

Pediatric Intake Form

Patient Name: _____ DOB: _____

Sex (m/f): _____ Grade of School: _____

Mother's Name and Occupation: _____

Father's Name and Occupation: _____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name and city located in: _____

Last time you had blood work done and with what physician: _____

List All Surgeries & Hospitalizations, including date occurred:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

List All medicines (from drugstore or prescription) child is on now:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

List all supplements child is taking:

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Any known Allergies to food, drugs, environment, animals: _____

Previous Medical History

YES (Y) indicates the child gets the problem **regularly**; **NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently**. **Please circle the correct one for your child.**

Ear Infections: Y N P If has had, how many total: _____

Colds: Y N P If has had, how many total: _____

Strep Throat: Y N P If has had, how many total: _____

How many times has the child taken antibiotics: _____

What other medicines has the child taken and how often:

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

Hearing Tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Speech Impediments: Yes No Past

Learning Impediments: Yes No Past

Patient Name: _____

DOB: _____

Vaccination History:

YES, has had; NO, has not; SOME, did not finish all shots:

MMR: Yes No Some DPT: Yes No Some Hep B: Yes No Some

Hib: Yes No Some Chicken Pox: Yes No Some Polio: Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family History:

Allergies: Y N P

Obesity: Y N P

Cancer: Y N P

Tuberculosis: Y N P

Mental Illness: Y N P

Cardiovascular Disease: Y N P

Diabetes mellitus: Y N P

Mother's Pregnancy History:

Age at conception: _____

Did she have other children already? Yes No

Health During Pregnancy:

Smoking: Y N

Diabetes: Y N

Coffee: Y N

Nausea/Vomiting: Y N

Recreational Drugs: Y N

Emotional Stress: Y N

Preeclampsia: Y N

Length of Labor : _____

Vaginal Birth: Y N

Traumatic Birth: Y N

If the birth was difficult, please explain: _____

Health of baby at birth: _____

Health History of Child:

Child Breastfed: Y N

For how Long: _____

When put on formula: _____

What Formula was used: _____

When was child put on solid food: _____

When did child walk: _____

Talk: _____ Develop Teeth: _____

Jaundice as baby:	Y N	Colic:	Y N
Cradle Cap:	Y N	Anemia:	Y N
Eczema or Psoriasis:	Y N	Asthma:	Y N
Diarrhea:	Y N	Warts:	Y N
Constipation:	Y N	Nightmares:	Y N
Finicky Eating:	Y N	Bed-wetting:	Y N
Poor Teeth:	Y N	Tantrums:	Y N
Chronic Sniffles:	Y N	Disobedient:	Y N
Bad Foot Odor:	Y N	Fears/Phobia:	Y N
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity:	Y N	Early Puberty:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Patient Name: _____

DOB: _____

Any Particular household stressors child has witnessed or gone through:

1) _____

2) _____

3) _____

4) _____

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies

List all known Allergies (food, drugs, environment): _____

FINANCIAL POLICIES STATEMENT
the naturopathic physician, L.L.C.
15436 West Statler Circle, Surprise, Arizona 85374 623-792-8889

1. We respect the relationship you have with your health insurance provider. We do not have a relationship with your insurance provider and do not know the coverage and terms your company provides for naturopathic medical care. For this reason it is your responsibility to verify coverage for services or laboratory testing.
2. We do not bill insurance companies nor accept third-party payment for services rendered. We will provide you with a statement of services which contains all information needed to seek reimbursement from your insurance company. Please be advised that many insurance companies do not offer coverage or reimbursement for naturopathic medical care.
3. We do not bill patients for services rendered. Payment for services is required at the time services are provided. For your convenience we accept cash, check, debit card, Master Card, Visa and Discover. We do not accept American Express.
4. Medicare does not provide insurance coverage for services or laboratory tests provided in this office, nor neutraceuticals dispensed from the medicinary.
5. The cost for laboratory testing and other services may not be covered by your insurance provider. It is your responsibility to verify coverage for such services, or alert our office if there are questions regarding a specific service. Once services are rendered or ordered they become your financial responsibility.
6. We request a 24-hour notice to cancel or change appointments. Appointments missed or canceled with less than 24 hours notice will be charged at the intermediate rate. Exceptions are made for extraordinary events and inclement weather.
7. Bank checks returned for insufficient funds will accrue a fee of \$50.00.
8. In order to maintain fresh neutraceuticals dispensed from the medicinary we cannot offer refunds for products 60 days from purchase date. There is a 10% restocking fee for all returns.
9. All special orders require payment in advance or a credit card on file. Charges incurred for shipping and handling on special orders will be passed on to you.

I have read, understand and agree to abide by the above policies:

Signature (Parent or Guardian if patient is under 18 years of age)

Date

INFORMATION REGARDING LABORATORY PROCEDURES

**** PLEASE READ CAREFULLY - THIS MAY AFFECT CHARGES BILLED TO YOU ****

Laboratory tests ordered through this office are sent to many outside laboratory providers. In some cases we will have information about your insurance and the particular lab test and laboratory being used. In other cases we do not have such information. The following is a listing of common occurrences regarding laboratory testing and payment of such services. It is intended to give you information prior to the ordering and incurrence of charges for laboratory tests.

1. Our office orders the test(s) we believe to be medically necessary for your case. **The office has no involvement in the charges for those tests, the billing of those tests, or the insurance company's payment or non-payment of those tests.** These issues are between you, your insurance carrier, and the laboratory used. If clarifications of indication for the test or coding of tests are required, we will provide the necessary information to the laboratory or insurance company.
2. If we know that a particular laboratory is favored by your insurance company, we will use that facility. **However, occasionally we are not notified by the insurance companies when they change preferred laboratory providers.** The use of a non-preferred laboratory can increase the cost to you for a given test. If we know a particular lab test is never covered we will inform you in advance, but occasionally we do not have access to that information.
3. Laboratory testing is often very expensive. We do not establish the cost of laboratory tests. Laboratories establish the cost for the test they perform. If your insurance provider offers coverage for the laboratory test, the cost of the test is negotiated between your insurance provider and the laboratory. If your insurance provider provides partial coverage for a specific laboratory test your co-payment is paid directly to this office, will appear on your bill, and is due at the time the test is ordered.
4. There are times this office is not informed by the laboratory when there is an increase in the cost of a laboratory test. In the event of lack of communication between your laboratory and this office regarding the cost of a laboratory test, you are still responsible for the cost of the laboratory test or any difference between the published cost and actual cost for laboratory testing.
5. It is possible that even after your insurance carrier authorizes a lab test that they will refuse to pay for it. You need to be aware of this, and realize that if your insurance does not pay you are still responsible for the charges, either to this office or to the laboratory. We have no control over, nor responsibility for this eventuality.

I have read, and understand this information regarding laboratory fees:

Signature (or signature of parent if patient is a minor child)

Date

NOTICE OF PRIVACY POLICIES FOR
the naturopathic physician, L.L.C.
15436 West Statler Circle, Surprise, Arizona 85374 623-792-8889

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

Introduction

the naturopathic physician, L.L.C. is committed to treating you and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, how and when we use or disclose the information. It also describes your rights as they relate to your protected health information. This Notice is effective July 1, 2006 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the naturopathic physician, L.L.C., a record of your visit is made. This record contains your symptoms, examination and test results, diagnosis treatment, and a plan for future care or treatment. This information, often referred as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to other.

Your Health Information Rights

Although your health record is the physical property of the naturopathic physician, L.L.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided in 45 CFR164.528,
- Amend your health record as provided in 45 CFR164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided in 45 CFR164.528,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

the naturopathic physician, L.L.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

To Report a Problem

If you believe your privacy rights have been violated, you can file a complaint at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Building HHH, Room 509F
Washington, D.C. 20201

Examples of Disclosure for Treatment and Health Operations

Health Information for Treatment: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to the treatment.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and produce defects, or post-marketing surveillance information to enable produce recalls, repairs or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Spouse: We may talk to your spouse in the case of emergency, unless there are specific written instructions not to do so.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potential endangering one or more patients, workers or the public.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I acknowledged that I have received a copy of
the naturopathic physician, L.L.C.'s Notice of Privacy Practices.**

Patient or legally authorized individual signature

Date

Print name if signed on behalf of the patient

Relationship to patient

Revisions:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained for this reason:
