

# Windrose Naturopathic Clinic

Family Practice – Preventative Care

1023 W Francis 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

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 your 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? \_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS, SUPPLEMENTS & OVER THE COUNTER DRUGS**

Please list all of the over-the-counter drugs, prescription medications & supplements you take regularly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Continued on next page . . .

## YOUR CHILD'S FAMILY HISTORY

	Father	Mother	Grandparent	Sibling	Other (specify)
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Hay Fever, Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Age at Death	_____	_____	_____	_____	<input type="checkbox"/> _____
General Health	_____	_____	_____	_____	<input type="checkbox"/> _____

*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) 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 may 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 lab 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.	\$ 390.00
General returning patient office visit (1hr); (with venipuncture, Bolen blood analysis recheck and ACG add \$70.00).	\$ 145.00
Hyperbaric Oxygen Therapy (1hr)	\$ 135.00
Constitutional Hydrotherapy Treatments (1hr)	\$ 65.00
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
Limited office visit (15 minutes)	\$100.00	\$ 95.00
Intermediate office visit (30 minutes)	\$ 125.00	\$ 125.00
Extended office visit (45-60 minutes)	\$ 145.00	\$ 145.00
Comprehensive office visit (90 minutes)	\$ 260.00	\$ 260.00
Phone Consult w/treatment Short (1-15 minutes)	n/a	\$ 45.00
Phone Consult w/treatment Medium (>15 minutes)	n/a	\$ 75.00
Venipuncture	n/a	\$ 45.00
Acoustic Cardiograph	n/a	\$ 70.00
Bowen Manipulation (1 hr)	n/a	\$ 125.00

## 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