Pediatric New Patient Intake Form

Patient Information

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

Age: Female❒ Male❒ E-mail: _____

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: Naturopathic Coverage?

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

Policy Holder's Employer: Co-payment for Office Visits:

OFFICE POLICIES

PAYMENT POLICY: 100% of all doctor visits, other treatments, and supplements fees are due at the time of services. We accept cash, checks, debit and credit cards as payment. All sales are final. We cannot provide refunds or exchanges. We charge $35.00 for any returned check. If you have insurance coverage for Naturopathic care, we are happy to bill your primary insurance for you.

CANCELATION 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 visits.

I, the patient, understand that I am financially responsible for all charges regardless of insurance coverage and/or treatment outcome. I understand that 100% of fees are due at the time service is rendered, and that all sales are final. I authorize Baker Family Naturopathic to bill my health insurance for services rendered. I understand that I will be charged for any appointment missed or cancelled less than 24 hours in advance. I hereby agree to pay any and all charges.

Parent/Guardian Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

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: _____ Today's Date: _____ /_____ /_____

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

INFORMED CONSENT TO TREATMENT

Patient Name:_____ Date of Birth: _____ /_____ /_____

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

1. As a Naturopathic Physicians, Dr. Emma Baker and Dr. Emily Livengood do 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 and Dr. Emily Livengood offer **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. or Dr. Emily Livengood 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: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

Witness Signature: _____ Today's Date: _____ /_____ /_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:_____ Date of Birth: _____ /_____ /_____

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

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: _____

_____

ADVANCED BENEFICIARY NOTICE (ABN)

Patient Name:_____ Date of Birth: _____ /_____ /_____

The purpose of this notice is to help you make an informed decision about whether or not you want to receive these items and/or services, fully knowledgeable that you might have to pay for them out of pocket.

I, the patient, accept that my insurance company may or may not pay for the items and/or services that are described below:

1. Naturopathic Office Visits and Exams
2. Bowen Therapy
3. Massage
4. Nutritional and/or herbal supplements
5. Injectables and Injections
6. Any service ordered by a Naturopathic physician (including labs, imaging or any other service(s))

Before you make a decision about your options, you should read this entire notice carefully. If you do not understand why your insurance may not pay ask us to explain. Ask us how much the items and/or services will cost you, in case you have to pay for them out of pocket.

Please choose **ONE** of the following options:

☐ Option 1: **YES**, I want to receive these items and/or services

I, the patient, understand that my insurance will not decide whether to pay unless I receive these items and/or services and have a claim submitted. I understand you may bill me for these items and/or services in full if my insurance denies my claim and refuses to pay within **60 days** of the submitted claim. I agree to be personally and 100% fully financially responsible for payment.

☐ Option 2: **NO**, I do not want to receive these items and/or services

I will not receive these items or services. I understand that you will not be able to send a claim to my insurance.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF DISCLOSURE AND ACCEPTANCE OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name:_____ Date of Birth: _____ /_____ /_____

Initial the following

_____ I, the patient, understand that I am 100% financially responsible of all doctor visits, other treatments, and supplements, regardless of insurance coverage and/or treatment outcome. I understand that not all services rendered may not be covered by insurance and that I, the patient, am financially responsible for the balance.

_____ I, the patient, understand that my copay and/or deductible is due at the time of services rendered.

_____ I, the patient, understand that all fees are due at the time service is rendered, that all sales are final, and that Baker Family Naturopathic cannot provide refunds or exchanges.

_____ I, the patient, authorize Baker Family Naturopathic to bill my health insurance, if applicable, for services rendered.

_____ I, the patient, understand if my insurance company does not pay my claim within **30 days**, and we are not notified by insurance company of late payment, then it is my responsibility as the patient to contact them and expedite payment. I understand that if my insurance company refuses to pay I then am 100% financially responsible for payment.

_____ I, the patient, understand if my insurance company does not pay within **60 days**, then I the patient am required to pay the balance on my account in the form: cash, check, Visa, or MasterCard.

_____ I, the patient, understand that there is a $25 returned check fee, when applicable.

_____ I, the patient, understand that I personally, not my insurance company, will be charged for any appointments missed or cancelled less than **24 hours in advance**.

I, the patient or the patient's legal representative, hereby agrees to pay any and all charges.

Signature: _____ Today's Date: _____ /_____ /_____

Relationship to Patient: _____