Health For Life Naturopathic Medicine

Pediatric Confidential Patient Information

Patient Contact Information

Today's Date: _____/_____/_____

Name:_______________________________________ ________ _____/_____/_____
(Last) (First) (Sex) (Date of Birth)

Address: ________________________________ City: ________________ State: _____ Zip: _________

Home Phone: ________________ Cell Phone: ________________ Phone Work: _________________

Email Address: _______________________________ Preferred mode of contact: ___________________

May we send you emails regarding updated office information and events: _____Yes _____No

Name of nearest relative not living with you: _____________________________ Relation:_____________

Phone: _______________________

Additional Patient Information

Mother's Name: ______________________________ Father's Name: ____________________________

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Whom may we contact in case of an emergency: ____

Relationship to child: ____

Emergency Contact Phone #: _____________________________________

How did you hear of us? ____

Were you referred by another physician: ❑ Yes ❑ No
If "Yes" please provide us with as much information as possible for the Referring Physician?

Referring Physician's Name:____

Address, City, State, Zip: ____

Telephone Number: ____

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Insurance Information

Insurance Company: _______________________________________ Phone: _______________________

Name of Insured: ___________________________________ Relationship to the Insured: ______________

Policy #: _______________________________ Group #: ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Furthermore, in the event that payment is not made on this account and it is place with a licensed collection agency, I/we agree to pay the fees of the collection agency. Should legal action also be necessary to collect the account, I/we agree to pay attorney's fees and court costs incurred for the collection.

Releases may be requested prior to specific procedures being performed (i.e., minor surgery, etc.)

Clinic Policy requires payment at time of services.

Signatures

___________________________________ _________________________________ ____/____/____

Patient's Signature **Parent or Guardian's Signature** **Date**

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Pediatric Health History Summary

Patient Name: ______________________________ **DOB:** ________________ **Sex (M/F):** _____

Street Address: ____

City: _______________________ **State:** _______ **Zip Code:** ____________

Phone: ___________________ **Alternate Phone**:____

Name of School and Grade: ____

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, phone number and city located in:
____

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

List All Surgeries & Hospitalizations, including date occurred:
1)
2)
3)
4)
5)
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

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:** ____________
Colic?_____________

Review of Systems

Circle Yes (Y), No (N) or Past (P):

Skin:

Rash/ Diaper Rash: Y N P	Bad Foot Odor: Y N P	Jaundice as Baby: Y N P
Hives: Y N P	Very Sweaty baby/Child: Y N P	Abnormal Mole: Y N P
Eczema /Psoriasis: Y N P	Warts: Y N P	Dry/Itchy: Y N P

Head:

Headache/Migraines: Y N P	Dandruff: Y N P	Oily/Dry Hair: Y N P
Cradle Cap: Y N P	Hair Loss: Y N P	Head Injury: Y N P

Nose:

Nose Bleeds: Y N P	Allergies: Y N P	Frequent Colds/Sinus Infection: Y N P
Chronic Sniffles: Y N P	Congestion: Y N P	Problems Smelling: Y N P

Eyes/Ears:

Dryness: Y N P	Vision Problems: Y N P	Pain: Y N P
Itching: Y N P	Redness: Y N P	Watery/Discharge: Y N P
Hearing Loss: Y N P	Drainage from Ears: Y N P	Ear Infections: Y N P

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Mouth/Neck/Throat:

Cavities: Y N P	Gum Disease: Y N P	Problems Swallowing: Y N P
Canker Sores/Cold Sores: Y N P	Sore Throat: Y N P	Finicky Eating: Y N P
Neck Stiffness: Y N P	Swollen Glands: Y N P	Poor Teeth: Y N P

Respiratory:

Asthma: Y N P	Cough: Y N P	Wheezing: Y N P
Pneumonia: Y N P	Bronchitis: Y N P	TB: Y N P
Pain with Breathing: Y N P	Shortness of Breath: Y N P	Other:

Cardiovascular:

Racing heart: Y N P	Chest Pain: Y N P	Murmurs: Y N P

Urinary Tract:

Incontinence: Y N P	Bed Wetting: Y N P	Blood in Urine: Y N P
Urgency: Y N P	Frequent UTI's: Y N P	Painful Urination: Y N P

Gastrointestinal:

Heartburn: Y N P	Nausea/Vomiting: Y N P	Change in Appetite: Y N P
Indigestion: Y N P	Gas/Bloating: Y N P	Stomachaches: Y N P
Constipation: Y N P	Diarrhea: Y N P	Other:

Male Genitalia:

Testicular Pain/Swelling: Y N P	Hernia: Y N P	Discharge: Y N P
Early Puberty: Y N P	Other:	

Female Genitalia:

Age of First Menses: ____________ First Day of Last Menses: ___________ Length of Menses: ____________

Abnormal Pap: Y N P	Discharge: Y N P	Menstrual Cramping: Y N P
Mood Swings: Y N P	Odor: Y N P	Heavy Bleeding: Y N P
Early Puberty: Y N P	Other:	

Musculoskeletal:

Leg Cramps/Growing Pains: Y N P	Aches in Muscle/Joint Pain: Y N P	Weakness: Y N P

Nervous:

Seizures: Y N P	Fainting: Y N P	Numbness/Tingling: Y N P

Mental/Emotional:

Depression: Y N P	Mood Swings: Y N P	Nightmares: Y N P
Anxiety: Y N P	Fears/Phobia: Y N P	Hyperactivity: Y N P
Eating Disorder: Y N P	Irritability: Y N P	Behavioral Concerns: Y N P
Tantrums: Y N P	Aggressiveness: Y N P	Other:

Any Particular household stressors child has witnessed or gone through:

1) 2)

3) 4)

<u>Toxin Exposure</u>

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: ____

Beverages: ____

Bowel movements (# of times per day, formed/not formed, etc.):

____

Urination (# of times per day, etc.):

____

Potty trained: yes or no

Any concerns with potty training?____

Sleep (location, total hours per night, naps, night waking): ___________________________

____

Anything else you would like to talk about today that is not listed on this document?

____

____

____

____

____

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INFORMED CONSENT FOR PEDIATRIC TREATMENT:

Patient Name: ____ Date:____________

It is necessary for us as health professionals to obtain your consent for your child's evaluation and/or treatment today. Please read this form carefully and ask about anything that you do not understand.

I hereby authorize Dr. Krystal Tellier and her medical staff to perform upon my child the following procedures: (please initial next to each procedure you agree upon)

1. Vitals such as blood pressure, pulse, respirations, and temperature _________(initials)
2. Physical exams for diagnostic purposes ___________ (initials)
3. Blood draws for laboratory testing ____________ (initials)
4. Urine collection or stool collection for specialized testing _____________ (initials)
5. Injections of either medicines or nutrients into the muscle or vein ___________ (initials)
6. Counseling with ________ (initials) or without a parent present ________ (initials)
7. Acupuncture __________(initials) or acupressure ____________ (initials)
8. Spinal manipulation __________ (initials) or massage ___________ (initials)

I have had explained to me by Dr. Krystal Tellier or her staff, and have had sufficient opportunity to discuss the patient's condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

Although their occurrence is extremely remote, some risks are known to be associated with some of these procedures. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during or after the treatment, swelling, infection, bleeding, bruising, allergic reactions, and emotional distress in the child.

I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

I understand that should the patient become uncooperative during procedures such that it may affect the safety of the child, a few things may be done: immediate cessation of treatment, parent asked to counsel child, and/or assistance from medical staff to stabilize the patient to either complete treatment or begin process of discontinuing treatment prior to completion.

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

I confirm that I have read (or it was read to me) and understand the information on the form. The proposed treatment has been explained to me, as have any alternative methods of treatment, and the advantages and disadvantages of each. I am advised that although good results are expected, the possibility and nature of complications cannot always be accurately anticipated. Therefore, there can be no guarantee as to the result of the treatment.

______________________________________ ___________ ___________________________
Parent/Guardian Date Witness

____ ___________________
Provider Date

Health For Life Naturopathic Medicine

Payment Agreement & Cancellation Policy

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

- Payment is always due at the time of service.
- We accept the following forms of payment: Cash, Check, Debit Card, Visa, MasterCard, and American Express
- We do not accept insurance, however:
- If you have a PPO-style plan (these are plans that allow you to see doctors who are not part of your insurance company's provider network), we can do the following.
  - Prepare a health insurance claim form and give it to you to submit to your insurance company to request reimbursement of your visit charges.
  - Bill your insurance company for labs and imaging studies.
  - We can never guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.
  - All new patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment.

New Patient Appointments:

- If you cancel your appointment with less than 48 hours' notice, or fail to show for your appointment without notification, your credit card will be charged $100.
- If you call to cancel your appointment with less than 48 hours' notice and choose to reschedule another appointment at that time, your credit card will be charged $50.
- New patient visits require the doctor to block out large time slots, making last-minute cancellations and rescheduling of visits very problematic. We spend an inordinate amount of time and energy with each and every one of our new patients because we are committed to providing the highest quality care to be found anywhere.

Follow-Up Visits:

- If you cancel a follow-up visit within 24 hours of your scheduled appointment, or fail to show for your appointment without notification, your credit card will be charged $100.
- Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule with adequate notice, it is more likely that another patient in need will be able to use your time-slot. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient of the care they need.

Phone Consultations:

- We bill for phone consultations. They require the same time and expertise as office visits.
- Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to address a quick question. If the number of questions needing to be addressed is greater or takes more time, it is likely your doctor will bill for the phone consultation. Phone consult fees are the same as our in office fees (see Fee Schedule for cost)

There are no refunds on any labs or services.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. **We will only automatically charge this card as described by the terms above.** If you request, phone consults or other services may be paid with another card or account at the time of service. Your card on file can also serve as a convenient way to pay for supplements or services without having to wait in line at check out. As a courtesy, the front desk staff will call two work days prior to your appointment to remind you of your scheduled time.

Signature:____ Date:___________________

Type of Card: Visa MC AmEx Card Number:____

Expiration Date:_____________ Security Code:____________ Billing Zip Code:___________________

Health For Life Naturopathic Medicine

Confidentiality Statement

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your rights from the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can

- File a complaint with your doctor
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose any relevant information.

You are authorized to discuss my personal medical information with the following people or medical practices:

1) ____

2) ____

3) ____

4) ____

Name of Patient or Legal Guardian:____

Signature:____ Date:____________________

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Fee Schedule, Labs & Other Diagnostic Testing

Fee Schedule:

Initial Visit Adult or Pediatric (1 Hour)	$275-$32+
Follow-up Visits: (for in office or phone consultations)	
Under 15 minute	$60-$75
Under 30 minutes	$120-$150
Under 45 minutes	$180-$225
Under 60 minutes	$240-$300
Labor Support Package	$1,500
Home Birth Package	$4,600
Acupuncture Initial	$150
Acupuncture Follow-up	$75
Acupuncture Packages available	Prices vary; inquire with front desk
IV Therapy	Prices vary depending on treatment given
B Vitamin Injections	$20-40
Child Wellness Visit	$150
After hours Phone Consult (Urgent Medical Matters)	
Under 7 min	$30-$45
8-15 min	$60-$75
16- 30 min	$120-$150

The purpose of this document is to help you make an informed choice when your doctor recommends lab tests, imaging studies (x-rays, MRI, etc.) or other diagnostic procedures.

You should be aware that **Medicare and private insurance companies may not pay for all diagnostic tests ordered by your doctor**, even those your doctor considers absolutely necessary. If you agree to any testing recommended by your doctor and your insurance company refuses to pay for the testing, you are responsible for the cost of the ordered tests. **Medicare does NOT cover any testing ordered by non-Medicare providers. Currently**, **naturopathic physicians are NOT Medicare providers.**
As a general rule, many specialty lab tests are not covered by private insurance companies or Medicare, though there are exceptions. Your doctor will be happy to tell you whether the tests being recommended are specialty labs.

Once ordered, there will be NO REFUNDS on labs or any other diagnostic testing.
Several things to keep in mind when your doctor recommends diagnostic testing:

1) Your doctor will be happy to explain any testing to you and why they believe it is necessary.
2) You always have the right to refuse any testing recommended, though your doctor also has the right to discharge you from their care if they believe the testing is mandatory.
3) Our front desk staff will be happy to inform you of the cost of the recommended tests.
4) Even if you have insurance, you may opt to pay for tests out-of-pocket at the discounted cash price in order to avoid any possibility that your insurance company will refuse to pay. You may be able to pay for diagnostic testing not covered by your insurance company using a Health Savings Account or Flex Spending Account.
5) If your insurance company does refuse to pay, the lab or imaging center will usually charge you the full retail price of the tests.

Please choose one option below:

- ❖ **Yes,** I am open to receiving laboratory testing as recommended at this office. All of the testing options and prices can be discussed before making any decisions to run labs. I understand that Medicare or my private insurance company may not pay for these tests, and I will be responsible for any lab charges not covered by insurance.

- ❖ **No,** I have decided not to receive any laboratory tests at this office. I understand that by not having tests done, my doctor may not be able to properly diagnose and treat me, and has the right to discharge me from care. I also understand that if my insurance company covers testing when ordered by my primary care physician or another doctor, I can request tests through my other doctor's office and authorize for a copy of the results to be sent here.

Patient Name: ____

____ ______________
Signature of Patient/Responsible Party Date

Health For Life Naturopathic Medicine

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g) (1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effect on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding the use of these substances in order to upgrade the quality of foods in a patient's diet and supplement nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Health for Life Naturopathic Medicine

You are under no obligation to purchase nutritional supplements at our office
As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering (1) the quality of science behind the product and (2) the quality of the product components. The brands of supplements that we carry in our center are those that meet our high standards and tend to produce predictable results. While these supplements may come at higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body) and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality with over the counter. There is a lack of stringent testing requirements for dietary supplements over the counter, therefore, product quality varies widely. If you have concerns about this issue, please discuss them with our staff.

By signing this form, I acknowledge receiving this:

____ ____________

Patient or Authorized Representative Date