Pediatric New Patient Intake Form

Patient Information

Patient Name: Date of Birth: Today's Date:

Age: Female ❒ Male ❒ SS#: Email:

Address: City: State: Zip:

Home Phone: Parent's Work &/or Cell Phone:

Parent's Name: Child lives with: Father ❒ Mother ❒ Both ❒ Other ❒

Alternate Emergency Contact Name & Phone Number:

Who do you give permission to bring your child to my office for treatment?

Child's MD/DO physician:

Referred by:

Health Insurance Information

Primary Insurance: Policy Number: Group Number:

Policy Holder's Name: Policy Holder's Date of Birth:

Policy Holder's Name of Employer:

Co-payment for Office Visits: Insurance's Phone Number:

Insurance's Billing Address:

Office Policies

Payment Policy: 100% of all doctor visits, other treatments, and supplements fees are due at the time of services. We accept cash and/or checks as payment. All sales are final. We cannot provide refunds or exchanges. We charge $25.00 for any returned check (hopefully that won't happen to you!). If you have insurance coverage for Naturopathic care, we are happy to bill your primary insurance for you.

Cancellation Policy: Last minute cancellations of scheduled appointments are challenging to fill, wasteful of an opportunity for another patient, and costly for the clinic. We therefore require changes or cancellations to be made at least 24 hours prior to your scheduled appointment. Otherwise, you will be charged $35.00 for the 1st missed visit, and $100.00 for any subsequent missed visit.

I understand that I am financially responsible for all charges regardless of insurance coverage and or treatment outcome. I further understand that 100% of fees are due at the time service is rendered, and that all sales are final. I understand that I will be charged for any appointment missed or cancellation less than 24 hours in advance as explained above. I hereby agree to pay any and all charges.

Parent/Guardian Signature: Date:

Patient Name:

What are your Top Three Health Concerns for your child?

1) _____

2) _____

3) _____

Current Medications:_____ Current Supplements:_____

Allergies to Medications: _____ Known Food Allergies:_____

Birth History:

Where was your child born? Home ❒ Hospital ❒ Birth Center ❒

Any problems with the pregnancy or birth? Yes ❒ No ❒

If yes, please explain:_____

Was your child breastfed? Yes ❒ No ❒ How long?_____

Health History:

Has your child had any of the following conditions in the past or currently?

- ❒ Asthma
- ❒ Ear Infection
- ❒ Eczema
- ❒ Rashes
- ❒ Allergies
- ❒ Chicken Pox
- ❒ Bladder/Urinary Infection
- ❒ Colic
- ❒ Bronchitis
- ❒ Strep Throat
- ❒ Constipation
- ❒ Heart Problem
- ❒ Other:_____

Vaccination History:

Which vaccinations has your child had?

- ❒ DTaP (diphtheria, tetanus, pertussis)
- ❒ DT
- ❒ Tetanus only
- ❒ Hepatitis
- ❒ Pneumococcal conjugate
- ❒ Meningococcal (MCV4)
- ❒ HIB (Haemolphilus influenzae B)
- ❒ Polio
- ❒ MMR (measles/mumps/rubella)
- ❒ Varicella (Chicken pox

The information I have provided is accurate and true to the best of my knowledge.

Parent/guardian signature:_____ Date:_____

Thank you for the opportunity to work with you on your child's health!

INFORMED CONSENT TO TREATMENT

Patient's Name:_____

This is to acknowledge that I have been informed and understand that:

1. As a Naturopathic Physician, Dr. Emma Baker does not have hospital privileges and can only prescribe certain drugs. Therefore, I, the patient, will maintain an on-going relationship with a local primary care M.D. or D.O. physician of my choosing.

2. **In the case of a medical emergency, I, the patient, am to call 911 or proceed to the nearest emergency room.**

3. I, the patient, understand that Dr. Emma Baker offers **adjunctive care only to cancer patients**, and I will therefore maintain care with an M.D. or D.O. oncologist of my choosing should I be diagnosed with cancer.

4. Any treatment or advice provided to me as a patient of Dr. Emma Baker N.D. is not mutually exclusive from any other treatment or advice that I maybe receiving now or in the future from another healthcare provider.

5. I, the patient, am at liberty to seek or continue medical care from any physician, surgeon, or other healthcare provider.

6. The treatment and therapies provided or recommended by this health center may be different than those usually offered by other licensed healthcare providers.

7. There have not been any representations made regarding the likelihood of success of any recommendation(s) or treatment(s) offered.

8. I understand that I am responsible for all fees regardless of insurance coverage and/or treatment outcome. I further understand that 100% of these fees are due at the time service is rendered.

I hereby authorize and consent to treatment.

_____ _____

Signature of Patient/Guarantor (if patient is a minor) Date

_____ _____

Signature of Witness Date

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____