



# West Valley Naturopathic Center

Time to listen, Time to Care, Time to Heal

## PEDIATRIC INTAKE FORM (Birth- 5 years)

Patient's name \_\_\_\_\_ Date of first visit \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_

Phone # (home) (\_\_\_\_) \_\_\_\_\_ Parents work # (\_\_\_\_) \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

Health insurance: Company \_\_\_\_\_

Policy/I.D. No. \_\_\_\_\_ Group # \_\_\_\_\_

Name policy is in \_\_\_\_\_

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept \_\_\_\_\_

Reason for referral or presenting problems \_\_\_\_\_

<b>MEDICATIONS</b>	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Ibuprofen	_____	_____
Any other medications _____					

## MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis, approx. no.
_____ Measles	_____ Pneumonia	_____ Ear infections, no. _____
_____ Mumps	_____ Frequent colds	_____ other (please list) _____
_____ Rubella	_____ Rheumatic fever	_____



Child's sleep patterns (first year)

\_\_\_\_\_

Food intolerances (if any)

\_\_\_\_\_

Feeding: Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_

Formula? milk /soy \_\_\_\_\_ how long? \_\_\_\_\_

Age began solids \_\_\_\_\_ Which foods? \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_

Talking \_\_\_\_\_

**SYMPTOMS** (mark **Y** if current, **P** for past symptoms)

_____ Hives	_____ Burning of urine	_____ Bloody urine
_____ Eczema	_____ Frequent urination	_____ Cries easily
_____ Bleeding gums	_____ Heart murmur	_____ Nervous
_____ Nose bleeds	_____ Vomiting spells	_____ Sleep problems
_____ Acne	_____ Anemia	_____ Night sweats
_____ High fevers	_____ Stomach aches	_____ Sensitive to light
_____ Chronic rash	_____ Jaundice	_____ Body/breath odor
_____ Hearing loss	_____ Easy bruising	_____ Motion/car sickness
_____ Diarrhea	_____ Flat feet	_____ No appetite
_____ Sore throats	_____ Constipation	_____ Nightmares
_____ Headaches	_____ Gas	_____ Canker sores
_____ Frequent colds	_____ Bleeding tendency	_____ Unusual fears
_____ Wheezing	_____ Joint pains	_____ Excessive fatigue
_____ Cough	_____ Dizzy spells	_____ Hair loss

**DIET**

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

**Thank you. We look forward to helping your child in any way we can.**



## **West Valley Naturopathic Center**

Time to listen, Time to Care, Time to Heal

### **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



# **West Valley Naturopathic Center**

Time to listen, Time to Care, Time to Heal

## **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