Natural Choices Health Clinic

Your natural choice for health care

3007 SE Belmont Street, Portland, OR 97214 ph: (503) 445.7115 fax: (503) 445.7116

www.NaturalChoicesClinic.com info@NaturalChoicesClinic.com

Dr. Mary Frazel, N.D. *Dr. Keivan Jinnah, N.D.*

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: ____ Zip: _____

Phone # (home): (_____)_____ Parents # (cell): (_____)_____

Phone # (work): (_____)_____ Parents e-mail address: _____

How did you hear about this clinic? _____

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

_____

Reason for referral or presenting problems: _____

_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no. _____

_____ Measles _____ Pneumonia _____ Ear infections, no. _____

_____ Mumps _____ Frequent colds _____ other (please list) _____

_____ Rubella _____ Rheumatic fever

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram			
Psychological evaluation			
Hearing			
Speech/Language			

Injuries/Surgeries/Hospitalizations (please list): _____

_____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria

_____ Mumps _____ DPT _____ Tetanus _____ Influenza

Others (list) _____

Any adverse reactions? Y N What ? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects

_____ Hypertension _____ Arthritis _____ Tuberculosis

_____ Cancer _____ Allergies _____ Mental illness

PLEASE COMPLETE BOTH SIDES

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

_____ Bleeding	_____ Physical or emotional trauma	
_____ Nausea	_____ Cigarettes, alcohol, drug consumption	
_____ Illnesses	_____ Medications	
_____ Hypertension	_____ Thyroid problems	_____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth_____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects	_____ Birth injuries	_____ Blue baby
_____ Cerebral palsy	_____ Seizures	_____ Jaundice
_____ Colic	_____ Fever	_____ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

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

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ 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 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.

NATUROPATHIC INFORMED CONSENT TO TREAT

Patient Name: _____

Office Name: **Natural Choices Health Clinic / Dr Keivan Jinnah, ND, MSOM, LAc.**

Consent: I hereby request and consent to the performance of naturopathic treatments and / or other naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named above, for whom I am legally responsible) by the doctor of naturopathy named above and/or other licensed doctors of naturopathy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathy named above, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not.

Type of Care: I have had an opportunity to discuss with the doctor of naturopathy named above and/or with clinic personnel the nature and purpose of naturopathic care and procedures. A description of the specific care which is currently contemplated follows:

Homeopathic, herbal, nutritional, and lifestyle treatment.

No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, as in the practice of medicine, in the practice of naturopathy, there are some risks to treatment, including, but not limited to:

Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies, allergic reaction to prescribed herbs, supplements, prescription medication; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests."

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

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Dear New Patient,

Welcome to our clinic. We, the healthcare providers at the Natural Choices Health Clinic, look forward to providing for your health needs. We encourage your questions and participation in all aspects of your health care. **Please read and initial the following**:

_____ **I understand that full payment for all services and products I receive from Natural Choices Health Clinic and its practitioners is required at the time of service, except that portion billed to my insurance company.**

_____ **Further, I understand that Natural Choices Health Clinic may submit my bill to insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.**

_____ **You will be charged a Missed Appointment fee of $75.00 for any missed appointments. This includes late cancellations with less than 24 hours notice or arriving more than 15 minutes late to your scheduled appointment.**

_____ **I give permission for the staff at NCHC to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.**

_____ **I hereby give my consent for Natural Choices Health Clinic to use and disclose protected health information about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided upon request describes such uses and disclosures more completely.**

We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of $25.00 for returned checks due to insufficient funds. We can arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at the Natural Choices Health Clinic. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at the Natural Choices Health Clinic.

Your health care provider may prescribe medication, which may be purchased either at the Natural Choices Health Clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of the Natural Choices Health Clinic and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____
Your Signature (parent or guardian if minor)

_____ _____
Print your name (parent or guardian if minor & patient name) Date

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Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

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 Natural Choices
Patient's name
Health Clinic has offered to provide me with a copy of its *Notice of Privacy Practices* that describes the manner in which my medical information may be used and disclosed, as well as how I can access this information for myself. I understand that if I have questions or complaints I may contact:

National: Region X, Office for Civil Rights
US Dept. of Health/Human Services
2201 Sixth Avenue--Suite 900
Seattle, WA 98121-1831
1-866-627-7748

Local: Dept. of Human Resources
500 Summer St, NE
Salem, OR 97301
503-945-5944

I also understand that I am entitled to receive updates upon request if Natural Choices Health Clinic amends or changes its *Notice of Privacy Practices* in any way.

_____ _____
Signature of patient or legal sig Relationship to Patient,
(if signed by someone other than patient)

_____
Date

****

SECTION BELOW FOR OFFICE USE ONLY:

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In the event that Natural Choices Health Clinic is unable to obtain written acknowledgment from the patient, the following must be completed:

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices 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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Patient Name: _____

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as the whether or not a dispute is subject to arbitration, will also be determined y submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as back up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.
All claims for monetary damages exceeding the jurisdiction limit of small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief or punitive damages.

Article 3: Procedures an Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the party within thirty days thereafter. The neutral arbitrator shall then ne the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with the other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, or other expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future damages conformed to periodic payments, shall apply to disputes within the Arbitration Agreement.
The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action. Would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: The agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as the date of first professional services.
If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED NY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature: _____ Date: _____
(Or Patient Representative)

Office Signature: _____ Date: _____