

Do you have any current concerns regarding you child's health? _____

Have you had these conditions evaluated before? YES NO
 If yes, by whom and what did they find? _____

When did you first notice these symptoms? _____
 Are these symptoms getting progressively worse? _____

Which symptoms are constant? _____

Which symptoms come & go? _____

How many hours does your child sleep/night?



On a scale from 0-10, how would you rate the healthiness of your child's overall diet?

0 = the worst
10 = the best



Child's favorite foods 1. 2. 3. 4.	Child's Most Common Beverages 1. 2. 3. 4.	Has your child...? <input type="checkbox"/> ... ever been x-rayed? <input type="checkbox"/> ... ever had any broken bones? <input type="checkbox"/> ... ever been vaccinated? <input type="checkbox"/> ... had problems nursing?
Any Medications? YES NO IF YES, please list. 1. 2. 3. 4.	List any surgeries and/or dates of hospitalization? 1. 2. 3. 4.	What descriptions fit your child? 1. Obedient, compliant 5. None of these even 2. High maintenance remotely 3. Chronically sick resembles 4. Tired and/or lazy my child.

CONDITIONS YOU HAVE HAD OR BEEN DIAGNOSED WITH AT ANY TIME IN PAST

1. ADD/ADHD 2. Aggressive personality 3. Allergies <input type="checkbox"/> animal <input type="checkbox"/> dust <input type="checkbox"/> food <input type="checkbox"/> grass <input type="checkbox"/> mold <input type="checkbox"/> pollen <input type="checkbox"/> ragweed <input type="checkbox"/> other <input type="checkbox"/> _____ <input type="checkbox"/> _____ 4. Antibiotics – How many times? _____ 5. Appendicitis 6. Asthma 7. Behavior problems 8. Bladder Infection 9. Bleeding disorders 10. Bronchitis 11. Bumpy skin on back of arms	12. Cancer 13. Cavities (dental) FEW SOME MANY 14. Chicken pox 15. Colic 16. Constipation 17. Cough (chronic) 18. Diabetes 19. Diarrhea (regular or persistent) 20. Ear Infections 21. Eczema 22. Epilepsy 23. Fractures 24. Frequent colds/flus 25. Headaches 26. Heart disease 27. Hernia 28. HIV positive 29. Insomnia or other sleep problems 30. Kidney disease 31. Liver disease 32. Measles	33. Mononucleosis 34. Mumps 35. Pneumonia 36. Polio 37. Rheumatoid arthritis 38. Rheumatic Fever 39. Ringworm 40. Scarlet fever 41. Sinus Infections 42. Stomach aches 43. Temper tantrums 44. Throat infections/sore throat 45. Thyroid problems 46. Thrush 47. Tonsillitis 48. Tumors/growths 49. Whining and/or weepy 50. Whooping cough 51. Yeast infections 52. OTHER CONDITIONS
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Family History		Vaccinations	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Gestational Diabetes	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Mumps	<input type="checkbox"/> Polio
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Rubella	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Food allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Pertussis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Pneumonia/Flu-# of times ____	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Stroke	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> I have chosen to not have this child vaccinated	

Circle Blood Type	Ethnicity
<input type="checkbox"/> A positive	<input type="checkbox"/> Caucasian
<input type="checkbox"/> A negative	<input type="checkbox"/> Asian
<input type="checkbox"/> B positive	<input type="checkbox"/> African
<input type="checkbox"/> B negative	<input type="checkbox"/> American Indian
<input type="checkbox"/> O positive	<input type="checkbox"/> Jewish
<input type="checkbox"/> AB positive	<input type="checkbox"/> Middle Eastern
<input type="checkbox"/> O negative	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> AB negative	<input type="checkbox"/> Hispanic
	<input type="checkbox"/> Other (describe)

By signing below, I acknowledge the above to be true to the best of my knowledge.

Parent/Guardian Signature _____ Date _____ Doctor's Initials/date _____

This section is entirely voluntary: The following questions are geared to help the doctor in evaluating where your beliefs are at spiritually. There is a connection between mind, body and spirit. Although the doctor is not a pastor, nor is he a psychologist, it is necessary for the doctor to evaluate your condition from every perspective to gain insight into what is going on and how best to help you.

Check those box(es) that describe your beliefs (as many as apply):

- I believe that there is a God/creator.
- I am a Christian (believe in Jesus Christ)
- I am a Muslim
- I am a Buddhist
- I am Jewish
- I am an atheist/agnostic (do not believe in a god)
- Other (please describe) _____

Which Church/synagogue/temple/mosque do you attend? _____ City _____

Body Symptom Diagram

Name _____ Date _____

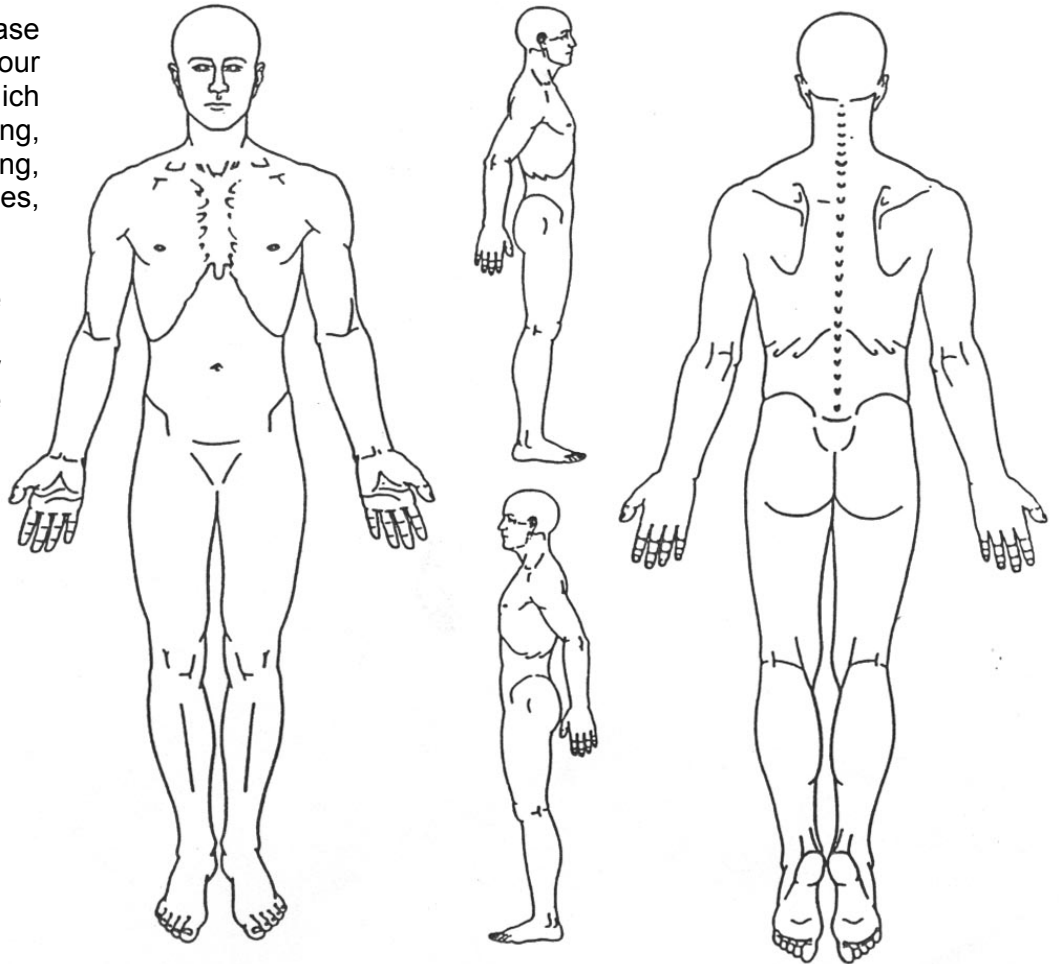
Describe the conditions you would like the doctor to address:

1.	5.
2.	6.
3.	7.
4.	8.

On a 0-100 scale with 0 being no symptoms and 100 being the worst symptoms imaginable, please write the numbers in the box to the right (corresponding to the numbers above) indicating the level of symptoms (pain, fatigue, burning, indigestion, etc) for the conditions listed above.	1.	_____	5.	_____
	2.	_____	6.	_____
	3.	_____	7.	_____
	4.	_____	8.	_____

On the body diagram, please mark the areas of all your symptoms. Please note which symptoms are achy, burning, numb, stabbing, pounding, tingling, pins and needles, congested, itchy rash, etc.

(Placing the appropriate condition number noted above on the diagram below may help the doctor isolate the problem area better.)



Signature _____ Date: _____

Email newsletter opt-in request



Berglund Health & Wellness Center

- . Clinic promotions - stay updated on our lectures, events, etc.
- . Learn about health - receive Dr. Berglund's articles via email
- . New product updates - stay posted on which new natural products we carry
- . Website updates - information on our website, our blog, our forum, and our store

(hosted by Constant Contact)

sign me up!



The Truth Ministry

- . Missions & ministry updates - what's the Berglund family up to on the missions field?
- . Ministry events - information on local events hosted by The Truth
- . Trip reports - detailed reports and links to photos of recent missions trips

visit www.thetruthministry.net for more information

(hosted by Google Groups)

sign me up!

Name: _____

Email: _____

* You will always have the option to opt-out/unsubscribe

** We NEVER sell email addresses



"Like" us on Facebook

- Get daily articles, comments, discussions, and updates from Dr. Berglund via our Facebook page
- To "sign up", simply search for "Berglund Health & Wellness Center" and click "like"

If you'd like Dr. Berglund to "friend" you first and have us send you a "we suggest you like this page" link, please fill out the information below:

Name (as you have it listed on Facebook) _____

I would like Dr. Berglund to suggest his page to me after "friending" me on Facebook (check here):



5027 Green Bay Road, Suite 118 • Kenosha, WI • drb@berglundcenter.com • www.berglundcenter.com

Dr. Michael Berglund
PEDIATRIC & FAMILY PRACTICE

262.925.8600

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date ____/____/____

My signature on this form acknowledges that I have read and understood the Berglund Health & Wellness Center's Notice of Privacy Practices. I understand that this document provides and explanation of the ways in which my health information may be used or disclosed by Berglund Health & Wellness Center and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient Signature _____
Date

If patient is unable to sign or is not of age to give proper authorization::

Representative Signature _____
Date

Name of Personal Representative _____

Relationship to Patient _____

Address _____

Home Phone # () _____ - _____

Work Phone # () _____ - _____

Patient is unable to sign because _____

I give permission for my personal health information TO BE RELEASED to my immediate family (spouse and/or parents) upon their request.

Patient Signature _____
Date

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

1. Was patient provided with a copy of the Notice of Privacy Practices? YES NO

2. Briefly describe efforts made to obtain patient's acknowledgement of receipt of the Notice and explain why the patient did not sign this form: _____



BERGLUND

Health & Wellness Center

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Dr. Michael Berglund
PEDIATRIC & FAMILY PRACTICE

262.925.8600

Notice of Privacy Practices

Berglund Health & Wellness Center

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. USE AND DISCLOSURE OF HEALTH INFORMATION

Berglund Health & Wellness Center (BH&WC) may use your health information (information that constitutes protected health information as defined by the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the purposes stated below. BH&WC have established a policy to guard against unnecessary disclosure of your health information.

Your health information may be used to: **Provide Treatment:** BH&WC may use your health information to provide care to you and disclose your health information to others who provide care for you. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. BH&WC may also disclose your health care information to individuals outside of the provider involved in your care including family members, pharmacists, suppliers of medical equipment or other health professionals.

Obtain Payment: BH&WC may include your health information in invoices to collect payment from third parties for the care you receive. For example, BH&WC may be required by your health insurance to provide information regarding your care in order to reimburse you and/or BH&WC. In addition, BH&WC may need to explain your need for health care and the services that will be provided to you in order to obtain prior approval from your insurance.

Conduct Health Care Operations: BH&WC may use and disclose health information for its own operations in order to facilitate the function of BH&WC and as necessary to provide quality care to all of our patients. Health care operations include activities such as:

Quality assessment and improvement activities: • Activities designed to improve health or reduce health care costs.

- Protocol development, case management, and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and
- other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses formulary development.
- Business management and general administrative activities of BH&WC.
- Certain marketing activities for BH&WC.

For example, BH&WC may use your health information to evaluate its staff performance, combine your health information with other BH&WC patients in evaluating how to more effectively serve all of their patients, disclose your health information to BH&WC staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you or your family as part of general fundraising and community information mailings (unless you do not want to be contacted).

For facility directory:

BH&WC may disclose certain information about you including your name, general health status, and where you are located in a facility directory while you are in the facility. Provider may disclose this information to people who ask for you by name. If you do not want BH&WC to include your information in the directory, you must notify the clinic at 262-925-8600.

For appointment reminders:

BH&WC may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or care with BH&WC.

For treatment alternatives:

BH&WC may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

When legally required:

BH&WC will disclose your health information when it is required to do so by any Federal, State, or Local law.

When there are risks to public health:

BH&WC may disclose your health information for the following public activities and purposes:

- To prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- To report adverse events, product defects, to track products or enable product recalls, repairs, and replacements of the Food and Drug Administration.
- To notify a person who has been exposed to communicable disease or who may be at risk of contracting or spreading a disease.
- To an employer about an individual who is a member of the workforce as legally required.

To report abuse, neglect, or domestic violence:

BH&WC are allowed to notify government authorities if BH&WC believes the patient is a victim of abuse, neglect, or domestic violence. BH&WC will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To conduct health oversight activities:

BH&WC may disclose your health information to a health oversight agency for activities including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary action. BH&WC, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to your receipt of health care or public benefits.

In connection with judicial and administrative proceedings:

As permitted or required by State law, BH&WC may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when BH&WC makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For law enforcement purposes:

As permitted or required by State law, BH&WC may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

In the event of a serious threat to health or safety:

BH&WC may, consistent with applicable law and ethical standards of conduct, disclose your health information if BH&WC in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of the public.

For specified government functions:

In certain circumstances, the Federal regulations authorize BH&WC to use or disclose your health information to facilitate specified government functions relating to the military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For worker's compensation:

BH&WC may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO US OR DISCLOSE HEALTH INFORMATION

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization. If you or your representative authorizes BH&WC to use or disclose your health information, you may revoke that authorization in writing at any time. You may be unable to revoke your authorization for health information that has already been released before your request to revoke authorization is received, or 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.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights with respect to your health information that BH&WC maintains:

- **Right to request restrictions:** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on BH&WC disclosure of your health information to someone who is involved in your care or payment of your care. However, BH&WC are not required to agree to your request. If you wish to make a request for restrictions, please contact the office at 262-925-8600.
- **Right to receive confidential communications:** You have the right to request that BH&WC communicates with you in a certain way. For example, you might ask that BH&WC only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact the office at 262-925-8600.
- **Right to inspect and copy your health information:** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the office at 262- 925-8600. If you request a copy of your health information, BH&WC may charge you a reasonable fee for copying and assembling costs associated with your request.
- **Right to amend your health information:** You or your representative have the right to request that BH&WC amend your records, if you believe your health information records are incorrect or incomplete. That request may be made as long as the information is maintained by BH&WC. A request for an amendment of records must be made in writing to the office. BH&WC may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by BH&WC, if the records your are requesting are not part of BH&WC records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of BH&WC, the records containing your health information are accurate and complete.
- **Right to an accounting:** You or your representative have the right to request an accounting of disclosures of your health information made by BH&WC for certain purposes authorized by law and certain research. The request for an accounting must be made in writing to Drs. Michael or Eileen Berglund, 5027 Green Bay Road, #118, Kenosha, WI 53144. Accounting requests may not be made for periods of time in excess of six (6) years. Accounting requests will be subject to a reasonable cost-based fee.
- **Right to a paper copy of this Notice:** You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact either of the doctors at 262-925-8600.

DUTIES OF BH&WC

BH&WC are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of its duties and privacy practices. BH&WC are required to abide by the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If BH&WC makes a material change to this notice, they will provide a copy of the revised **Notice to you or your appointed representative**. You or your representative have the right to express complaints to BH&WC and the Secretary of Health and Human Services if you or your representative

believe that your privacy rights have been violated. Any complaints to BH&WC should be made in writing to 5027 Green Bay Road, Suite #118; Kenosha, WI 53144-1771. BH&WC encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

BH&WC has both Drs. Eileen and Michael Berglund as their contact individuals for all issues regarding patient privacy and your rights under the Federal privacy standards. If you have any questions regarding this Notice or your rights, please contact him at: 5027 Green Bay Road, Suite #118; Kenosha, WI 53144-1771. Phone number: 262-925-8600

EFFECTIVE DATE

This Notice has been effect since October 18, 2004.



BERGLUND

Health & Wellness Center

Office policies

Patients: Please read carefully, sign, and date. Check off each item that has been read.

Payment options

- If you choose to be a cash patient, we offer a 50% “same day cash” discount. This means that if you pay for your office visit on the SAME DAY as your appointment (with cash, a check, or a credit/debit card), you will receive the discount. If you do not pay for your services on the same day, or you choose to go on a payment plan, you will be billed for the full 100% of that day’s charges.
- Dr. Berglund is an out-of-network provider for all types of insurance except for Medicare and Title I 9/Medicaid/Forward Card. We will be happy to verify your benefits ahead of time, but the verification is not a guarantee of benefits. You will be required to pay for anything your insurance does not cover once your claim is processed. If you choose to be an insurance patient ONLY, our office and billing company will take care of 100% of the insurance billing process. We require payment for deductibles and copays on the same day of service.
- Patients also have the option of taking the 50% “same day cash” discount, getting a printed receipt from our front desk, and then submitting the charges to their insurance company on their own. The benefit is that you are guaranteed at least a 50% discount, in addition to whatever your insurance might pay. The drawback is that you need to submit your own claims. Our office will be more than happy to supply you with a printed receipt with charges, CPT codes, and diagnosis codes, but we are unable to do any insurance processing after this point.

Missed appointments

- Reminder calls are just a courtesy provided by this office. Although we try to remind our patients every time they are scheduled, it is not guaranteed that you will receive a reminder call. It is your responsibility to remember your appointment on the day it is scheduled. If you do not show up for your appointment without notifying us ahead of time, you will be charged a \$20 no show fee.
- Medicare and Medicaid patients can not be charged the \$20 no show fee. However, they will be limited to three “no show” visits every 12 months, starting with the date of their first “no show”. After the 3rd no show visit has been reached, that patient will no longer be able to see Dr. Berglund until one year after the date of the first “no show”.

Supplements

- We offer a 10% discount on in-house supplement refills. (Exceptions apply on a handful of supplements where the retail price has already been reduced.) If you need us to ship supplements to you, we will be more than happy to. However, the 10% discount does not apply if they are shipped. The refill discount also does not apply on “novelty” retail items, such as candy, gum, mixes, bars, cleaning products, etc.
- We require payment for supplements on the same day they are purchased. If you want us to put supplements on hold for you, we will hold them for up to one week. Supplements that have not been purchased after one week will be re-stocked.

- If you need a particular supplement, please call ahead to be sure that we have it in stock, and that our office is open. Please respect Dr. Baertlien's time at our clinic. If you need to pick up supplements, please pick them up during Dr. Berglund's hours.

Bringing children to appointments

- We do provide a room and video player for children. However, please do not expect the staff to "baby-sit" your kids. If you know your kids require supervised attention, it may be best to take them in the treatment room with you, or leave them at home or somewhere where they can be continually supervised. Please be sure that your children clean up after themselves and turn the lights off when they are done using the kids' room.

Handling questions for Dr. Berglund

- We like to keep the friendly and relaxed atmosphere at Berglund Health & Wellness Center. Please, however, respect the boundaries of Dr. Berglund and his staff. Dr. Berglund's office, the area behind the front desk, staff computers & screens, and our supplement closet are off-limits to patients. If you have a question for Dr. Berglund, please ask the front desk and they will gladly assist you.
- If you are at home and have a question for Dr. Berglund ("How often should I take this supplement?", "Was I supposed to use ice or heat?", etc.), please email him at drb@berglundcenter.com, and he will respond to you as soon as he is able. Dr. Berglund does not call patients or return phone calls. If you have a list of questions that involve more detail, please call our office to schedule an appointment. If you do not have internet access, please call our office with your question and talk to our staff. They will talk to Dr. Berglund and call you back as soon as they are able.
- As Dr. Berglund's schedule has become busier, he will no longer be able to just check you on "just a few supplements" without an office visit. His scheduled patients take priority. If you need him to check you on supplements or food, please schedule an appointment to guarantee that Dr. Berglund can give you his complete attention.

Courtesy toward other patients

- Please be courteous to our patients with allergies. When you come in for your appointment, please refrain from wearing perfumes, colognes, or scented lotions. Please also refrain from smoking before coming in. We have many patients who are extremely sensitive to particular scents and chemicals, and these types of products can trigger allergic reactions.

I have read, understand, and agree to the office policies at Berglund Health & Wellness Center.

Patient Signature

Date

Staff Signature

Date