1*Pediatric Intake Form

Patient & Parent or Guardian Information:

Patient Name: ____Date: ______________________
Age: ____________________ DOB: ___________________ Gender: Female / Male
Allergies: ____
Address: ____
City: __________________________________State: __________________ Zip Code: _____________
Telephone (Home): __________________________________ Work: ___________________________________
Parents Email Address: ____
Parent 1 Name & Occupation: ____
Parent 2 Name & Occupation: ____
Parents are: _____Married _____ Separated _____Divorced _____Living together ____Other
Name of Pediatrician: ____ **Phone:** _________________________

Most Important Health Concerns:

1. ____
2. ____
3. ____

Medications & Supplements:

1. Medication: ___________________________________ Dose: _______________________________
2. Medication: ___________________________________ Dose: _______________________________
3. Medication: ___________________________________ Dose: _______________________________

List hospitalizations or surgeries have you had with corresponding dates:_______________________________________
____
____

Medical History (Please Circle)

Chicken Pox	Scarlet Fever	Tonsillitis	Frequent Colds	Measles
Pneumonia	Ear Infections	Rheumatic Fever	Mumps	Rubella
Strep Throat	Hives	Burning Urine	Bloody Urine	Eczema
Bleeding Gums	Heart Murmur	Nervousness	Hair Loss	Nose Bleeds
Vomiting Spells	Sleep Problems	Asthma	Anemia	Night Sweats
High Fevers	Jaundice	Sensitivity to Light	Chronic Rashes	Sore Throats
Diarrhea	Hearing Loss	Easy Bruising	Cough	Flat Feet
Loss of Appetite	Constipation	Allergies	Stomach Aches	Unusual Fears
Excessive Fatigue	Nightmares	Bleeding Tendency	Frequent Urination	Wheezing
Joint Pains	Dizzy Spells	Colic	Cradle Cap	Poor Teeth
Diaper Rash	ADD/HD	Growing Pains	Tantrums	Early Puberty

Family History: Is there a family history of the following? (Please Circle)

Heart Disease Diabetes Birth Defects Allergies Hypertension
Arthritis Tuberculosis Asthma Mental Illness Osteoporosis
Cancer
Other: ____

Immunizations:

___MMR ____DPT ___Chicken Pox ___Small Pox
___Measles ___Diphtheria ___H. Influenza ___Hepatitis B
___Mumps ___Tetanus ___Rubella ___Polio
Others: ____Adverse Reaction: Yes / No

Has Your Child Ever Had Any of the Following? When? Results?

Electroencephalogram (EEG): ____
Psychological Evaluations: ____
Hearing Test: ____
Speech/ Language Tests: ____
Injuries/Surgeries/Hospitalizations: ____
____
____

Prenatal History:

Mothers Age at Birth: __________
Mothers Health during Pregnancy:
___Bleeding ___Physical or Emotional Trauma ___Illnesses ___Nausea
___Hypertension ___Cigarettes/Alcohol/Drug Consumption ___Medications___Diabetes
___Thyroid Problems

Birth History:

Term: Full / Premature / Late Length of Labor: ____
Any Complications? ____

Did your Child have any of the Following Problems Shortly After Birth?

Rashes Birth Injuries Blue Baby Colic Birth Defects
Jaundice Seizures Cerebral Palsy Fever
Other: ____

Family Health Habits:

How often does your child use a seatbelt/car seat?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes / No

In the past year, have you ever felt threatened in your home? Yes / No

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes / No

If you have a gun at home, is it locked up somewhere safe? Yes / No

Does anyone in the household smoke? Yes / No

Besides you, does anyone else take care of the child? Yes / No If Yes, Who? ___________________________

Diet: (Typical Breakfast, Lunch, Dinner, snacks and cravings, or foods you avoid:)________________________
____
____
____
____

Exercise: Type & Frequency: ____
Sleep: restful? **No / yes** Hours / night: ______ Do you snore? **No / Yes** Do you move/ kick in your sleep? **No / Yes**

Do you have any Concerns about Your Childs Behavior or Development?
____

Additional Comments:
____
____
____

Parent or Guardian's Name: ____
Signature of Parent or Guardian: ____ **Date:** ________________

How did you hear or learn about us?

Referred by (circle one): Friend Family Member Workmate Other (Name):
____

Internet search: Please circle one: Google Yahoo MSN Facebook Twitter Other
Radio commercial Magazine article ValPak

1429 Broadway, Everett WA 98201 Phone: (425)293-0107 Fax: 425-293-0329 email: drmcquinn@gmail.com

Naturopathic Health Care Informed Consent for Treatment:

I, ____________________**,** hereby authorize the physician(s) at McQuinn Naturopathic, LLC to perform the following specific procedures as necessary to facilitate my diagnosis and treatment including, but not limited to:

Common diagnostic procedures: e.g. venipuncture, laboratory, Pap smears, or radiography.
Minor office procedures: e.g. dressing wounds, ear lavage, or immunization.
Medicinal use of nutrition: therapeutic nutrition, diet therapy, nutritional supplementation, and intramuscular or intravenous vitamin/mineral/nutrient injection.
Botanical medicine: botanical substances may be prescribed as teas, alcohol- or glycerite-based tincture, capsules, tablets, creams, plasters or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling & hygiene: promotion of wellness including recommendations for diet, exercise, sleep, stress reduction and balancing of work and social activities.
Psychological counseling & Contraception: natural family planning, counseling and/or referral.
Physical Medicine: Massage therapy, muscle energy stretching, trigger point release, manipulation, hydrotherapy, etc.
Pharmaceuticals: prescription drugs, hormones or over the counter recommendations may be made. **HCG is presently relied upon as a medication for fertility and it is also used to safely promote the production of testosterone in males. It is not approved by the FDA for weight loss.**

The physician(s) at McQuinn Naturopathic, LLC do not make recommendations for medical treatments or pharmaceuticals or for the discontinuation of other treatments and/or procedures with other health care professionals that are not within their scope of practice. Patients that require such treatments will be referred appropriately.
I recognize the potential risks and benefits of these procedures as described below:
Potential benefits: Restoration of health and the body's maximum 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 its progression.
Potential risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipunctures or procedures, tenderness/soreness or bruising from physical treatments.
Side Effects: The hCG side effects to monitor include the onset of headaches, irritability, restlessness, slight water retention, tenderness of breast tissue, swelling of the injection site, and mood changes. There are some rare, severe side effects as well which include the development of ovarian hyperstimulation in females. The latter condition requires immediate medical treatment and is accompanied by the following symptoms: tremendous pain in the region of the pelvis, the swelling of feet, legs, and hands, abdominal pain, abdominal swelling, difficulty breathing, diarrhea, vomiting, nausea, a diminishing of urination, and weight gain. If a user of HCG products notes any side effects it is recommended that he or she cease using the products immediately and that he or she seek out the assistance of a physician. ****Notice to all 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 pregnancy.**

With this knowledge, I voluntarily consent to the above procedures. I realize that neither the doctor nor any personnel of McQuinn Naturopathic has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition by signing this agreement.

Print Name__________________________________**Signature**_____________________________________

Date _______________ **Representative or Guardian (if under 18)** _________________________________

1429 Broadway, Everett WA 98201 Phone: (425)293-0107 Fax: 425-293-0329 email: drmcquinn@gmail.com

McQuinn Naturopathic Insurance and Payment Disclosure

Please present a photo ID and your Insurance card(s) to the receptionist so that we can retain a copy in your file and be able to issue any prescription(s) and comply with FDA regulations.

We ask that you provide a credit card to hold your appointment. We will need a 24 hour notice if you cancel or reschedule. If a 24 hour notice is not given, we will charge $25.00 for missed lab appointments and a $50.00 office visit as a non cancellation fee.

We feel strongly that our patients deserve the best care. In an effort to provide high quality care, we would like to share information with you about financing healthcare. We hope that by providing you with the following information, we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us.

- We ask that if you are paying cash that you pay in full at your first visit or arrange a payment plan prior to your appointment. If you have insurance, please pay your co-pay and you will be billed for the portion which insurance does not cover including co-insurance or deductible.

  - We accept VISA, Mastercard, Discover, Credit Cards, Checks & Cash.

  - Remember that, if you have insurance, the insurance contract is between the patient and the insurance company. The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but we cannot guarantee you benefits. We will only bill those insurance companies for which you guarantee your benefits. We will only bill those insurance companies for which you provide written information to us prior to the treatment given. *Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this writing.*

  - This information sheet is full and final agreement between this office and you regarding your insurance and benefits and may not be modified without a written agreement signed by you and this office.

  - Within 60 days of service, the balance should be paid in full, unless arranged otherwise. Interest will be charged at 12% per year (1% per month) on balances over 90 days past due. Checks returned due to insufficient funds will be charged $25.00 fee. Past dues accounts will be sent to a collection agency at our discretion.

  - Please be familiar with the benefits provided by your plan. Refer to the 1-800 number on the back of your insurance card to call and inquire as to your benefits regarding naturopathic services and prescriptions.

  - The age majority in this state is 18 years old. The parent that brings in the minor child is responsible for payment.

- I understand credit information may be accessed in order to determine my credit worthiness. I understand that I am responsible for the entire balance of the account and that this office is extending credit to me.

Confirmation of Benefits

McQuinn Naturopathic is contracted with Premera, Regence, Lifewise, BlueCross Blueshield, Aetna, First Choice, Whole Health Pro, and Healthways. Dr. McQuinn is a preferred provider as a Naturopath in these insurance networks. However, ***Naturopathic care is not included*** **with every plan, and some plans have yearly limits and coverage**. Before your appointment, please confirm the details of your plan to avoid a large bill or unexpected charges if your insurance has limited coverage.

Please fill out the following information that can be obtained by calling the number on the back of your insurance card. Provide your name and insurance ID number, and ask what your plan's policy is for Naturopathic coverage.

Do you have Naturopathic Benefits? Y / N
(Please initial that you have called your insurance company to check your benefits) __________
Number of visits per year or $$ Yearly limit: ____________________
Deductible: ____________________ $$ Met: ____________________
Co-Insurance: ____________________
Co-Pay: ____________________

1) **I AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR OR CLINIC PROVIDING MEDICAL CARE. I ALSO GIVE PERMISSION FOR THE DOCTOR TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THE CLAIM. I AGREE THAT I AM RESPONSIBLE FINANCIALLY FOR ALL BALANCES DUE.**

2) **IN THE CASE THAT YOU ARE NOT UTILIZING INSURANCE, WE CONSIDER YOU A "CASH-BASED" CLIENT AND YOU ARE, THEREFORE, PERSONALLY RESPONSIBLE FOR ALL CHARGES, OUT-OF-POCKET, FOR EACH SERVICE OR PRODUCT YOU RECEIVE AT TIME OF SERVICE.**

3) **PLEASE BE AWARE: Products and supplements are generally NOT coverable by insurance and you will be required to pay for them out-of-pocket when you receive them.**

Credit Card Number: ______________________ Expiration Date: __________
Name on card: ______________________ 3 Diget Code: __________

Signature: ______________________

Printed Name: ______________________

Date: ______________________

McQuinn Naturopathic's Notice of Privacy Practices

This is a summary of McQuinn Naturopathic's Notice of Privacy Practices. You have a right to receive a copy of the complete document.

McQuinn Naturopathic recognizes that your medical information is personal. We are committed to providing privacy and confidentiality of your medical information. This notice describes McQuinn Naturopathic's privacy practices and the way in which we may use and disclose medical information about you.

We are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment given, including the results of all tests, procedures and therapies. We must maintain this information in a safe and secure manner that protects your privacy and confidentiality. You have the right to read or get a copy of your medical information.

McQuinn Naturopathic May Use and Disclose Medical Information About You in the Following Ways:

a. For Treatment: Other health professionals within or outside of McQuinn Naturopathic who are involved in your care may need to access your information.
b. For Payment: To bill or collect for payment of services from you, your insurance company, or a third party billing agency we may disclose your information.
c. For Health Care Operations: We may use or disclose medical information about you to the extent necessary to run the facility or ensure quality care.
d. For Research: Information that may identify you will not be released to anyone outside of McQuinn Naturopathic without your prior written permission but we may remove information that identifies you so that others may use it to study health care.
e. Appointment Reminders: We may use your information to contact you as a reminder that you have a scheduled appointment
f. Treatment Alternatives, Health Related Benefits and Services: We may use or disclose medical information to tell you about or recommend possible treatment options, alternatives to your current treatment, health related benefits or services that may be of interest to you.
g. To Avoid Serious Threat to Health or Safety: When necessary your information may be used or disclosed to prevent a serious threat to the health and safety of you, of the public or of another person.
h. Public Health Risks: We may disclose medical information about you for public health activities to prevent or control disease, injury or disability; to report births and deaths; to report child abuse and/or neglect; to report reactions to medications or problems with products; to notify people of recalls of products; to notify a person that they may have been exposed to a disease or may be at risk for contracting or spreading a disease; to notify a government agency about abuse, neglect or domestic violence as required by law.
i. Worker's Compensation: We may release medical information about you for worker's compensation benefits for work related injuries or illnesses.
j. Military or Veteran's: If you are a member of the armed forces, we may release information about you as required by military command authorities.
k. Law Enforcement: We may release information about you in response to a court order, subpoena, warrant, summons; to identify or locate a suspect, fugitive, material witness or missing person; about a victim of crime; about a death as a result of a crime; about criminal conduct at our clinic; in emergency circumstances to report a crime.
l. Coroner's, Medical Examiners and Funeral Directors: We may release medical information about you to a coroner or medical examiner to identify a deceased person or determine cause of death. We may release information to funeral directors as necessary to carry out their duties.
m. As required by law: We may release your information as required by Washington Law.

We do not allow others outside of McQuinn Naturopathic to access your medical information unless we have authorization from you to do so. Any authorization to use or disclose medical information may be revoked by you in writing at any time unless (1) McQuinn Naturopathic has already taken action in reliance on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage.

YOU HAVE THE FOLLOWING RIGHTS REGARDING MEDICAL INFORMATION WE MAINTAIN ABOUT YOU:

- You have the right to inspect and receive a copy of your medical information.
- You have the right to amend your medical information if you believe it is incorrect or incomplete (restrictions may apply).
- You have the right to request restrictions or limitations of your medical information.
- You have the right to request the method by which we communicate with you about medical matters so that the communication is kept confidential.
- You have a right to receive an accounting of all disclosures of your medical information.
- You have a right to receive a paper copy of the McQuinn Naturopathic's Notice of Privacy Practices.

Acknowledgement of Receipt of Statement of Privacy Practices

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, my representative, or unless law requires. I understand that I may look at my medical record and can request a copy of my record by my paying the appropriate fee. I understand that my medical record will be kept no more than ten years after the date of my last treatment. I understand that the doctor will answer any questions that I might have.

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of McQuinn Naturopathic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

McQuinn Naturopathic reserves the right to change the privacy practices that are describes in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. (Please circle)

ANY MEMBER OF THE IMMEDIATE FAMILY Y / N SPOUSE: Y / N
OTHER (please Specify) Y / N ____

Name of Patient or Personal Representative____

Signature of Patient or Personal Representative____

Filing a Complaint:

If you wish to request restrictions, amendments or accountings of your medical information, you may file such a request in writing to McQuinn Naturopathic located at 2808 Hoyt Ave, Everett, WA 98201.

If you believe your privacy rights have been violated, you may file a complaint with the McQuinn Naturopathic or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be penalized in any way for filing a complaint.
Print (< Guardian if < 18)

____

Signature (& Guardian if < 18)____

Date:________________________

Lifestyle counseling & hygiene: promotion of wellness including recommendations for diet, exercise, sleep, stress reduction and balancing of work and social activities.

Psychological counseling & Contraception: natural family planning, counseling and/or referral

Physical Medicine: Massage therapy, muscle energy stretching, trigger point release, manipulation, hydrotherapy, etc.

Pharmaceuticals: prescription drugs, hormones or over the counter recommendations may be made. **HCG is presently relied upon as a medication for fertility and it is also used to safely promote the production of testosterone in males. It is not approved by the FDA for weight loss.**

The physician(s) at McQuinn Naturopathic, LLC do not make recommendations for medical treatments or pharmaceuticals or for the discontinuation of other treatments and/or procedures with other health care professionals that are not within their scope of practice. Patients that require such treatments will be referred appropriately.

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

Potential benefits: Restoration of health and the body's maximum 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 its progression.

Potential risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipunctures or procedures, tenderness/soreness or bruising from physical treatments.

With this knowledge, I voluntarily consent to the above procedures. I realize that neither the doctor nor any personnel of McQuinn Naturopathic has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition by signing this agreement.

Print Name___________________________________**Signature**_____________________________________

Date _______________ **Representative or Guardian (if under 18)** _________________________________