Fox Valley
NATURAL MEDICINE

PEDIATRIC PATIENT PROFILE

Date:_____

Last Name: _____ First Name:_____

Date of Birth:_____ Sex: M F Email:_____

Address:_____

Home/Work Telephone:_____Mobile/Work Telephone:_____Circle Preference

Referred By?_____

Please fill out the following information. This is a confidential health record and will not be released unless Fox Valley Natural Medicine receives written permission.

Chief Complaint and Present Health Concerns

List the most important health concerns in their order of significance	Prior Diagnosis of the problem

What are your goals for today?_____

_____

Please list prescription medications that you are taking, with dosages and prescribing physician:_____

_____

List any vitamins or nutritional supplements that you are taking:_____

_____

List any severe or life-threatening allergies. Please explain:_____

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Personal Habits

Any dietary restrictions or food sensitivities? If Yes please explain:_____

_____

Exercise? Yes No What Type/ How Often:_____

_____

Past Medical History

Hospitalizations:_____

Serious Illnesses and Injuries:_____

Date of last physical Exam:_____ Date of Last Blood Test:_____

Prenatal History: Mother's health during pregnancy with this child

Age	Trauma	Alcohol
Bleeding	Stress	Drugs
Nausea	High blood pressure	Smoking
Illness	Radiation	Antibiotics
Toxemia	medications	Gestational diabetes

First Year

Term age _____ birth weight _____ place of birth _____

Breastfed Y / N Duration _____ Formula Y / N Duration _____

Food Introduction Age _____ What Food _____

Vaccination history: please not any adverse reaction

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Childhood Diseases History

Condition	Yes	Complication	Condition	Yes	Complication
Chicken pox			Scarlet fever		
Measles			Rheumatic fever		
Mumps			Strep throat		
Rubella			Pneumonia		
Whooping cough			Asthma		
Tonsillitis			Croup		

Family History: Please check yes if the condition applies a family member. Please use P for past and C for current.

Condition	Yes	Relation	P / C	Condition	Yes	Relation	P / C
Alcoholism				Headaches			
Allergies				Heart disease			
Anemia				Hepatitis			
Arthritis				High blood pressure			
Asthma				Kidney disease			
Cancer				Mental illness			
Depression				Stroke			
Eczema				Tuberculosis			
Epilepsy				Diabetes			
drug addiction				Other			

Social History

Parents: Married / Significant Other/ Divorced

Mother's Occupation _____ Father's Occupation _____

Do you have siblings? Yes No List their ages:_____

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CONSENT TO TREATMENT OF MINOR CHILD

I, being the parent of legal guardian, hereby authorize Dr. _____ and whomever s/he may designate as assistants to administer treatment as deemed necessary to:

Full name of child _____

Child's address _____

Signature _____ Date _____

Printed name _____ Relationship to child _____

Witness _____

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Informed Consent for Treatment

Patient Name: _____ Date of Birth: _____

I, _____, hereby authorize the practitioners of Fox Valley Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment: common diagnostic procedures (venipuncture, PAP smears, laboratory, physical exam, etc.), minor office procedures (dressing a wound, ear cleansing), medical use of nutrition (therapeutic and supplementation), botanical medicine (teas, alcohol tinctures, capsules, tablets, creams, plaster, suppositories), homeopathic medicine (the use of highly dilute quantities of naturally occurs substances that stimulate healing in the body), lifestyle counseling and hygiene (diet therapy, wellness promotion, sleep, reduction of stress, work and social balance), acupuncture (application of acupuncture needles into the body to facilitate the flow of chi), hydrotherapy (the application of hot and/or cold to the body), low volt EMS (to reduce muscle spasm, decrease pain, or stimulate lymphatic flow), massage (soft tissue manipulation), chiropractic manipulation (movements to joints of the spine or extremity either manually or with an instrument).

I recognize the potential risks and benefits to these procedures as follows: allergic reactions to prescribed herbs and supplements, side effects of natural medications (the most common being that of gastrointestinal upset such as gas or bloating), inconvenience of lifestyle changes, injury from venipuncture (such as bruising) or other procedures (such as soreness following a massage, acupuncture, or chiropractic manipulation).

Pregnant women must alert the physician and therapist if they know or suspect that they may be pregnant because some therapies are contraindicated during pregnancy.

With this knowledge, I voluntarily consent to the above procedures, with the understanding that no guarantees have been given to me by Fox Valley Natural Medicine or any of its personnel regarding a cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Fox Valley Natural Medicine will keep a record of the health services provided to me. This record will be kept confidential and will not be released to other unless so directed by myself or my representative or unless required by law. I understand that I may look at my medical record at any time and can request a copy it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three but no more than ten years after the date of my last visit. I understand that any questions I have will be answered by my physician to the best of their ability.

_____ _____

Date Signature of Patient or Guardian

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PRIVIACY PLEDGE, INSURANCE VERIFICTION, & CANCELATION POLICY

Privacy Pledge:

Fox Valley Natural Medicine is committed to you privacy. There are several circumstances in which Fox Valley Natural Medicine may have to disclose your health care information such as: referral to another health care provider or hospital for additional diagnosis, assessment or treatment; to a third party if they are responsible for payment of your received services; for the purposes of quality control or other operational procedures within Fox Valley Natural Medicine.

Along with this consent form you have a right to a copy of our privacy policy upon request. You have the right to review this policy prior to signing this form. We reserve the right to change our privacy policy. If we make changes to our privacy policy you will be notified in writing when you come in for treatment or by mail.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your health information, please inform Fox Valley Natural Medicine of this in writing. Please note that we are not required to agree to your restrictions; however, if we are in agreement then they will be binding with us.

You may revoke your authorization at any time. However, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request for revocation. If you were required to give your authorization as a of condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to the terms. I am also acknowledging that I have received a copy of this consent for and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

Insurance Authorization and Cancelation Policy

Please check the following boxes to acknowledge having read:

- ☐ I authorize the release of my medical or other information necessary to process my insurance claims. I also request payment of government benefits to myself or to the party who accepts assignment. (If desire, please ask for a copy of the 1500 HIC form for further information.)
- ☐ I authorize payment of medical benefits to the undersigning physician or supplier for services described below.
- ☐ I understand that I am responsible for payment of all benefits not covered by my insurance whether in part or full, and for the payment of copays, coinsurance, and deductibles as required by my insurance carrier. I agree this may be charged to my credit card on file.
- ☐ I understand there is a **24 hour cancelation policy**. I agree to a $75 cancelation fee as a new patient and a $50 cancelation fee for follow up appointments. I agree this may be charged to my card on file and will not be billed to my insurance.

_____ _____

Print Name Authorized Provider Representative

_____ _____

Signature Date

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Today's Date:_____

Patient Contact Information

NAME Last: _____First:_____Middle:_____

Date of Birth:_____ SS#: _____ Sex: M F

Email:_____

Home Address:_____

Employer:_____

Employer Address:_____

Circle Preference for Telephone Contact:

Home:_____ Mobile:_____ Work:_____

Emergency Contact Information

Name: _____ Relation: _____

Home Address:_____

Employer:_____

Employer Address:_____

Home:_____Mobile:_____Work:_____

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FIRST OFFICE VISIT RESERVATION POLICY

Thank you for choosing to become a part of the Fox Valley Natural Medicine family. We are excited to have you. Your initial visit with the doctor will be for approximately 1 hour and 30 minutes so the doctor may go into detail with you regarding your concerns. Given the lengthy time set aside and dedicated to your first visit we would like to inform you of our 24 hour cancelation and no-show fee of $75 for first office visits.

Before we can officially reserve your time on the schedule we need for you to **sign this form**. Once completed please **email this form to** office@foxvalleynaturalmedicine.com to permanently reserve your appointment.

In signing this form you agree and understand to the following

1. You agree to call within 24 hours of your scheduled appointment to avoid a cancelation fee. Failure to do so will result in a $75 charge on the credit card you provided
2. Failure to show up for your first appointment will result in a $75 charge on the credit card provided
3. You agree to complete this form within 24 hours of initially scheduling your first appointment. Failure to receive this agreement voids your ability to permanently reserve your appointment.

Our office is happy to confirm your appointment via telephone at 1 week and the business day before your scheduled appointment.

Please complete the following:

_____ _____

Print Name Date

_____

Sign Name

PLEASE EMAIL THIS FORM TO OFFICE@FOXVALLEYNATURALMEDICINE.COM

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Credit Card Authorization

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is stored and later used to pay your bill. This is an advantage for both you and the rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charge to your credit card and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us a check. It will be an advantage to us as well since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping us keep the cost of health care down. The American Medical Association estimates it costs $7 to $12 to collect $20 dollars.

This in no way will compromise your ability to dispute a charge or question your insurance determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,

Fox Valley Natural Medicine LLC

I authorize Fox Valley Natural Medicine LLC to charge outstanding balance on my account to the following card:

☐ Visa ☐ MasterCard ☐ Discover

Account Number _____

Expiration Date _____ CVV _____

Name on Card (please print)_____

Signature _____

Date _____

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