



West Valley Naturopathic Center

Time to listen, Time to Care, Time to Heal

PEDIATRIC INTAKE FORM (6-12 years)

Name _____ Date _____
 Age ____ Date of Birth ____ / ____ / ____ female _____ male _____
 Mother's name _____ Father's name _____
 Address _____
 City _____ State _____ Zip Code _____
 Telephone # (home) _____
 How did you hear about this clinic _____
 Health insurance: Company _____
 Policy/I.D. No. _____ Group/code No. _____
 Name policy is in _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N
Tonsillitis	Y N	approx. number	_____
Ear infections	Y N	approx. number	_____
Other	Y N	list	_____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Has your child had any of the following tests? When Where

Electroencephalogram (EEG)
Psychological evaluation
Hearing tests
Speech/Language tests

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? _____	

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

REVIEW OF SYSTEMS

Y = a condition now **P** = a condition in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N
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NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

Y = a condition now **P** = a condition in the past **N** = never had

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
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Terms of Agreement

Patient Name: *Last* _____ *First* _____ *M.I.* _____

Age: _____ Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Welcome to the *West Valley Naturopathic Center* and thank you for selecting us for your health care needs. We look forward to helping you along the way to great health.

Office hours: Our hours of operation shall be M-F 9am-5pm and Thursdays from 1pm-7pm. We will close on Mondays in the summer time. We also reserve the right to change our office hours without prior notification.

Cancellation: Please give at least 24 hours notice to reschedule an appointment. Failure to cancel an appointment without giving the clinic a 24-hour notice will result in a \$50.00 charge to you.

Fees & Financial Policy: Payment of fees is the direct responsibility of the patient. *We shall collect payment for services and products at the time of visit.* We accept cash, check, visa, mastercard and discover as forms of payment.

Insurance Billing: Please see our separate Insurance Policy

Medicinary: To pick up refills of your medicinary items, please call the center in advance so that any waiting time will be minimized.

Terms: All of our fees are subject to change without prior notice. Past due balances are subject to a 2% per month (18% per annum) service charge, plus a monthly billing charge of \$10.00.

Statement: I have read and understand the above policies of West Valley Naturopathic Center, LLC and agree with them. I consent to treatment with Dr. Karen Freeze, N.M.D., and/or Dr. Brian Archambault, N.M.D. and accept full responsibility for all expenses incurred by or on the account of the patient. In the event of non-payment, I will bear the cost of collection and/or all court costs and legal fees should it be required.

I authorize the release of any medical information necessary to process an insurance claim and authorize payment directly to the signed physician.

Due to the new privacy policies, this form must be signed by you to disclose your private health information. A copy of our privacy policy is available upon request.

Signature of Patient or Guardian

Date (D/M/Y)

West Valley Naturopathic Center
10320 W. McDowell Rd Suite M-1342
Avondale, AZ 85323
Tel: 623.643.9598

SUMMARY OF NOTICE OF PRIVACY PRACTICES

We strongly believe in maintaining the confidentiality of the personal information we obtain and/or receive about you and we are committed to protecting your privacy. We do not disclose any non-public information about you to anyone, except as permitted or required by law. We do not sell or otherwise disclose your personal information to anyone for purposes unrelated to our health practice. We maintain physical and procedural safeguards that comply with federal and state regulations to protect information about you from unauthorized disclosure. We may disclose any information we believe necessary to conduct our business as is legally required. You have the right to access, review, and correct all personal information collected. You may review our Privacy Policy in its entirety. You may also request the Privacy Policies of other entities who provide information to our office. We will provide phone numbers and addresses.

Please take a moment to sign the Acknowledgment of Receipt of Notice of Privacy Practices Summary on the opposite side of this page.

West Valley Naturopathic Center
10320 W. McDowell Rd. Suite M-1342
Avondale, AZ 85323
Tel: 623.643.9598

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES SUMMARY

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that The West Valley Naturopathic Center has provided me with a copy of its Notice of Privacy Practices Summary that summarizes how medical information about me may be used and disclosed. I further acknowledge that a complete copy of Privacy Practices Policies (approx. 13 pages) is available upon request and in the waiting area.

I understand that if I have questions or complaints I may contact:

**Privacy Officer: Erin Cortise
Tel: 623.643.9598**

I also understand that I am entitled to receive updates upon request if The West Valley Naturopathic Center amends or changes its Notice of Privacy Practices in a material way. Privacy Practices Policy effective July 1, 2004

Signature

Relationship to Patient, if signed by someone other than patient.

Date

**THIS SECTION IS TO BE COMPLETED BY THE WEST VALLEY
NATUROPATHIC CENTER IF UNABLE TO OBTAIN WRITTEN
ACKNOWLEDGMENT FROM PATIENT**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices Summary from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgment.

Other (specify): _____

Name and title of employee

Date



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Insurance Billing Office Policies

1.) We will as a courtesy to our patients, bill any PPO insurance plan. Your plan should reimburse for office visits at West Valley Naturopathic Center once your deductible has been reached, however, we cannot guarantee this for any plan, nor will your insurance provider. It is your responsibility to contact your insurance provider to determine what your deductible is and how much of your deductible has been met.

2.) If you have our office bill your insurance on your behalf you agree to follow up with your insurance provider in **30 days** from the time of your office visit if they have not either accepted or denied your claim. This will allow our office to follow up with your insurance provider to ensure that your claim gets processed.

3.) Upon your initial visit you will be asked to complete the highlighted portions of a health claim form which will be kept in your chart to help our staff to facilitate insurance billing on your behalf.

4.) Payment shall be made in full at the time of the visit, unless, we are in-network with you insurance provider. Currently, Lifewise is the only insurance provider that we are contracted in-network. For these individuals we will accept your co-pay, and you will be responsible for payment to West Valley Naturopathic Center for any remainder of the bill that was not covered by Lifewise. For any service that is not covered by Lifewise we shall again take full payment at the time of the visit.

Your insurance provider should respond to the filed claim within **30 days** with an EOB (explanation of benefits), that will inform you if your claim has been either: accepted, denied, why it was denied, applied to your deductible or paid. West Valley Naturopathic Center shall in turn write a check to the patient for the portion of the visit that was covered by your insurance provider which can be verified on your EOB.

If you have any further questions please feel free to contact our insurance biller.

By signing below you agree to the above terms and conditions and that you will follow up with our office in the event that your insurance provider has not responded to the claim in **30 days**.

Patient's Signature/Date