Steelsmith Natural Health Center

Dr. Laurie Steelsmith, N.D., L.Ac.
Dr. Kristen Coles, N.D., L.Ac.

Our Location:
Eaton Square in Waikiki
438 Hobron Lane, Suite 314
Honolulu, HI 96815

Phone: (808)943-0330
Fax: (808)943-0334
Website: www.steelsmithhealth.com

Hours:
Monday-Friday: 9:00am-5pm
Saturdays: 9:00am-4pm
Closed Sundays

Parking:
There is metered parking, however, we do have a parking garage that attaches to our building. We recommend parking on level 2½ or 3. While in the garage, look towards the mountains and walk towards the end of the garage. The entrance/exit to the garage is at the end. We are located directly above First Hawaiian Bank. We are not located in the Villa Professional Building. If you see suite 315 you are not in the right building. Call us if you are lost. Please bring the pink parking validation with you, we charge a flat rate of $6.00.

Cancellation Policy/No Show Policy for Doctor Appointments
****If an appointment is not cancelled at least 48 hours in advance you will be charged half of the appointment's fee.****
We understand that there are times when you must miss an appointment due to an emergency or obligations for work or family. However, please understand that when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a doctor's "full" appointment book.

Scheduled Appointments
If you are more than 20 minutes late we will do our best to accommodate you, however, we may have to reschedule depending on the service being rendered.

Account Balances
It is our policy that payment is due at the time of service.

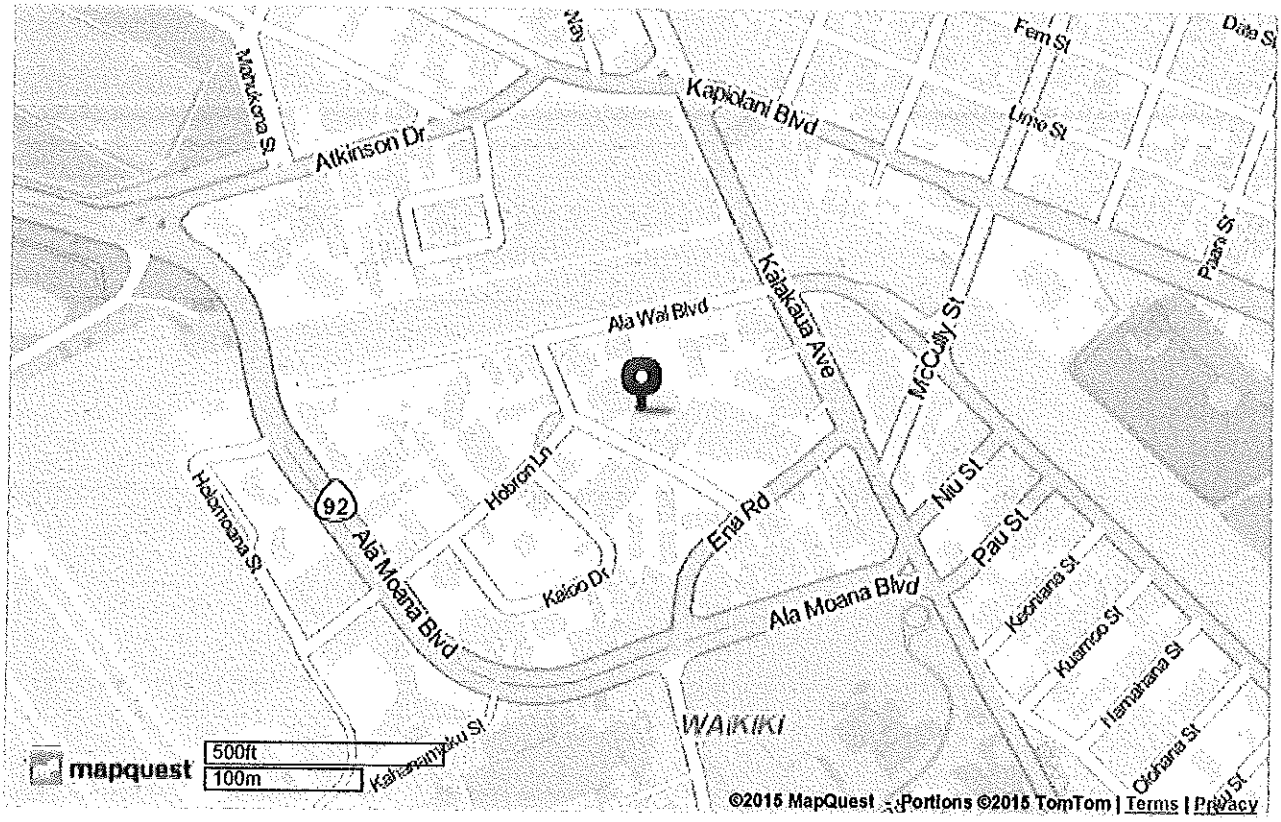
_____ _____ _____/_____/_____
Print Name Patient Signature Patient/Guardian Date

mapquest

Map of:
438 Hobron Ln
Honolulu, HI 96815-1222

Notes

We are located in Eaton Square, in the open courtyard area right above First Hawaiian Bank. Please arrive 10-15 minutes early for parking and so that we may process your paperwork.



Steelsmith Natural Health Center, Inc.
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Thank you for taking the time to care for yourself! Successful health care and preventive medicine are possible only when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please answer the following questions as completely as possible. The information you provide will help us create a quality treatment protocol specified to your individual needs.

Confidential Pediatric/Adolescent Patient Profile

Name: _____ Today's Date: _____

Address: _____ Age: _____ Birth Date(mm/dd/yyyy): _____

City: _____ State: _____ Gender(M/F): _____ Height: _____

Zip Code: _____ Weight: _____

Parent's Phone Home: _____ Can messages be left for you here? ◯ Yes ◯ No

Work: _____ Can messages be left for you here? ◯ Yes ◯ No

Cell: _____ Can messages be left for you here? ◯ Yes ◯ No

Parent's Email: _____ Would you like to receive our free informational newsletter? ◯ Yes ◯ No

Please note: email is the best way for us to stay in touch with you about educational events and Steelsmith Natural Health Center news.

Would you prefer we contact you via U.S Postal mail? ◯ Yes ◯ No

Parent or Guardian: _____ Emergency Contact: _____

Child's School: _____ Emergency Contact's Phone: _____

Insurance: _____ How did you hear about us? _____

What goals would you like to achieve in regard to your child's overall health?

In 4 to 6 months: _____ In 1 to 2 years: _____

Please list your health concerns for your child in order of their priority:

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

Please list any prescription or over-the-counter medications that your child is currently taking:

Name of Medication	Dose	Reason for Taking	How Long Taken	Who Prescribed

Please list any vitamins, minerals, herbs, or homeopathic remedies that your child is currently taking:

Name of Medication	Dose	Reason for Taking	How Long Taken	Who Prescribed

What medications is your child allergic to? _____

What foods or other substances is your child allergic to? _____

Does your child crave certain foods? ◯ Yes ◯ No What Kinds? _____

Please list your child's current health care providers, type of practitioner, and why you saw them:

Name	Type of Practitioner	For What Reason	Phone (if available)

Hospitalizations, serious illnesses, injuries, and surgeries (please list reasons and dates):

_____

_____

_____

_____

Date of last full physical exam: _____ Results: ◯ Normal ◯ Other Explain: _____

Date of last blood work: _____ Results: ◯ Normal ◯ Other Explain: _____

Lifestyle Habits:

Coffee: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

Black Tea: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

Soft Drinks: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

Alcohol: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

Recreational Drugs: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

Current Tobacco Use: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

Past Tobacco Use: ◯ None ◯ Daily ◯ Weekly ◯ Monthly Amount? _____

When and for how long? _____

Your Child's General History: Please check any of the following conditions your child has, or has had in the past, and indicate when.

☐ Acne	_____	☐ Drug Abuse	_____	☐ Migraines	_____
☐ Alcoholism	_____	☐ Dry Skin	_____	☐ Muscle Cramps	_____
☐ Allergies	_____	☐ Excessive Hunger	_____	☐ Muscle Pain	_____
☐ Anemia	_____	☐ Excessive Thirst	_____	☐ Night Sweats	_____
☐ Anxiety	_____	☐ Fatigue	_____	☐ Phlebitis	_____
☐ Arthritis	_____	☐ Fevers	_____	☐ Pneumonia	_____
☐ Asthma	_____	☐ Fibroid Tumors	_____	☐ Polio	_____
☐ Blood in Stool	_____	☐ Fluid Retention	_____	☐ Poor Circulation	_____
☐ Blood Pressure (High)	_____	☐ Genital HPV	_____	☐ Pruritis (Itching)	_____
☐ Blood Pressure (Low)	_____	☐ Giardia / Parasites	_____	☐ Psoriasis	_____
☐ Breast Implants	_____	☐ Gonorrhea	_____	☐ Rapid Heart Beat	_____
☐ Bronchitis	_____	☐ Gout	_____	☐ Rectal Itch / Burn	_____
☐ Cancer (What Type?)	_____	☐ Headaches	_____	☐ Ringing in Ears	_____
☐ Candidiasis	_____	☐ Hemorrhoids	_____	☐ Severe Diarrhea	_____
☐ Chest Pain	_____	☐ Hepatitis	_____	☐ Shortness of Breath	_____
☐ Chlamydia	_____	☐ Herpes	_____	☐ Skin Rashes	_____
☐ Colitis	_____	☐ High Cholesterol	_____	☐ Staph Infections	_____
☐ Constipation	_____	☐ Hypoglycemia	_____	☐ Strep Infections	_____
☐ Cysts (breast)	_____	☐ Irritable Bowel	_____	☐ Stroke	_____
☐ Cysts (ovarian)	_____	☐ Joint Pain	_____	☐ Thyroid Disorder	_____
☐ Depression	_____	☐ Malaria	_____	☐ Tremors	_____
☐ Dizziness	_____	☐ Mental Disorder	_____	☐ OTHER	_____

Family History: Please check all that apply to your child's family history(including both mother and father's family) and indicate which relative had which condition.

☐ Alcoholism	_____	☐ Genetic Disorder	_____	☐ Obesity	_____
☐ Alzheimer's Disease	_____	☐ Glaucoma	_____	☐ Osteoarthritis	_____
☐ Autoimmune Disease	_____	☐ Heart Disease	_____	☐ Osteoporosis	_____
☐ Cancer (What Type?)	_____	☐ High Blood Pressure	_____	☐ Parkinson's Disease	_____
☐ Diabetes	_____	☐ Mental Disorder	_____	☐ Thyroid Disorder	_____

Childhood Illnesses: Please check if your child had any of the following.

☐ Chicken Pox	☐ Mumps	☐ Rubella	☐ Scarlet Fever
☐ Measles	☐ Polio	☐ Rheumatic Fever	☐ Whooping Cough

Vaccinations: Please indicate if your child has been vaccinated for any of the above illnesses.

_____

Birth History: Please indicate any concerns present for mother or child during pregnancy or childbirth, including method of delivery.

_____

_____

Feeding: Please indicate whether your child was breast fed, formula fed, or both. _____

HIPAA Notice of Privacy Practices

Effective: Apil 14, 2003 - Revised: August, 2013

** *SIGNATURE REQUIRED AT BOTTOM OF FORM* **

Steelsmith Natural Health Center
438 Hobron Lane, Suite 314
Honolulu, HI 96815
Web version located at: www.steelsmithhealth.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your **protected health information (PHI)** 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. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, imaging centers, workers compensation adjusters and nurse case managers, etc. to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your PHI for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must also disclose your PHI when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) - Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your PHI - This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to request an amendment to your protected health information - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures - You have a right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive a notice of a breach - We will notify you if your unsecured PHI has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe you privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer, by telephoning us at 808-943-0330, of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number listed above.

Please sign below to acknowledge you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

***** SIGNATURE REQUIRED AT BOTTOM OF FORM *****

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 treatment.

Patient(or representative) Signature: _____ **Date:** _____ _____

(Please indicate re relationship if signing for patient)

CONSENT FOR TREATMENT

***** SIGNATURE REQUIRED AT BOTTOM OF FORM *****

I hereby authorize the doctors at Steelsmith Natural Health Center, licensed Naturopathic physicians and licensed acupuncturists, to perform the following specific procedures as necessary to facilitate the diagnosis and treatment:

General Diagnostic Procedures: These include but are not limited to venipuncture (drawing blood), pap smears, radiography, blood and urine labwork, general physical exams, and neurological and musculoskeletal assessments.

Psychological Counseling, Lifestyle Counseling, and Exercise Prescriptions

Herbs and Natural Medicines: This includes the prescribing of various therapeutic substances including plants, minerals, animal materials, substances from traditional Chinese medicine, and homeopathic remedies, Substances may be given in the form of teas, pills, powders, tinctures (which may contain alcohol), topical creams, pastes, plasters, washes, suppositories, or other forms. I understand that I am not required to take these substances but agree to follow the directions for administration and dosage if I decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to, changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. In the event that I experience any problems that I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.

Dietary Advice and Therapeutic Nutrition: This includes the use of foods, diet plans, or nutritional supplements for treatment.

Soft tissue and Osseous Manipulation: This includes the use of massage, neuromuscular techniques, muscle energy stretching, visceral manipulation, acupuncture, tui na (a form of massage), and manipulations of the extremities and spine, including traction and craniosacral therapy, as part of an array of treatment to modify or prevent pain, or pain perception, and to normalize my body's physiological functions. I am aware that certain adverse side effects may result from these treatments. These could include, but are not limited to, bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is uncomfortable.

Electromagnetic and Thermal Therapies: These include the use of muscle stimulation with an interferential machine, microcurrent stimulation, infrared and ultraviolet therapies, moxabustion (warming, or indirect burning of an acupuncture point), and hydrotherapies. I understand that I may be asked to have electro- acupuncture administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to, electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the surface of the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain or pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to, local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to terminate treatment at any time.

Cupping: I understand that if I receive cupping, bruising may occur.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for more detailed explanation. I give my permission and consent to treatment, understanding that the Doctors at Steelsmith Natural Health Center have given no guarantees regarding improvements of my condition. I hereby release the physicians at Steelsmith Natural Health Center from any and all liability that may result from any procedures, including any of the above procedures, when performed with appropriate medical care. I understand that I am free to withdraw consent and to discontinue participation in any of these procedures at any time. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Signature: _____ **Date:** _____

(Patient, or legal guardian if under 18 years of age)

Printed Name: _____ **Date of Birth:** _____

Steelsmith Natural Health Center, Inc.
438 Hobron Lane, Suite 314
Honolulu, HI 96815
808-943-0330 (ph), 808-943-0334 (fax)

Release Form

Print Name: _____ **Date:** _____

I give permission to the doctors at Steelsmith Natural Health Center to discuss the following health concerns:

1) _____
2) _____
3) _____
4) _____
5) _____

With the following physicians or health care workers:

1) _____
2) _____
3) _____
4) _____
5) _____

Sincerely,

Signature: _____