New England Naturopathic Health

Pediatric Intake Paperwork

Child's Full Name: _____ Date: _____

Address: _____City: _____Zip: _____

Cell Phone: _____Work Phone: _____ Email: _____

Date of Birth: _____Social Security Number: _____

Parent's/Legal Guardian's Names: _____

Your occupation: _____Your employer: _____

Whom to contact in case of emergency? (Please list relation and best contact number)

_____

Personal History

Who is your child's pediatrician? _____

Please list complaints for your child in order of priority:

_____

_____

Please list any allergies to medicines or foods your child has:

_____

_____

Please list pharmaceutical medicines your child takes, along with the dose:

_____

Please list any health supplements your child takes, along with the dose:

_____

Please list any major illnesses, accidents or hospitalizations your child has experienced including dates:

_____

_____

Date of your child's last physical exam: _____

Any abnormal results? _____

Date of your child's last blood work: _____

Any abnormal results? _____

Family Medical History

Do any members of your child's immediate family suffer from any of the following health conditions?

☐ Heart Disease/High Cholesterol:

☐ Diabetes:

☐ High Blood Pressure:

☐ Cancer: Type?

☐ Alcoholism/Drug Addiction:

☐ Mental Health Disorder: Type?

☐ Any other serious health conditions?

Does your child have any problems with any of the following body systems?

☐ EENT: (head, ears, eyes, nose, throat)

☐ Endocrine: (thyroid or another hormone imbalance)

☐ Nervous system: (dizziness, imbalance, slow thinking, poor memory)

☐ Respiratory: (allergies, asthma, chronic cough)

☐ Skin: (psoriasis, eczema, acne)

☐ Cardiovascular: (heart palpitations, chest pain, cold hands and feet, varicose veins)

☐ Digestive: (GERD, heartburn, nausea, constipation, diarrhea, gas, bloating)

☐ Musculoskeletal: (chronic back or limb pain)

☐ Psychological: (anxiety, depression)

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Lifestyle

Please give examples of typical meals:

Breakfast:

Lunch:

Dinner:

Snacks:

How much water does your child drink in a day? _____

Does your child exercise? If so, please list types and amount per week:

_____

_____

Are there any problems with sleep? How many hours does your child typically sleep in a night?

_____

Please list your health goals for your child in order of priority:

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Terms of Consent for Care

I, _____, hereby authorize Dr. Marinaro to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, radiology, laboratory, x-ray

Minor office procedures: e.g., cleaning, dressing a wound, ear lavage, skin scraping

Medical use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: plant substances may be prescribed as teas, alcohol-based tinctures, glycerites, capsules, tablets, creams or suppositories

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals

Craniosacral Therapy, Visceral Manipulation: gentle forms of bodywork used to address back pain and other musculoskeletal complaints, headaches and organ dysfunction

Medical use of Ozone Therapy: use of ozone/oxygen gas to treat skin conditions, infections, allergies and GI conditions. Ozone may also be used as an intra-muscular injection (Prolozone therapy) to decrease pain in a muscle or tendon and help to heal injuries.

I recognize the potential risk and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Please notify Dr Marinaro's office if you experience any symptoms which may be secondary to the above procedures.

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or it's progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by physician, or any personnel regarding 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 a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of 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 last day of my visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

New England Naturopathic Health

I understand that all sales of goods and services are final.

Signature of Patient: Date:

New England Naturopathic Health Policies:

Please initial in the following boxes:

☐ I understand that payment of consultation fees, lab fees, supplements and any other services are due at the time of service.

☐ I understand that phone consultations and phone lab reviews with Dr. Marinaro will be billed at the same rate as an in-office visit.

☐ I understand that I may message Dr. Marinaro's support staff through Patient Fusion. Email is not an acceptable communication format due to confidentiality concerns.

☐ I understand that any supplements purchased at NENH or via Health Wave (per NENH request) cannot be returned once opened.

☐ I understand that if I am more than ten minutes late for an appointment. I may not be seen and may be assessed a cancellation fee.

☐ I understand that should I miss an appointment or cancel with less than a twenty-four hours' notice, I will be assessed a cancellation fee.

☐ I understand it is my responsibility to ensure insurance coverage for both office visits and labs ordered by a Naturopathic Doctor. Please refer to the Insurance Benefits Verification form for additional information.

New England Naturopathic Health

Dr. Corrie Marinaro & Dr. Erin Hayford
179 Main Street, Suite 408 | Waterville, ME 04901
Phone: 207-873-9380 | Fax: (207) 352-5217| info@naturopathicme.com | www.naturopathicme.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize _____ to release healthcare information of the patient named above to:

Office Name:

Fax Number:

Requesting documentation regarding:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ Labs and Imaging only

☐ Other:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: [Date]

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

New England
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Corrie Marinaro, Naturopathic Doctor

phone: (207) 873-9380
fax: (207) 873-9360
179 Main Street, Suite 408
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www.naturopathicme.com
info@naturopathicme.com

INSURANCE BENEFITS VERIFICATION

Please ensure this form is completed and submitted prior to your first appointment. Please allow 1 hour to complete this form.

PATIENT INFORMATION

Full Name: _____

Address: _____

Phone #: _____ Date of Birth: _____

INSURED INFORMATION

Full Name: _____

Address: _____

Phone #: _____ Company: _____

Date of Birth: _____ Relationship to Insured: _____

INSURANCE COMPANY INFORMATION

Name: _____

Phone #: _____

ID #: _____ Group #: _____

NENH patients, it is your responsibility to be aware of your insurance benefits, including coverage, co-pay, deductible, and maximums. Please call the number listed on the back of your insurance card and fill out the information below prior to your first appointment.

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QUESTIONS FOR YOUR INSURANCE

1. Name of Insurance Representative:

2. Date of call:

3. Beginning Date of Coverage: Ending Date:

4. Does my insurance cover Naturopathic Doctors? Yes / No

5. Is New England Naturopathic Health a covered provider under my plan? Yes / No

6. Do I need a referral from my primary care physician to see an ND? Yes / No

7. What is my co-pay or % covered for:

    a. Specialty Office Visits?

    b. Lab Work?

    c. Diagnostic Imaging?

8. What is my yearly maximum for naturopathic office visits?

9. What is my yearly maximum for naturopathic lab work/diagnostic imaging?

10. Do I have an annual deductible? Yes / No Amount met to date:

11. Is my deductible based on calendar year?

12. Are office visits or labs subject to my deductible?

13. Is Labcorp a preferred lab? Yes / No

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I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by any provider at New England Naturopathic Health. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to New England Naturopathic Health. This authorization will be considered valid unless revoked by me in writing.

Signature: Date: