appointment.** Please understand that I dedicate a significant amount of time for each patient visit, and a missed appointment is lost time that could have gone to a patient on my wait list. My office will endeavor to contact you in advance to confirm your appointment.

CURRENT FEE SCHEDULE

DR. EKSTROM

Initial Patient Evaluation and Treatment for new adult	**$ 400**
Initial Patient Evaluation and Treatment 1-18 years old	**$ 360**
Initial Patient Evaluation and Treatment under 12 months old	**$ 300**
Follow-up Treatments for adult	**$ 240**
Follow-up Treatments for children under 18 years old	**$ 200**
Travel Fee	**$50 + $1/mile**

Payment is required at the time of your appointment. I regret that I am unable to accept any of the following: Disability insurance, Worker's compensation, Medi-Cal, Medicare, Liens, or assignments from your insurance carrier. Cash and check are preferred; I do accept visa or master card. Please write checks to "Intuitive Wellness."

Please refrain from wearing perfumes to my office in consideration of patients with chemical sensitivities.

Thank you for taking the time to read my policy sheet. I look forward to working with you and supporting your health!

Patient Signature_____ Date_____

Parent/Guardian Signature for Patient Under 18_____

Date_____

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Practice Policies, Disclosure Statement and Consent to Treat

Welcome to my practice. My mission is to combine osteopathic manual medicine with the best of integrative medicine from both Eastern and Western approaches. I partner with you to help you heal, recover and thrive. I use hands-on manual medicine to restore the natural functions of your body. When your body works, you can heal yourself and avoid further illness and pain. Research has demonstrated that osteopathic manual medicine supports the nervous and immune systems, helping your body to not just feel and move better, but be better.
Decades of studies have shown structural problems can cause illness. Somatic dysfunction can make you sick, and can prevent you from benefitting from the health benefits of other lifestyle interventions you are choosing. I help remove this obstacle to health and wellness, allowing you to live as fully as possible.

Osteopathic Manual Medicine:
Osteopathic medicine is a distinct form of medical practice in the United States. Osteopathic medicine provides all of the benefits of modern medicine including prescription drugs, surgery, and the use of technology to diagnose disease and evaluate injury. It also offers the added benefit of hands-on diagnosis and treatment through a system of therapy known as osteopathic manipulative medicine. Osteopathic medicine emphasizes helping each person achieve a high level of wellness by focusing on health promotion and disease prevention. The principles of osteopathic medicine emphasize the interrelationship between the structure and function of the body and recognize the body's ability to heal itself. Osteopathy in the Cranial Field is a holistic healing practice that uses very light touching to balance the craniosacral system in the body, which includes the bones, nerves, fluids, and connective tissues of the cranium and spinal area.
I use osteopathic manual medicine (OMM) as an integral part of my patient care for many conditions. Osteopathic manual care is hands on medical care to improve the function of muscles, bones, nerves, and organs, which requires that the physician touch the patient. Because the body is a continuous whole, restrictions in one part of the body can have far-reaching consequences, and cause problems at part of the body not immediately connected. An example of this might be a short leg causing headaches, or a pelvic problem causing neck pain. I welcome questions from patients. Please let me know if there are questions about your care that I have not anticipated or addressed.

Specialty Care:
Just as all doctors are capable of taking and treating your blood pressure, all osteopaths are capable of using OMM, and therefore some insurances will list us as primary care. But even though all doctors are capable of treating blood pressure, there comes a time you may need a blood pressure specialist. Similarly, I am a Neuromusculoskeletal specialist, treating more complicated patients. Because of this, I am operating under the standard of care for my specialty. Because of this, some of your treatment recommendations may be substantially different from those of your primary care provider/physician. You will be provided with information to help you make the most educated decision about your health. In my Osteopathic Manual Medicine practice, I do not provide primary care. This means that you must have a primary care provider who is available for routine, on-call and emergency care. If you require urgent care, please call your primary provider, go to an urgent care or emergency room, or call 911.

Medication:
I rarely prescribe controlled substances, and never on the first visit. Current standard of care does not support controlled substances for most pain syndromes. All refills, regardless whether controlled or not, can take up to two business days to refill. Please request that your pharmacy contact me well in advance if you're running out. If you have not been seen recently, I may require an office visit before prescribing. This is the standard of care as determined by our profession and state statues, and is for your safety. Certain medication will not be refilled unless lab tests have been done.

Care for a Minor:
A parent or legal guardian is required to give consent to treat a minor and acknowledge payment responsibility. In case of joint legal custody, both parents need to sign this document. If a minor is the subject of a court order, settlement or custody agreement, I will need to see a copy or agreement by the parent or guardian who has been awarded or granted legal custody of the child. If two separated or divorced parents share legal custody, both parents must approve all requests for information or consent.

A minor has the right to request their private data be kept from their parents or legal guardians under certain circumstances. Their request will be honored if it is believed to protect a child from physical or psychological harm, or if confidentiality is in the best interest of the child. However, parents and legal guardians have the right to information regarding their underage child, and efforts will be made to engage in family participation.

I have read, understand, and agree with Dr. Anna Ekstrom's Policy and Disclosure, and Privacy Statements. I also understand that Dr. Anna Ekstrom does not provide primary care, on-call, hospital or emergency care services.

Anna Ekstrom, DO, MPH does provide specialty care and requires me to have my own primary care practitioner. By signing below, I agree to the policies and practices as outlined above. I understand the cancellation policies, and agree that any services I receive are my financial responsibility to be paid at the time of service. I give my consent to be treated and will pay for services with either cash or check.

Patient's Name (print), guardian's name and relationship to patient

Patient's or guardian's signature

Date

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Notice of Health Information Privacy Practices (HIPAA)

What Is This Notice and Why It Is Important?

This noticed is required by law and described policies, which conform to federal and state laws, designed to safeguard and protect your privacy. The following describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please read it carefully.

Your Rights

You have certain rights regarding your health and billing records, which include the right to:

- Request restrictions on the use and disclosure of your protected health information.
- Receive confidential communications concerning your medical condition and treatment.
- Inspect and copy your protected health information.
- Amend or submit corrections to your protected health information.
- Add information or revoke authorizations at any time or stop future disclosures.
- Receive accounting of how and to whom your protected health information has been disclosed
- Receive a copy of this notice

My Responsibilities:

I am required by law to maintain the privacy of your protected health information and provide you with this notice of privacy practices.

I am also required to establish policies and procedures that govern my workforce and business associates, and abide by the terms of this notice.

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, health professionals who may provide treatment or who may be consulted by staff members may request copies or results of laboratory tests and procedures available in your medical record.

Payment. Your health information may be used to seek payment from your health plan or from credit card companies that you may use t pay for services, and from other sources of coverage. For example, your health plan may request and receive information on dates of service, the services provided, and the health condition being treated.

Health Care Operations. Your health information may be used as necessary, to support the day-to-day activities and management of my practice. For example, information on the services you received may be used to provide budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. We may disclose your health information for required law enforcement purposes or in response to a valid subpoena, issued by a judge, court or administrative order, or other mandated reporting requirements.

Regulatory Oversight. Your health information may be disclosed as required by law to public health agencies or legal authorities charged with preventing or controlling disease, injury or disability.

Averting Serious Threats to Health and Safety. We are mandated to report health information when necessary to prevent a serious threat to you, the public, or another person. Disclosures would be made to the County Department of Health, or for immediate threats, the police.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to remind you of upcoming appointments or advise for health maintenance. Please indicate a private number or email where you would like us to leave messages on the attached contact section.

Workers' Compensation. We may disclose your health information to Workers' Compensation or other similar programs established by law.

Marketing. We may use your health information to inform you about our health care services, treatment alternatives or other health related benefits that may be of interest to you.

Information About Treatments. Your health information may be used to send information pertinent to the treatment and management of your health. You may be informed about products or services that may relate to your health conditions.

Business Associates. There are some services provided through contracts with business associates. Examples include medical record transcriptionists, copy services, patient satisfaction surveyors or consultants. All business associates sign a confidentiality agreement verifying that they will safeguard your information.

Research. Occasionally, I may participate in research studies. You may be contacted about the nature of the research and request your participation. If treatment is part of the study, the researcher will explain the benefits and risks, how your health information will be used during the course of study, and whether any of your rights will be affected.

Request 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. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Right to Revise Privacy Practices:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices; federal and state laws and regulations may require these changes. 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.

For More Information or to Report a Problem:

If you have questions, would like additional information, or if you believe we have not properly protected your privacy, have violated your privacy rights, or disagree with a decision we have made about your rights, you should call the matter to our attention. Please write a letter describing the cause of your concern to:

Anna Ekstrom, D.O., M.P.H.
1 First Street, Suite 3, Los Altos 94022
Sunnyvale, CA 94087

NEW PEDIATRIC PATIENT FORM

Dr. Anna Ekstrom, 1 First Street, Suite 3, Los Altos, CA 94022

Child's Name:_____ Date: _____
Parent's Name: _____
Address: _____ E-mail: _____
City/State/Zip: _____ Cell Phone: _____
Date of Birth: _____ Sex: _____ Referred by: _____

1. Current symptoms, problems, health concerns, and reason for visit: _____
_____
_____

2. Prescription medications: _____

3. Other medications (including over-the-counter meds, supplements, herbs, homeopathic remedies, etc.):
_____
_____

4. Allergies to medications: _____
5. Other allergies (foods, mold, pets, etc.):_____
6. Other food sensitivities:_____
_____

7. Major medical problems (including illnesses, hospitalizations, surgeries, major dental work): _____
_____

8. Describe any traumas, including car accidents, falls, head injuries, sports injuries, fractures (include year occurred):_____
_____
_____

9. Other therapies & treatments (past or present): _____
_____
_____

10. Describe child's sports activities, exercise routine, or level of activity: _____
_____
_____
_____

11. Birth History: ☐ Full-term ☐ Premature ☐ Late ☐ C-Section ☐ Forceps/Vacuum ☐ Vaginal Delivery
Any complications during pregnancy, delivery, or post-partum? _____
_____

Older Siblings _____ # Younger Siblings _____

Mother's Age at Delivery: _____ Current Weight: _____

Gestational Age at Delivery: _____ Birth Weight: _____

12. Neonatal History

Breast milk	Yes ☐ No ☐	Colicky	Yes ☐ No ☐
Formula	Yes ☐ No ☐	Failure to Thrive	Yes ☐ No ☐
Bottle fed (either)	Yes ☐ No ☐	Good sleeper	Yes ☐ No ☐
Pacifier	Yes ☐ No ☐	Placed on belly as infant	Yes ☐ No ☐
Strong suck	Yes ☐ No ☐	Favored one side	Yes ☐ No ☐
Frequent Spit-ups	Yes ☐ No ☐		

Age first slept through night: _____ Age started solid foods: _____

13. Please describe sleep habits: _____

_____

14. Orthodontia? When? _____

15. Learning difficulties? _____

16. Past Medical History (please check all that apply)

☐ Seizures	☐ Lyme Disease	☐ Bladder Infections
☐ Asthma	☐ Hepatitis	☐ Kidney Disease
☐ Hives/Eczema	☐ Anemia	☐ Easy Bruising
☐ Bronchitis	☐ Low Blood Pressure	☐ Frequent ear infec.
☐ Ear	☐ Meningitis	
☐ Other _____		

17. Immunization Status (check if received, indicate most recent date)

☐ MMR _____	☐ Polio _____
☐ Hep B _____	☐ Hepatitis A _____
☐ Varicella _____	☐ Meningococcal _____
☐ Rotavirus _____	☐ Annual Flu _____
☐ Hib (Haemophilus) _____	☐ HPV _____

☐ Tetanus/Diphtheria/Pertussis (Whooping cough) _____

18. Other Exams (Date/Result)

☐ Food Sensitivity _____

☐ Saliva/Urine Hormone Testing _____

☐ Hair/Urine Heavy Metal _____

☐ Digestive Function/Stool Analysis _____

☐ Neurotransmitter Testing _____

19. Does child use:

☐ Glasses ☐ Contact lenses ☐ Hearing aid

20. Last Dental Exam _____

21. Imaging (Date/Result)

X-ray _____

MRI_____

CT Scan _____

Ultrasound/Sonogram _____

22. Any other abnormal labs or tests? _____

23. Intake

Glasses water per day: _____ Sodas (# per week) – Diet or regular? _____

Dietary restrictions/preferences: _____

24. Family History (please indicate relationship)

Cancer _____
Leukemia _____
Tuberculosis _____
Depression _____
Bipolar/Schizophrenia _____
Substance Abuse _____
Suicide _____
Migraines _____
Seizures _____

Allergies _____
Asthma _____
Eczema _____
Anemia _____
Chronic Lung Disease _____
Thyroid Disease _____
Kidney Disease _____
Diabetes _____
Bleeding Tendency _____

25. List present age of family members & state of health (good, fair, poor). If deceased, list cause of death & age.

Father _____
Mother _____

Sibling(s) _____
_____
_____

Review of Systems

26. Please mark any symptoms that child has experienced in the past year

Change in appetite ☐	Blurry vision ☐	Bloating/belching ☐
Persistent fever ☐	Tinnitus ☐	Flatulence ☐
Hot flashes ☐	Sinusitis ☐	Constipation ☐
Night sweats ☐	Nasal congestion ☐	Diarrhea ☐
Skin rash ☐	Mouth breathing ☐	Hemorrhoids ☐
Change in nails/hair ☐	Shortness of breath ☐	Abdominal pain ☐
Easy bruises/bleeding ☐	Palpitations ☐	Frequent urination ☐
Headaches ☐	Restless legs ☐	Burning w/urination ☐
Migraines ☐	Cold hands/feet ☐	Urinary hesitancy ☐
Double vision ☐	Heartburn ☐	Urinary urgency ☐

27. Please describe any major stressors in patient's life (family, school, living situation, etc.).

_____

_____

_____