flow
natural health care

11630 SE 40th Ave. Suite C
Milwaukie OR 97222
503.974.9283

PEDIATRIC INTAKE FORM (Birth-12 YEARS)

Name: _____ Date: _____

Age: _____ Date of birth: _____ Gender: Female / Male

Parent/Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Secondary phone: _____

Email: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Name of current Pediatrician/Clinic? _____

_____

HEALTH HISTORY QUESTIONNAIRE

Child's birth weight: _____

Today's health concerns?

1. _____
2. _____
3. _____
4. _____

Has your child had any of the following tests? Indicate **when** and **result**.

Electroencephalogram (EEG) _____

Psychological evaluation _____

Hearing tests _____

Speech/language tests _____

Injuries/surgeries/hospitalizations (please list): _____

_____

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IMMUNIZATIONS

Polio	Y N		
Pertussis	Y N	DTap	Y N
Tetanus Shot	Y N	Chicken pox	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Hib	Y N	Hep B	Y N

Other: _____

Has your child ever had an adverse reaction to a vaccine? If yes, please list the vaccine and reaction.

_____

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? _____

And foods? _____

Any environmentals? _____

TYPICAL FOOD INTAKE

Currently: Breast feeding: Y N Formula: Y N

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

MEDICATIONS & SUPPLEMENTS

Please list all prescription medications, vitamins or supplements that your child is taking. Please include the dose.

_____

_____

_____

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INFORMED CONSENT & REQUEST FOR NATUROPATHIC MEDICAL CARE

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Hamilton, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____ , hereby request and consent to examination and treatment with naturopathic medicine by Dr. Hamilton, and/or other licensed doctors of naturopathic medicine who may serve as substitutes in their absence, hereafter called allied health care provider.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Hamilton, and/or with the allied health care provider who acts as a substitute in their absence:

1. My suspected diagnosis(es) or condition(s).
2. The nature, purpose, goals and potential benefits of the proposed care.
3. The inherent risks, complication, potential hazards or side effects of treatment(s) or procedure(s).
4. Reasonable available alternatives to the proposed treatment procedure.
5. Potential consequences if treatment or advice is not followed and/or nothing is done.

I understand that as part of the practice of naturopathic medicine, evaluations and treatment may include, but are not limited to:

- Physical exams (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments).
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva).
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intramuscular injections).
- Botanical/herbal medicines, prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, pastes, plasters, washes or other forms.
- Homeopathic remedies (highly diluted quantities of naturally occurring substances).
- Hydrotherapy (use of hot and cold water).
- Counseling for improved lifestyle strategies.
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians).

Potential benefits: Restoration and improvement of the body's functioning and healing capacity, relief of pain and other disease symptoms, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness, allergic reactions to prescribed herbs, supplements, aggravations of pre-existing symptoms.

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Please read and INITIAL the following:

_____ I understand that Dr. Hamilton is not licensed to prescribe any controlled substances.

_____ I understand that Dr. Hamilton will only prescribe medications if she believes they are in the best interest of myself, the patient.

_____ I understand the US Food and Drug Administration has not approved all nutritional, herbal and homeopathic substances that may be prescribed.

_____ I understand that Dr. Hamilton is not a psychologist or psychiatrist. Counseling services are provided for improved lifestyle strategies. I do not expect Dr. Hamilton and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on known facts.

_____ I understand that it is *my* responsibility to request that Dr. Hamilton explain therapies and procedures to *my* satisfaction.

_____ I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.

By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment by Dr. Hamilton. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____
Patient printed name

_____
Parent/guardian printed name (if patient is a minor)

_____
Patient Signature (or parent or guardian of patient is a minor)

_____
Date

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for

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marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. **It is important that you understand that your information can be used and shared in the following ways**:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives or others that *you identify* who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- Obtain payment from third party payers.

I acknowledge that I have reviewed the Notice of Privacy Practices of Flow Natural Health Care.

_____

Patient name (Please print. Include parent/guardian name is patient is a minor).

_____ ____ / ____ / ____

Patient Signature (Parent/guardian signature if a minor) Date

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OFFICE POLICIES & FINANCIAL AGREEMENT

Please **read** and **initial** the following statements:

_____ Payment for all services, lab fees and medicinary items is due at the time of the your visit. You are responsible for deductibles, coinsurance, copays, or denied insurance charges.

_____ We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a $35.00 NSF fee.

_____ Emailing is for clarification of treatment plans only and not for diagnosis, treatment or prescription refills.

_____ You will be charged a Missed Appointment Fee of $40.00 for any missed appointments or cancellations of less than 24 hours notice. Insurance companies do not cover late cancellation fees.

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_____ Prescription refill requests require 48 business hours.

_____ It is your responsibility to verify insurance coverage. Flow Natural Health Care cannot guarantee coverage for office visits or lab work.

I have read and understand the above stated policies of Flow Natural Health Care LLC and will comply with them in all respects.

_____

Patient Name (Please print. Parent or guardian if patient is a minor).

_____ _____

Patient signature (Parent or guardian if patient is a minor) Date

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For Patients with Insurance:

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Flow Natural Health Care.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature:_____Date: _____