(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.

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.

<u>Signature</u>

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

LAKESIDE
Natural Medicine

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:____________________

Email: info@lakesidenaturalmedicine.com | Ph: 414-939-8748 | Fax: 414-377-4203
3510 N Oakland Ave, Shorewood, WI 53211

LAKESIDE
Natural Medicine

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?