



Dear Parent/Guardian:

Thank you for the opportunity to be a partner in your family's health care.

We have included several important forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time more effectively. **Please bring these forms in at your first office visit.** The first visit will be a thorough assessment of your child's health and you should allow up to one hour for the visit.

The physician's recommendations will be reviewed at a second appointment and you should allow approximately 45 minutes.

If you are unable to keep your scheduled appointment time, please let us know at least 48 hours prior the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in copies of any recent lab work or medical records as well as all the bottles of supplements and/or medications that your child is currently taking.

Please note that we are a fragrance-free facility; please refrain from wearing any perfumes or colognes on the day of your appointment.

We look forward to meeting you and your family. Our goal is to become a trusted partner in assisting you with your family's health care needs.

Yours in Health,

Carolinas Natural Health Center

p: 704.708.4404 f: 704.708.4417
1126 Sam Newell Road, Suite A Matthews, NC 28105
www.CarolinasNaturalHealth.com



FINANCIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing Carolinas Natural Health Center (CNHC) for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

CNHC is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover and American Express. Returned checks are subject to a \$25 return fee and no further personal checks will be accepted.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that *cover new material, require new information, take an extensive amount of time, or require a change in the treatment plan* are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a limited visit will be billed at \$100.

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Thus, for naturopathic visits there is a \$100 charge for new patient and a \$50 charge for follow-up cancellations. For all other services (massage, acupuncture, etc.), 50% of the service will be charged for late cancellations. Full service fees will be charged if no notice is given.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document.

Patient or Parent/Guardian Signature

Date



Naturopathic Medicine Legal Disclosure

As a valued patient of Carolinas Natural Health Center, it is important to us that you are fully aware of the laws surrounding Naturopathic Medicine in North Carolina.

- The state of North Carolina does not offer a Naturopathic License to Naturopathic Physicians, but our physicians do hold current medical licenses from other states.

_____ **initial**

- As a result, our physicians cannot legally prescribe pharmaceutical drugs, perform minor surgeries, administer injections, or diagnose illnesses.

_____ **initial**

- Our Naturopathic Physicians are trained as primary care physicians. However, we are unable to fill that role in the state of North Carolina. Because of this, we ask you to maintain your relationship with a primary care physician. If you need a referral, we can provide a list of primary care physicians.

_____ **initial**

Signature

Printed Name

Date



Patient-Provider E-Mail Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember, there are important differences. E-mail is not the same as calling the office; there is no person at the other end of the e-mail – just a computer. You can't tell for certain when your message will be read or even if the doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via e-mail.

- E-mail is never appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion.
- E-mail should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is not confidential!** It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become part of the medical record when we use it; a copy may be printed and placed in your chart.
- **E-mail is not a substitute for seeing your physician.** If you think that you need to be seen, please call and schedule an appointment!
- E-mails may be forwarded to our staff for handling, if appropriate.

Finally either party can revoke permission to use the e-mail system at any time.

I **DO** want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted.

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____



PEDIATRIC PATIENT REGISTRATION FORM

Date: _____

New Patient Information

Name: _____ DOB: ____ / ____ / ____ Age: _____
(Last) (First) (Sex)

Address: _____ City: _____ ST: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Parent/Guardian Email : _____ Would you like to receive our email newsletter? Y N

Additional Patient Information

Pediatrician: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Name: _____ Occupation: _____ Tel: _____

Father's Name: _____ Occupation: _____ Tel: _____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Whom may we contact in case of an emergency: _____ Relationship to patient: _____

Emergency Contact #: (____) _____

Referral Information

How did you hear of us? _____

Were you referred by a physician?: Yes No

If "Yes", could you provide us with as much information as possible for the Referring Physician?

Referring Physician's Name: _____

Address, City, State, Zip: _____

Telephone Number: _____

Entered by: _____



NATUROPATHIC PEDIATRIC INTAKE FORM

Today's Date: _____

Patient Name: _____ DOB: _____

Sex (m/f): ___ Grade of School: ___ Reason for Office Visit: _____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

When was the most recent lab work and with what physician?: _____

List All Surgeries & Hospitalizations, including date occurred:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List All medicines (from drugstore or prescription) child is on now:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List all supplements child is taking:

- 1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Any known Allergies to food, drugs, environment, animals: _____

Previous Medical History

YES (Y) indicates the child gets the problem **regularly**; **NO (N)** indicates the child **never** had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently**. **Please circle the correct one for your child.**

Ear Infections: Y N P If has had, how many total: _____

Colds: Y N P If has had, how many total: _____

Strep Throat: Y N P If has had, how many total: _____

How many times has the child taken antibiotics: _____

What other medicines has the child taken and how often:

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

Hearing Tests Normal: Yes No Not Tested Speech Impediments: Yes No Past

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Vision Tests Normal: Yes No Not Tested Learning Impediments: Yes No Past

Patient Name: _____ DOB: _____

Vaccination History:

YES, has had; NO, has not; SOME, did not finish all shots:

MMR: Yes No Some DPT: Yes No Some Hep B: Yes No Some
Hib: Yes No Some Chicken Pox: Yes No Some Polio: Yes No Some

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family History:

Allergies: Y N P Obesity: Y N P Cancer: Y N P
Tuberculosis: Y N P Mental Illness: Y N P Cardiovascular Disease: Y N P
Diabetes mellitus: Y N P

Mother's Pregnancy History:

Age at conception: _____ Did she have other children already? Yes No

Health During Pregnancy:

Smoking: Y N Diabetes: Y N Coffee: Y N Nausea/Vomiting: Y N
Recreational Drugs: Y N Emotional Stress: Y N Preeclampsia: Y N Length of Labor: _____
Vaginal Birth: Y N Traumatic Birth: Y N If the birth was difficult, please explain: _____

Health of baby at birth: _____

Health History of Child:

Child Breastfed: Y N For how Long: _____ When put on formula: _____
What Formula was used: _____ When was child put on solid food: _____
When did child walk: _____ Talk: _____ Develop Teeth: _____

Table with 2 columns of health history items and Y/N response boxes. Items include Jaundice as baby, Colic, Cradle Cap, Anemia, Eczema or Psoriasis, Asthma, Diarrhea, Warts, Constipation, Nightmares, Finicky Eating, Bed-wetting, Poor Teeth, Tantrums, Chronic Sniffles, Disobedient, Bad Foot Odor, Fears/Phobia, Very Sweaty Baby/Child, Diaper Rash.

Hyperactivity:	Y N
Growing Pains:	Y N

Early Puberty:	Y N
Stomach Aches:	Y N

Patient Name: _____ DOB: _____

Any Particular household stressors child has witnessed or gone through:

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

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution was s/he exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____
