

(A) Save to computer. Fill out on your computer. Click blanks & type. Click check boxes. Type name to sign electronically. Save as & email back to us info@lakesidenaturalmedicine.com.



OR

(B) Print & fill out with pen. Scan + email, fax, mail to us or drop off at office.

If patient is a minor, use child new patient packet available here: <http://www.lakesidenaturalmedicine.com/for-patients/forms/>

CONSENT FOR SERVICES

I, _____ (patient full name), hereby request and consent to naturopathic and functional medicine services from Lakeside Natural Medicine, LLC.

I understand my services from Lakeside Natural Medicine, LLC will be provided by a Naturopathic Doctor and/or a Nurse Practitioner, Advanced Practice Nurse Prescriber.

I understand the health care professionals at Lakeside Natural Medicine have been trained as primary care providers, have a doctorate of naturopathic medicine and naturopathic doctor license in the state of Wisconsin or a doctorate of nursing practice and an advance practice nurse prescriber license in the state of Wisconsin.

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

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

I understand in the state of Wisconsin, naturopathic doctors are licensed and regulated, therefore treatment may be provided.

While naturopathic doctors are licensed in the state of Wisconsin, they do not currently have rights to prescribe medications or drug therapies in the state of Wisconsin, including controlled substances. It is best to maintain your relationship with your primary care provider in the event you need a prescription medication.

I understand in the state of Wisconsin, nurse practitioners who are advanced practice nurse prescribers are licensed and regulated, therefore treatment and medications or drug therapies, including controlled substances, may be provided. Our nurse practitioner can prescribe medications and can serve as your primary care provider if desired.

Signature

I confirm that I have read and fully understand the above prior to my signing. If I am filling this out on my computer, by electronically signing, I agree that the electronic signatures appearing in these consent forms are the same as handwritten signatures for the purposes of validity enforceability and admissibility.

Patient signature (typed name serves as electronic signature)

Date

TERMS OF SERVICE

Dear New Patient,

Welcome to Lakeside Natural Medicine. We look forward to supporting your health and wellness needs. **Please read terms and write/type your initials on the line next to** the following statements to indicate you accept our terms of service:

_____ Payment for all services and supplements is due in full at the time of visit. We accept cash, checks, credit card, health savings accounts (HSA) and flexible spending accounts (FSA). There is an 5% fee to change the method of payment after a transaction is complete. In the State of Wisconsin naturopathic doctors are not able to bill insurance.

_____ Please give Lakeside Natural Medicine 48-hours advanced notice of cancellations. If you don't cancel within 48 hours of your appointment, you will be charged a fee of \$50. Notice of cancellation should be given via phone/text to 414-939-8748 or email to info@lakesidenaturalmedicine.com.

_____ 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 wellness 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.

_____ To make an appointment by phone or video you need to put a credit card on file at Lakeside Natural Medicine. Credit card information is stored and processed using our secure encrypted card processing system.

_____ Supplements can be returned if unopened within 30 days of purchase for a credit on your account at Lakeside Natural Medicine. If defective, please notify us immediately and we will replace it. Refunds back to the original method of payment require a 5% restock fee.

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

Patient signature (typed name serves as electronic signature)

Date

EMAIL CONSENT

Email offers us an easy and convenient way to communicate with you between office visits. For us to serve you best, we ask that you follow these guidelines for email communication.

Terms 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 us within a reasonable amount of time.
- Confidentiality is not guaranteed with emails! It is like sending a postcard in the mail. By opting into email communication, you understand your private health information might be at risk.
- 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.

TEXT MESSAGE CONSENT

Text message offers us another convenient way to communicate with you.

Terms for text communication:

- If you opt in, we may use text message to reach you. Text message will be used to communicate about appointment reminders, appointment confirmations and offering you openings to get-in-sooner.
- Although we do check text messages regularly, we cannot guarantee that we will be able to read and answer your text 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 us within a reasonable amount of time.
- Your cellular phone carrier may charge message or data rates when you to send and receive text messages.
- Finally, either one of us can revoke permission to use text messages at any time.

YES I would like the option to correspond via text message. I agree to and understand the terms of text message communication as detailed above.

NO I do not want to correspond via text message.

Patient signature (typed name serves as electronic signature)

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 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 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 healthcare. It is important that you understand that your information can be used and shared in the following ways:

- For your healthcare & wellness coordination. Multiple healthcare 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.

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 do not contact me by text message.

I want you to be able to communicate with someone else about your appointments, billing, supplements or health?

For example, a parent, an adult child, a spouse.

Who? (full name) _____

What info? (check one) *All information* OR *Only appointment, billing & supplements*

Other request (please describe) _____

Patient signature (typed name serves as electronic signature)

Date

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

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 environmental? _____

Breast fed? _____ How long? _____ Formula? _____ Milk / soy? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

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?