LAKESIDE
Natural Medicine

CONSENT FOR TREATMENT

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine with Dr. Sarah Axtell.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Sarah Axtell:

- my suspected diagnosis(es) or condition(s)
- the nature, purpose, goals and potential benefits of the proposed care
- the inherent risks, complications, potential hazards or side effects of treatment or procedure
- the probability or likelihood of success
- reasonable available alternatives to the proposed treatment procedures
- potential consequences if treatment or advice is not followed and/ or nothing is done

I recognize that Dr. Axtell is a licensed naturopathic doctor in the state of Oregon, and that she has been trained as a primary care physician. I am aware that in the state of Wisconsin, there is no licensure regulating the practice of naturopathic medicine, therefore clinical diagnosis may not be made.

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

_____ _____

Signature of Patient (Parent/Guardian if patient is a minor) Date

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Dear New Patient,

Welcome to Lakeside Natural Medicine. We look forward to providing for 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. We do not bill insurance directly, but you are more than welcome to submit the receipt for reimbursement. Some insurance companies cover naturopathic medicine while others do not.

_____ Lakeside Natural Medicine is not responsible for any lab expenses. Insurance may not cover your lab work. Prior to getting your blood drawn, we recommend that you call your insurance company to inquire about in-network lab locations, as well as an estimated expense for the labs ordered.

_____ 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 treatment plans and past medical issues. Any new medical concerns will be scheduled as follow-up appointments. Your physician 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 your physician 24 hours advance notice of cancellations. If you cancel within 24 hours of your appointment, you will be charged a fee of $50.

_____ 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 2 months, a 5% compounded interest will accrue, after 6 months, 8% compounded interest will accrue.

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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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 your health care provider 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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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 health concerns or receive new treatment recommendations.
- Although I do check my email regularly, I cannot guarantee that I will be able to answer your email right away nor can I guarantee that I 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 the office 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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Child Health History Intake

Name _____Age _____ Date _____
Date of Birth _____Birth Weight _____ Sex _____
Mother's name _____Father's name _____
Address _____
City_____ State _____ Zip_____
Telephone # (home) _____
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 (eg. hospital, home, C-section) _____ Carried to term? _____
If no, how premature? _____
Complications of labor or delivery:
_____

Previous Illnesses

Describe difficulties during infancy (eg. 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

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: _____

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To Drink: _____

Medications/Supplements

Please list any prescription medications, over the counter medications, vitamins or other 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 our clinic?