CONSENT FOR WELLNESS SERVICES

I, _________________________________, hereby request and consent to naturopathic health and wellness consultation from Lakeside Natural Medicine, LLC.

I understand that I have the right to ask questions and discuss to my satisfaction with my Lakeside Natural Medicine practitioner:

- my diagnosis(es) or condition(s) identified by my treating provider (i.e. medical doctor)
- the nature, purpose, goals and potential benefits of the proposed wellness consultation,
- the inherent risks, complications, potential hazards or side effects of my naturopathic wellness consultation treatment or procedure
- the probability or likelihood of success
- reasonable available alternatives to the proposed wellness consultation
- potential consequences if a healthy lifestyle is not followed and / or nothing is done

I recognize that the Lakeside Natural Medicine practitioners have a doctorate of naturopathic medicine and have been trained as primary care practitioners. I am aware, however, that in the state of Wisconsin there is no licensure regulating the practice of naturopathic medicine, therefore medical diagnosis or treatment may not be made.

I acknowledge that nothing in the techniques or methods of natural healing is for the purpose of diagnosing, treating, alleviating, mitigating, curing or preventing of disease in accordance with conventional medical science in any way or manner whatsoever. I clearly understand that all the teaching and methods of natural medicine as administered by Lakeside Natural Medicine, LLC are for the sole purpose of assisting people to learn how to build and maintain their health and well-being. As a patient of Lakeside Natural Medicine, LLC, I agree to always seek medical advice for medical treatment.

I confirm that I have read and fully understand the above prior to my signing.

____ ___________________

Signature of Parent/Guardian of patient if patient is a minor Date

Dear New Patient,

Welcome to Lakeside Natural Medicine. We look forward to supporting your health care needs. Please read and initial the following statements:

__________ Payment for all services and medicinary items are due in full at the time of visit. We accept cash, credit card, and checks. In the state of Wisconsin naturopathic practitioners are not able to bill insurance.

__________ Lakeside Natural Medicine is not responsible for any lab expenses. The patient is responsible for all lab expenses

__________ Due to time constraints, you will be charged for scheduled and unscheduled phone consultations that exceed 10 minutes. Uncharged phone calls are for matters concerning clarification of wellness plans and past medical issues. Any new well-being concerns will be scheduled as follow-up appointments. Lakeside Natural Medicine will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

__________ Please give Lakeside Natural Medicine 24-hours advance notice of cancellations. If you cancel within 24 hours of your appointment, you will be charged a fee of $50. . Notice of cancellation should be given via phone to 414-939-8748 or email to info@lakesidenaturalmedicine.com .

__________ Unless a specific payment plan has been agreed upon and put into writing, we reserve the right to charge interest on any outstanding balance on the account. After one month, a 1% per month compounded interest will accrue on any unpaid balance. After one year, the late payment fee will be 12% on any unpaid balance.

I have read and understand the above-stated policies of Lakeside Natural Medicine and will comply with them in all respects.

____

Patient Name (Please print. Include parent/guardian if patient is a minor.)

____ ______________

Patient signature (Parent/guardian signature if patient is a minor) Date

____

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Email Consent

Email offers us an easy and convenient way to communicate between office visits. In order for me to serve you best, I ask that you follow the below guidelines for email communication.

Conditions for email communication:

- Emails are great for asking general questions that do not require detailed discussion and for clarification of previous recommendations.
- Emails are not meant to replace in-person or phone appointments, nor are they meant to discuss new wellness concerns or receive new wellness consultations.
- Although we do check email regularly, we cannot guarantee that we will be able to answer your email right away nor can we guarantee that we will receive it. Call the office if the matter is urgent or if you do not hear back from me within a reasonable amount of time.
- Confidentiality is not guaranteed with emails! It is like sending a postcard in the mail.
- Email is never appropriate for emergency situations. Please call your medical treatment provider or your local emergency department.
- Emails may be added to your patient chart.

Finally, either one of us can revoke permission to use the email system at any time.

- ☐ **YES**, I would like the option to correspond via email. I agree to and understand the terms of email communication as detailed above.
- ☐ **NO,** I do not want to correspond via email.

Name: ____

E-mail Address: ____________________________________

Signature: ______________________________________ Date: _______________

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law a health care practitioner generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number:_______________
___Please do not phone me at work. Use this alternate phone number:_______________
___Please do not leave messages on my answering machine.
___Please do not contact me by email.
___Please send mail, including my bills, to this alternate address: ___________________
____
___Other request (please describe): ____

____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

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Child Health History Intake

Name ______________________________________ Age _________________ Date _____________
Date of Birth _________________________ Birth Weight _________________ Sex ______________
Mother's name _____________________________ Father's name ______________________________
Address ____
City_____________________________________ State _________________ Zip_________________
Telephone # ____
How did you hear about this clinic?
____
Do you have Medicaid? Yes_____ No_____

Health History Questionnaire

What are your child's most important health problems? List as many as you can in order of importance.
1) ____
2) ____
3) ____
4) ____

What has already been done for the above mentioned problems (not applicable for a well-child visit)?
____
Does your child have a contagious disease at this time? Y N
If yes, what?____

Birth History

List major patterns of illness present in the child's birth mother, father or their families:
____
Did mother receive prenatal care? _______Prenatal vitamins? Medications (type)?
Did mother smoke cigarettes? _________ Drink alcohol? _______Illicit Drugs (type)? ________
Any previous pregnancies not carried to term? Y N How many? ________ When?
Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc):
____
Type of birth (e.g. hospital, home, C-section) ______________ Carried to term?
If no, how premature? ____
Complications of labor or delivery:
____

Previous Illnesses

Describe difficulties during infancy (e.g. colic, skin or lung problems): ____________________________
____
Has your child had (please circle one)?

Rheumatic Fever	Y N	German Measles	Y N
Chicken Pox	Y N	Measles	Y N

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How often does your child get (please fill in):

N = Never **O** = Occasionally **F** = Frequently **C** = Constantly

Colds__________ Sore throat Earaches Coughs Diarrhea
Constipation Abdominal aches ___________ Other ________________________________

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

Hospitalizations/Surgeries/Injuries

What hospitalizations/Surgeries/Injuries has your child had? When?

____

Immunization History

U = Up to date **P** = partial **N** = Not done

Pre-school: ______HBV (hepatitis B) _______Hib (hemophilus influenza type B)
______HAV (hepatitis A) _______DTaP (diphtheria, tetanus, pertussis)
______IPV (polio) _______MMR (measles, mumps, rubella)
______Varicella (chicken pox) _______PCV (pneumococcal bacteria)

*School age:*_______ Td (tetanus, diphtheria) _______MCV4 (meningitis)
Other: _______ Influenza

Reactions to immunizations? ____

____

Allergies

Is your child hypersensitive or allergic to:
Any drugs?____
Any foods? ____
Any environmentals? ____
Breast fed? _________ How long? _________ Formula? _________ Milk / soy? _______

Typical Food Intake

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
To Drink:____

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Medications/Supplements

Please list the name, dosage and date started of any prescription medications, over the counter medications, vitamins or supplements your child is taking:

1) ______________________ 5) ______________________
2) ______________________ 6) ______________________
3) ______________________ 7) ______________________
4) ______________________ 8) ______________________

Symptoms

____ Hives	____ Burning urine	____ Bloody urine	____ Eczema
____ Cries easily	____ Bleeding gums	____ Heart murmur	____ Nervous
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Asthma
____ Acne	____ Anemia	____ Night sweats	____ High fevers
____ Jaundice	____ Sensitive to light	____ Chronic rash	____ Stomach aches
____ Diarrhea	____ Hearing loss	____ Easy bruising	____ Sore throats
____ Flat feet	____ No appetite	____ Body/breath odor	____ Constipation
____ Nightmares	____ Frequent colds	____ Bleeding tendency	____ Unusual fears
____ Wheezing	____ Joint pains	____ Excessive fatigue	____ Cough
____ Dizzy spells	____ Hair loss	____ Frequent urination	____ Allergies

Describe problems in the following areas:

Digestion: ______________________________________

Skin: ______________________________________

Respiratory: ______________________________________

Urinary: ______________________________________

Behavioral: ______________________________________

How much sleep does he/she get? From ______pm to ______am

What is the quality of your child's sleep? ______________________________________

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with Lakeside Natural Medicine?

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