

HILLSBORO NATUROPATHIC CLINIC
245 SE 4TH AVE. STE. E / HILLSBORO, OR 97123
P: 503-844-6667 / F: 503-924-5905
hillsboronaturopathicclinic@yahoo.com

Circle Provider: Victoria Lutskovsky, ND Valerie Netherland, ND, Lac
 Kristin Kinnie, MScN, MSW

New Patient Pediatric Intake Packet – Print Clearly

Name (last, first, middle initial):	Gender:
Date of Birth:	
Address: Street:	
City, State, Zip code:	
Preferred Phone:	Type: Cell Phone / Landline / Work
Are we allowed to leave detailed messages on your voicemail? YES / NO	
Reminder Method: TEXT / VOICE CALL / EMAIL	
EMAIL:	
Reason for Visit:	
Parent Full Name:	Gender:
Preferred Phone:	Type: Cell Phone / Landline / Work
Patients 15-17 years of age: Are we allowed to speak to the above named regarding the following?	
• Medical Condition – Symptoms, diagnosis, medications, and treatment plan	Y / N
• Mental/Behavioral - Symptoms, diagnosis, medications, and treatment plan	Y / N
• Chemical Dependency - Symptoms, diagnosis, medications, and treatment plan	Y / N
Parent Full Name:	Gender:
Preferred Phone:	Type: Cell Phone / Landline / Work
Patients 15-17 years of age:	
• Medical Condition – Symptoms, diagnosis, medications, and treatment plan	Y / N
• Mental/Behavioral - Symptoms, diagnosis, medications, and treatment plan	Y / N
• Chemical Dependency - Symptoms, diagnosis, medications, and treatment plan	Y / N

Medical: Minors who are 15 years or older are able to consent to medical treatment without parental consent. This includes hospital care, as well as medical, dental, optometric & surgical diagnostic care. This would include services such as: Treatment for illnesses or injuries (colds, sprained ankle); Sports or camp physicals; Dental Visits; X-ray services; Emergency room visits; Vision care (except for first time contact lens visit); Immunizations. (ORS 109.640)

Mental Health/Chemical Dependency: A minor who is 14 years or older may access outpatient mental health, drug, or alcohol treatment without parental consent. Providers are expected to involve parents by the end of the minor's mental health, drug or alcohol treatments unless: the patient refuses involvement; Clear clinical indications to the contrary exist & are documented in the health treatment record; There is identified sexual abuse; or the minor has been emancipated and/or separated from the parent for at least 90 days. (ORS 109.675)

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Insurance Information – Print Clearly

- Verification of benefits does NOT guarantee payment from your insurance. You will be responsible for payment in the event insurance deems service(s) not payable under your plan.

Primary Insurance:
Member ID:
Group Number:
Address to submit claims to:
Phone Number:
Name of Policy Holder:
Policy Holder's Date of Birth:

Secondary Insurance:
Member ID:
Group Number:
Address to submit claims to:
Phone Number:
Name of Policy Holder:
Policy Holder's Date of Birth:

Is your visit related to an auto accident?

YES / NO

For Females Only:

Are you pregnant or may become pregnant?

YES / NO

Are you currently nursing?

YES / NO

Consent of Treatment: I hereby consent to the administration and performance of all diagnostic procedures and treatment, which, in the judgement of my physician, may be considered necessary or advisable.

I have provided the correct information to Hillsboro Naturopathic Clinic to the best of my ability.

Signature of Patient or Guardian: _____ Date: _____

Patient Name – Printed: _____

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Family History (Please list any major disease/s in the family, being specific to which family member is affected): _____

Current Health Concerns

Please describe your child's main current health problems, including your opinion as to what could possibly cause this. How long have he/she/they have had these problems? What treatment have been tried? How did it affect the condition?

Does your child have a contagious disease at this time? If so, What? _____

Current Medications or Supplements

Name	Dosage	Length of time being taken?

Food Allergies? (Include symptoms they bring)

Medication Allergies? (Include symptoms they bring)

List any past Hospitalizations, Surgeries or Injuries:

Has your child ever seen any of the following?

Naturopathic Physician Chiropractor Acupuncturist

Other Alt Care Provider (Pls specify) _____

If you marked any of the above, what was the treatment result?

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Review of Symptoms:

Symptom				Symptom			
Mental/Emotional	Yes	Past	Never	Head	Yes	Past	Never
Mood Swings				Headache			
Irritability				Dizzy Spells			
Sleep Problems				Head Injury			
Anxiety/Nervousness				High Fever			
Unusual Fears				Eyes			
Nightmares				Glasses			
Cries Easily				Contacts			
Hyperactive				Tearing			
Motion Sickness				Dryness			
Endocrine				Eye Pain			
High Blood Sugar				Eye Strain			
Low Blood Sugar				Ears			
Excessive Thirst				Ear Aches			
Excessive Hunger				Impaired Hearing			
Fatigue				Nose & Sinuses			
Coldness				Frequent Colds			
Skin				Nose Bleeds			
Rashes				Stuffiness			
Itching				Sinus Problems			
Eczema				Hay Fever			
Hives				Loss of Smell			
Boils				Musculoskeletal			
Acne				Joint Pain/Stiffness			
Mouth & Throat				Muscle Cramps			
Frequent Sore Throat				Broken Bones			
Canker Sores				Cardiovascular			
Breath Odor				Heart Disease			
Respiratory				Murmur			
Cough				Urinary			
Wheezing				Frequent Urination			
Asthma				Painful Urination			
Bronchitis				Bed Wetting			
Gastrointestinal				Blood/Peripheral Vasc.			
Belching/Passing Gas				Anemia			
Diarrhea				Easy Bleeding/Bruising			
Stomach Aches							
Constipation							
Bowel Movements day/week?							

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Has your child had any of the following tests (if yes, indicate when & where):

Electroencephalogram (EEG) : _____

Psychological Evaluation: _____

Hearing Test: _____

Speech/Language Test: _____

Previous Illness

Illness	Yes	No
Rheumatic Fever		
Chicken Pox		
Tonsillitis		
Ear Infection		
German Measles		
Measles		

Immunization Record

Immunization	Yes	No	Immunization	Yes	No
HIB			Polio		
Pneumococcal			Pertussis		
Meningococcal			Tetanus		
Hepatitis A			Diphtheria		
Hepatitis B			Influenza		
Varicella			MMR		
HPV					

Breast Fed? YES / NO

How Long? _____

Formula? _____

Milk/Soy/Other? _____

Please sign here to show that the information provided is true to the best of your knowledge.

 Parent/Legal Guardian Signature

 Date

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PAYMENT AND BILLING POLICY

The patient is responsible for paying any and all medical expenses incurred at the clinic. Your health insurance will be billed using information provided by you at the time of service. If you do not have any medical insurance, you will be responsible for the bill at the time of service. Monthly statements will be sent when there is a patient balance and payment is expected within 30 calendar days.

Balances due over 90 days are required to be paid in full. Unpaid balances over 90 days from the date of the first statement sent will be sent to collections.

It is the patient's responsibility to ensure their insurance company will pay for a specific medical procedure. In the event the insurance company denies an insurance claim or portion thereof, the patient is responsible for payment of the claim and account balance, including balances that may be due from an external service provider such as labs or radiology. Additionally, the patient is responsible for payment of the deductible, co-insurance, or copay in accordance with the insurance plan. Please note that if your account is sent to collections, you will be required to pay the balance due in full, *plus* the collections service fee prior to being reinstated as a patient and an appointment being made.

If a patient fails to present for a scheduled appointment, arrives so late for the appointment that they are unable to be seen by the provider, or fails to cancel the appointment 24 business hours prior to the time of the appointment, a \$75 "Missed Appointment Fee" will be assessed.

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs. The patient is expected to provide a PIP claim number and insurance adjuster contact information. If there is a lawsuit pending, the patient is expected to provide the clinic with attorney contact information and updates of the status of the lawsuit.

We may use and disclose Protected Health Information to obtain payment for services that we provide to you as well as for other health care operations such as appointment reminders, coordination of care with other providers, and as required for effective care and treatment. Use the Release of Medical Records Form if you wish to have your medical information transferred to or from Hillsboro Naturopathic Clinic.

PATIENT CONTRACTUAL AGREEMENT TO PAY

I hereby agree that I am directly and financially responsible for all medical expenses incurred at Hillsboro Naturopathic Clinic for medical care and treatment. I agree to pay all medical expenses within 30 days of the date I am billed for those expenses unless other arrangements have been made with the Billing Administrator.

I authorize the release of any medical information necessary to secure the payment of benefits. I authorize the use of my PHI on all insurance submissions. I authorize payment of all medical benefits by my insurance company to Hillsboro Naturopathic Clinic.

I further permit a copy of this authorization to be used in place of the original (if applicable.)

This assignment will remain in effect until revoked by me in writing.

 Signature of Parent or Legal Guardian

 Date

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TERMS AND CONDITIONS

- New Patients – Due to the significant amount of time reserved in the schedule for new appointments, a 24-hour business day notice is required for all new patient appointment cancellations. Any new patient appointment that is canceled without a 24-hour business day notice will be subject to being billed the full cost of the appointment time held (\$318.00).
- No Show / Late Cancel – Please do your best to keep your scheduled appointment. Our policy for missed appointments does not reset yearly, it is ongoing from day one. Each missed or late cancelled (less than 24 business hours) appointment will result in a \$75.00 missed appointment fee. For after-hours or weekend cancellations, please leave a message with our answering service.
- Medicinary and Supplements - All medicinary items are required to be paid for in full at the time of request and will only be held for a maximum of two weeks from the time of request. Failure to obtain requested items will result in re-stocking at the patient's expense.
- Controlled Substance Policy – Certain controlled substances that are prescribed require specific follow ups and can only be prescribed in certain increments. HNC physicians may require you to have follow up appointments more than once a year to continue to prescribe these medications.
- Phone call policy - Physicians encourage patients to call if you have questions after your office visit. It is understood by the physicians and staff that clarifying issues and answering basic questions could assist with the success in your health care. However, phone calls or questions that require a longer time frame (more than 5 minutes), may be billed as a phone consultation. All patients are encouraged to make follow-up office visits; we recommend utilizing this time for multiple questions and for more detailed clarification of information. We encourage our patients to contact us directly during regular business hours.
- Email Policy - Physicians and staff are happy to reply to questions and concerns through email correspondence. If the email correspondence becomes lengthy or excessive, the Hillsboro Naturopathic Clinic physicians and staff reserve the right to request follow-up, either with an office visit or through a Telehealth consultation. Appropriate charges will apply. There is no guarantee that an appointment offered through email will be available at the time that the patient responds. The clinic prefers any appointments made over the phone, to guarantee that the offered time is available at time of call.
- Payment - for your convenience we accept Cash, Check, Visa, MasterCard, Discover and American Express. Unless previously approved, payment is due in full at time of service.

I have fully read and understand the Terms & Conditions listed above.

 Signature of Parent or Legal Guardian

 Date

Name of Patient: _____

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Informed Consent

Any health care is not without its risks or is guaranteed to be successful. Naturopathic care is generally safer than other systems of medicine, but there are potential risks in what we do as well.

By reading and initialing below, you acknowledge your awareness and understanding of such risks.

1. Hillsboro Naturopathic Clinic, the physicians practicing within, and clinical staff do not recommend that you discontinue any other treatment or care provided by any other health care professionals.
2. There is no expressed or implied guarantee of any specific outcome with your treatment provided by the physicians at Hillsboro Naturopathic Clinic or staff. The care provided may or may not be a treatment for a specific disease, and may be preventive in nature, designed to improve your overall health and well-being.
3. Acupuncture treatments may result in a bruise at the site of the needle insertion. Any needle insertion carries a small risk of infection, though we use only single-use, sterile needles to minimize any risk.
4. Personnel of Hillsboro Naturopathic Clinic may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Digital Communications

Hillsboro Naturopathic Clinic offers the choice to communicate electronically via email, text, and for Telehealth consultations.

What is Telehealth?

Telehealth is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using information and communication technologies. Telehealth uses health information for diagnosis, therapy, follow-up and/or education. During the Telehealth health service, details of your medical history, examinations, x-rays, and tests may be discussed using interactive video, audio and/or telecommunications technology.

All existing laws regarding privacy and security of your health information and copies of your medical records apply to this Telehealth health service and the audio and video information transmitted.

Hillsboro Naturopathic Clinic will do our best to protect the confidentiality of the patient identification and imaging data.

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Before sending any electronic form of communication to Hillsboro Naturopathic Clinic, please read and understand the following information regarding the risks and conditions of the use of electronic communication.

Transmitting patient information electronically has several risks that should be considered. Some of these risks include, and are not limited to, the following:

- An electronic communication being misaddressed and sent to a non-affiliated recipient.
- Potential backup copies existing even after sender or recipient has deleted their copy or being stored in numerous paper and electronic files.

I understand that by signing below, I have read and fully understand and agree to the terms of the Terms & Conditions, Informed Consent and Digital Communication listed on these forms.

Signature of Parent of Legal Guardian

Date

Name of Patient – Printed

For any questions with billing or to establish a payment plan, please contact our billing company at 503-974-4409. Our reception staff has minimal knowledge of billing and may be unable to answer billing questions.