Windrose Naturopathic Clinic

Family Practice – Preventative Care

1137 W Garland Ave, Spokane WA 99205 (509) 327-5143 (509) 327-9813 (fax)

Date:______________

NEW PEDIATRIC PATIENT INFORMATION

To be filled out by parent or guardian:

Child's Name:____________________ Age: _____ DoB: _______ Height: ________ Weight: _______

Address:____________________

City, State, Zip ____________________ ☐ Male ☐ Female

Parent / Guardian Information:

Name: ____________________ Phone: ______________ Relationship:______________

Address:____________________ City, State, Zip ______________

Parent's Email:____________________

In case of emergency and neither parent can be reached, contact:

Name ____________________ Phone: ______________ Relationship: ______________

Pediatrician:

Name ____________________ Phone: ______________ Can we contact: ☐ Yes ☐ No

How did you hear about us? ____________________

YOUR CHILD'S HEALTH

Please tell us about your child's health concerns, history and family. Our health care and preventative medicine are only possible when we have a complete understanding of your child's physical, mental and emotional state.

First of all, does your child have any special needs? ☐ No ☐ Yes: ____________________

What goals / issues do you have for your child in coming to see us today: ____________________

____

If a "diagnosis" has been made by a previous doctor, please list below (with dates):

____

____

Does he / she have any known allergies? ☐ No ☐ Yes: ____________________

Please list any prescriptions, over-the-counter, homeopathics, supplements your child takes (list dosages): ______________

____

____

Has your child had any major childhood illnesses, accidents, injuries, surgeries, hospitalizations, traumas, etc (dates and age at time): __________

____

How was the pregnancy and childbirth for mom? ______________________________

____

____

X-Rays & Special Studies: ☐ X-Rays ☐ CAT Scans ☐ MRI's When: ______________________________

____

How would you rate the general health of our child: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent) circle one

What are some of your child's favorite activities / hobbies? ______________________________

____

Does your child have any fears? ______________________________

____

What are your child's favorite foods and how often are they eaten? ______________________________

____

What types of pets do you own? ______________________________

____

What are some of your child's favorite activities / hobbies? ______________________________

____

Does anyone in the house smoke? ☐ No ☐ Yes

How many hours of TV / Computer / Video games does you child engage in daily? ______________________________

How would you rate your child's academic performance: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent) circle one

Is there anything else you would like to tell us about your child? ______________________________

____

Continued on next page . . .

YOUR CHILD'S FAMILY HISTORY

	Father	Mother	Grandparent	Sibling	Other (specify)
Anemia	❑	❑	❑	❑	❑ ____________
Cancer	❑	❑	❑	❑	❑ ____________
Diabetes	❑	❑	❑	❑	❑ ____________
Heart Disease	❑	❑	❑	❑	❑ ____________
High Blood Pressure	❑	❑	❑	❑	❑ ____________
Stroke	❑	❑	❑	❑	❑ ____________
Epilepsy	❑	❑	❑	❑	❑ ____________
Mental Illness	❑	❑	❑	❑	❑ ____________
Psychological Disorder	❑	❑	❑	❑	❑ ____________
Asthma	❑	❑	❑	❑	❑ ____________
Hay Fever, Hives	❑	❑	❑	❑	❑ ____________
Kidney Disease	❑	❑	❑	❑	❑ ____________
Glaucoma	❑	❑	❑	❑	❑ ____________
Tuberculosis	❑	❑	❑	❑	❑ ____________
Smoke	❑	❑	❑	❑	❑ ____________
Alcohol	❑	❑	❑	❑	❑ ____________
Age at Death	________	________	________	________	❑ ____________
General Health *G=good, P=poor*	________	________	________	________	❑ ____________

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INFORMED CONSENT FOR TREATMENT

I,____, hereby authorize the doctor's of The Windrose Naturopathic Clinic (Dr. Letitia Dick, ND and/or Dr. Caryn Potenza, ND) to perform the following specific procedures as necessary to facilitate my child's diagnosis and treatment(s):

Common diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.

Minor office procedures: e.g., dressing a wound, ear cleaning.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrition.

Botanical medicine: botanical substances my be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring elements to gently stimulate the body's healing responses, given orally, topically or by injection.

Lifestyle counseling and hygiene: promotion of wellness including recommendations for exercise, sleep, contraception, and stress reduction.

Psychological Counseling and /or the ordering of lap procedures, referral for x-ray, MRI, or other imaging, thermal imaging.

Naturopathic manipulation: specific manipulation of muscles and joints or soft tissue.

Naturopathic physiotherapy / hydrotherapy: the use of electromagnetic therapies, water applications, thermal or cryo-applications to stimulate healing.

Prescription of pharmaceuticals and / or bio-identical hormones.

I understand that treatment by a naturopathic doctor is intrinsically different from treatment by a conventional medical doctor. While naturopathic medicine is intrinsically safer than other systems of medicine, there are potential risks in what we do as well. The care we provide may, or may not be directed at a specific disease or disorder. It may be preventative in nature, designed to improve overall health and well-being, and restore my child's body innate healing ability. We will always strive to provide full disclosure of all information relevant to your child's health care.

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

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, healing reaction as defined below, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Healing Reaction: Natural healing may occasionally generate a "healing reaction." If this is anticipated, we will offer you specific information about this phenomenon. Generally this will occur as a flu-like state with fever or a worsening of symptoms for a few days. It can also, however be different than this and may require expert attention and guidance.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Pregnancy; Please tell us (if you know) if your child is pregnant, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures and that I realize that no guarantees have been given to me by the doctor's or staff of The Windrose Naturopathic Clinic regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Privacy Notice: The Windrose Naturopathic Clinic is required by law to respect your privacy by following specific HIPPA guidelines. A "Notice of Privacy Practices" document is available upon request.

________________ ____________________________________
Date Parent's Signature or Legal Guardian

________________ ____________________________________
Date Doctor's Signature

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FEES & FINANCIAL AGREEMENT

You have come to us for results. Like many before you, this has been a long journey and, more often than not, you have tried other medical solutions with little or no relief. We don't just treat symptoms with drugs that simply mask your child's underlying causes. ***We DO treat the underlying causes of your child's illness***.

We practice medicine differently from the typical medical model. First of all, we take considerably more time with you and your child. Most of our appointments are reserved for about an hour. This is so we can thoroughly evaluate your child's concerns and talk with you about real cures. We dedicate our time with you for a full understanding of your condition and concerns.

We also compound on-site, custom remedies and homeopathic treatments that are tailored to each individual patient. Further, we have on-site therapeutic treatment capabilities

Because we operate entirely different from the typical medical office, we have found most insurance programs do not adequately compensate us for the time we take with all our patients. Consequently, we do not bill insurance plans. Some insurance plans may reimburse you for our care. It is up to you to submit our bill to your insurance carrier if you so choose***. In any event, complete payment for our services is due on the date of your child's visit.***

Here is a brief example of our typical office fees:

Typical first office visit includes: 2 one hour visits that fully evaluate food intolerance, Bolen blood analysis, Iris diagnosis, Acoustic Cardiograph, and a full case history followed by a 1 hour report of findings and plan of treatment.	$ 375.00
General returning patient office visit (1hr); (with venipuncture, Bolen blood analysis recheck and ACG add $110.00).	$ 130.00
Bio-identical hormone evaluation (w/ added lab fees as necessary, varies depending on specific panels) and result consultation.	$ 105.00 (30 min.) $ 165.00 (60 min.)
Digital Thermal Imaging for breast cancer risk assessment.	$ 275.00
Report of Digital Thermal Imaging and plan of cure (30 minutes)	$ 105.00
Hyperbaric Oxygen Therapy (1hr)	$ 115.00
Constitutional Hydrotherapy Treatments (1hr)	$ 55.00
Compounded therapeutic treatment remedies and / or supplements	$ varies

*Fees for medical services not listed are available upon request. Laboratory fees are not included in above fee schedule.

Cancellation Policy: Patients will be billed for any appointment cancelled with less than 24 hours notice. There is a 75.00 missed appointment fee.

I understand that I am wholly and personally responsible for ***payment on date of service***. The Windrose Naturopathic Clinic is not a participant in Medicare or insurance plans. I realize that I may request the attending physician's statement of diagnosis and services provided to me, which I may submit to my insurance company for reimbursement of the treatment cost, as may be provided by my plan. The Windrose Naturopathic Clinic does not guarantee that I will receive reimbursement from my insurance carrier. I understand that Windrose Naturopathic Clinic, at it's option, may charge me interest on any unpaid balances.

I have read and agree to the financial terms and cancellation policy above:

____________ Date

____________ Parent's Signature

____________ Social Security #

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Other Services	New Patient	Existing Patient
Brief office visit (1-10 minutes)	$ 65.00	$ 45.00
Limited office visit (15 minutes)	$100.00	$ 65.00
Intermediate office visit (20 minutes)	$ 115.00	$ 95.00
Extended office visit (45-60 minutes)	$ 135.00	$ 105.00
Comprehensive office visit	$ 160.00	$ 130.00
Telephone w/treatment (1-15 minutes)	n/a	$ 65.00
Telephone w/treatment (>15 minutes)	n/a	$ 95.00
Well Woman Exam w/Pap	n/a	$ 95.00
Vaginal Pack Therapy	n/a	$ 105.00
House Call (+gas)	n/a	$ 165.00
Venipuncture	n/a	$ 40.00
Acoustic Cardiograph	n/a	$ 70.00
Bowen Manipulation (1 hr)	n/a	$ 115.00

RESEARCH RELEASE

The naturopathic community is continually interested in furthering the goal of naturopathic medicine through scientific investigations and research. Would you consent to our use of your child's medical records by qualified investigators under protocols approved by an appropriate Institutional Review Board and/or utilized for teaching purposes? Your anonymity will be guaranteed.

☐ Yes ☐ No

_______________ Date

_______________________________________ Parent's Signature