PEDIATRIC NEW PATIENT INTAKE FORM

Patient Full Name:_____ Date of Birth:_____Today's Date:_____

Age: _____ Female ❒ Male ❒ Other ❒ E-mail:_____

Address:_____City:_____State:_____Zip:_____

Parent/Guardian 1: _____ Phone Number:_____

Parent/Guardian 2: _____ Phone Number:_____

Child lives with: Father ❒ Mother ❒ Both ❒ Other ❒ _____

Okay to leave a detailed message and/or text with: Parent/Guardian 1 ❒ Parent/Guardian 2 ❒

Alternate Emergency Contact Name & Phone Number: _____

Who do you give permission to accompany your child for treatment?: _____

Child's Primary Care (MD/DO) Physician:_____Okay to contact: Yes ❒ No ❒

Referred by:_____May we thank them: Yes ❒ No ❒

HEALTH INSURANCE INFORMATION

Primary Insurance:_____ Naturopathic Coverage: Yes ❒ No ❒ I don't know ❒

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

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

We check insurance benefits as a courtesy to our patients, but ***we do not guarantee insurance coverage***.

OFFICE POLICIES

CANCELLATION POLICY: Last minute cancellations of scheduled appointments are challenging to fill and may waste an opportunity for another patient in need. Due to both community demand and undo cost to the clinic, we therefore **require changes or cancellations to be made at least 24 hours prior to the scheduled appointment.** For missed appointments or cancellations made less than 24 hours before the scheduled appointment, you will be charged $50.00 for the first missed visit and $100.00 for any subsequent missed visits.

RETURN POLICY: **We do not accept any returns or exchanges** on any product or service sold or provided to you by Baker Family Naturopathic.

I, the patient, 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. Additionally, I understand that Baker Family Naturopathic will not accept any returns or exchanges as mentioned above.

Signature: _____ Today's Date: _____

Relationship to patient: _____

Patient Name:_____

What are your Top Three Health Concerns for your child?

1. _____

2. _____

3. _____

Current Medications: _____ Current Supplements: _____

Allergies to Medications: _____ Known Other 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 ❒ If yes, how long?_____

HEALTH HISTORY

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

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

Has your child had any surgeries, hospitalizations and/or major accidents? _____

VACCINATION HISTORY

Which vaccinations has your child had?

- ❒ DTaP (diphtheria, tetanus, pertussis)
- ❒ HIB (Haemolphilus influenzae B)
- ❒ Pneumococcal conjugate
- ❒ Hepatitis
- ❒ Polio
- ❒ MMR (measles/mumps/rubella)
- ❒ Varicella (Chicken pox)
- ❒ HPV (human papilloma virus)
- ❒ Meningococcal
- ❒ COVID19

I, the patient's* parent or legal guardian*, initial below as in agreement to the following statements:

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

_____ Baker Family Naturopathic requires a parent or legal guardian to be present for the patient's treatment if under the age of 15. I understand that Oregon State Law states that any patient under the age of 15 is considered a minor.

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

Relationship to Patient: _____

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

INFORMED CONSENT TO TREATMENT

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

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

1. As Naturopathic Physician, Dr. Emma Baker does not have hospital privileges and can only prescribe certain drugs. Therefore, I, the patient, may 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**. 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 is not mutually exclusive from any other treatment or advice that I may be 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 Baker Family Naturopathic 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.

I hereby authorize and consent to treatment.

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

Relationship to Patient: _____

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

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

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

- Conduct, plan and direct my course of treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read, and understand Baker Family Naturopathic Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that Baker Family Naturopathic 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 PHI 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 in writing.

Patient Full Name: _____

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:

Initials: _____ Date: _____ /_____ /_____

Reason: _____

_____

ADVANCED BENEFICIARY NOTICE (ABN)

Patient Full 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 provided by Baker Family Naturopathic should they become necessary in my course of treatment:

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))
7. Telemedicine and/or phone visits

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 these items and/or services will cost 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 should they become necessary.

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 45 days of the submitted claim. I agree to be personally and 100% 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.

☐ Option 3: **YES**, I want to receive these items and/or services

I will receive these items or services, **but I choose to pay by cash, check, or credit card in full at the time of service**.

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

Relationship to Patient: _____

ACKNOWLEDGEMENT OF DISCLOSURE AND ACCEPTANCE OF PATIENT FINANCIAL RESPONSIBILITY

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

Please Initial the following:

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

_____ I, the patient, understand that all fees are due at the time service is rendered, that **all sales on any products or services are final**, and that Baker Family Naturopathic cannot provide refunds nor exchanges.

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

_____ I, the patient, understand that my **insurance agreement is between me and my insurance company** and that Baker Family Naturopathic does not promise that my insurance company will pay the charges for my services rendered. If my insurance company denies payment, I, the patient, am 100% responsible for payment.

_____ I, the patient, understand if my insurance company does not pay my claim within **30 days**, and BFN is not notified by the insurance company of delayed payment, **then it is my responsibility as the patient to contact my insurance to expedite payment**

_____ I, the patient, understand if my insurance company does not pay within **45 days**, then I, the patient, am **required to pay the balance on my account** in the form of cash, check, Visa, or MasterCard.

_____ I, the patient, understand that there is a $45 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, understand that if I am late on making a payment, I may be charged a fee after 60 days, and if my **account balance is overdue by 90 days** then I will be **taken to collections** and a **200% collections fee** will be added to account balance.

_____ I, the patient, understand that in accordance with Oregon trade regulation 646.639 section n, I agree to pay all collection costs, interest, attorney fees and any other charges arising out of this account should Baker Family Naturopathic place any outstanding indebtedness that has been due to a collection of any debt I owe Baker Family Naturopathic. It is further understood that should my outstanding account be placed with a collection agency that the amount I owe **will be doubled** to cover the cost of collection. In addition, I understand that I will be liable for all court costs and attorney fees.

I, the patient or the patient's legal representative, hereby agree to pay any and all charges as listed above.

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

Relationship to Patient: _____