Sarah Paton, ND
Naturopathic Doctor

Pediatric New Patient Intake Form

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Name): _____

Cell Phone: _____ Email: _____

Parent/Legal Guardian Name): _____

Cell Phone: _____ Email: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ OK to leave message? Y N

Emergency Contact Name, Relationship + Phone: _____

Is there anyone additional you would like to give us permission to discuss your child's care with?
_____

Is there anyone (other than the patient's legal parent or guardian) that you authorize to bring your child to appointments?
_____

Who are your current health providers? Please list name, practice and city.

_____ _____

_____ _____

How did you hear about Dr. Paton? _____

-Do you give Dr Paton permission to discuss your child's care with colleagues and homeopathic students? (keeping your identity anonymous) Y N

-Would you like to receive Dr. Paton's email newsletter? Y N

--Please Complete Reverse Side As Well--

All information is strictly confidential and will only be used by the office of Dr. Sarah Paton

Payment + Cancellation Policy: Please read and sign. Leaving a credit card on file is optional.

Payment is expected at time of service using cash, check or charge. Appointments cancelled with less than 24 hours notice, or missed, will be **billed at 50%** of the rate for your scheduled appointment. Cancellation fees are billed via credit card on file or email and are due upon receipt. Credit card numbers are kept on file for orders plus any cancellation fees that may arise. You may choose to provide your credit card info below, all information will be kept confidential and secure.

Card Number: _____ Exp.: _____ 3 digit Security Code: _____
Type of card: _____ Your Billing Address: _____
Name as it appears: _____

Sign and date to acknowledge these terms: _____

HIPAA CONSENT FORM

Patient Name: _____ Date of Birth: _____

This consent form goes over the Health Insurance Portability & Accountability Act of 1996. HIPAA provides information about how we may use and disclose protected health information about you. This Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may be subject to change at any given point. A copy of our notice may be obtained at our website: http://www.drsarahpaton.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, health care operations, and/or coordination of care.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations and coordination of care. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, health care operations, and/or coordination of care.
- The patient has the right to obtain and view the Notice of Privacy Practices containing a more complete description by visiting the "form downloads" section of our website.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to look over and/or obtain a copy of their health care records with a signed release.
- The patient has the right to restrict the uses of their information.
- The patient may provide a written request to revoke this consent at any time during care.
- If the patient refuses to sign the consent form for purposes of treatment, payment, health care operations and/or coordination of care, the Practice has the right to refuse care to the patient.

_____ _____
Parent/Guardian Signature **Today's Date**

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