



MOMENTUM HEALTH NATUROPATHIC PEDIATRIC INTAKE FORM

Thank you for taking the time to complete the following new patient forms to the best of your ability. If possible, it can be fun to do this with your child. This form is an important step towards defining your child's health care needs and achieving his or her health goals.

Please scan and email this form prior to your child's first visit, drop it off in advance for review or bring this completed form to your child's first appointment. Please also bring any relevant blood work or health reports. All the answers on this form will be held **absolutely confidential**.

Child's Name: _____ Birthdate: _____

Address: _____ City: _____ Prov _____ PC: _____

Family Doctor: _____ Phone#: _____

Referring Professional: _____ Phone #: _____

AB Health #: _____

Guardian Information

Name: _____ Relationship: _____

Phone (Home): _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

Preferred method of communication: _____ Spouses name _____

Other children's names and ages _____

Emergency Contact (name, relationship): _____ Phone: _____

Why did you choose to come to this clinic?: _____

Have you seen a Naturopathic Doctor before? Y/N When: _____ Dr _____

Are you aware of the fees for the initial consultation and follow up visits? Y/N

Consent to receive email reminders: Yes No Initials: _____

Consent to receive newsletters Yes No Initials: _____

Signature of Parent/ guardian: _____ Date: _____

PRESENT HEALTH CONCERNS:

Please list most important health concerns in their order of significance. Please describe concerns in your own words.	How long have you been dealing with this concern?

What do you think causes your child's most important health concerns?

MOTHER'S HEALTH DURING PREGNANCY

- Increased Age Alcohol use Bleeding Cigarettes
- Diabetes Drugs Extreme nausea High blood pressure
- Illness Medications Stress Toxemia
- Trauma/ Injury X-rays Other _____

Details: _____

- Breast- fed Formula- fed
- How long? _____ How long? _____

Age solids began? _____ What foods? _____

Food allergies/ intolerances? _____

Favorite foods? _____

DIET:

Please describe a typical days diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Beverages: _____

Has your child tried any previous treatment? _____

On a scale of 1 (low) to 10 (high how would you rate your child's:

Sleep quality: _____ Eating Habits: _____ Stress level: _____

Exercise habits: _____ How many hours of sleep do YOU get per night? _____

SETTING THE STAGE

(Please ask these questions to your child if appropriate and allow for as candid of response as possible):

What is your main expectation from this visit: _____

What would you like to see the future of your health look like: _____

What would your ideal doctor be like: _____

If things in your life needed to change, like what you eat, or exercise or listening how likely would you be to be able to make these changes?: (1(low)- 10 (high): _____

What do you do that is healthy?: _____

What do you do that you don't think is healthy? _____

What do you think would be the hardest part to making changes in your life?:

Who do you know that will sincerely support you and help you out?:

What do you LOVE to do? _____

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____ as a patient of Dr. Kathryn Coombs, ND, understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that he has answered all of my questions to the best of his ability.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some treatments. This may include, but no limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

Signature (of patient, or legal guardian): _____

Date: _____

PATIENT CONSENT FORM

a. Consent to collect and disclose personal information

Personal information that Momentum Health collects, retains, uses, and discloses may include, without limitation, your name, age, contact information, health benefit information, occupation information, personal health information, medical history, and other information deemed necessary to fulfill the following purposes:

- ✓ To provide assessment and treatment services.
- ✓ To comply with the requirements of professional regulatory bodies, including file audits.
- ✓ To invoice you directly for services provided, and to process payment for those services.
- ✓ To provide information to Third Party Payers, Physicians and Legal Counsel already involved in your care
- ✓ To determine best clinical practices and ensure quality of service by the staff of Momentum Health.

I understand that Momentum Health may use, share, disclose and retain my personal information, in order to fulfill the purposes noted above, or where otherwise permitted by law. I hereby give Momentum Health permission and consent to maintain personal information on file. When requested, I hereby give consent for information to be released as required unless specified in writing.

b. Consent to be contacted

I give consent that I may be contacted at any of the phone numbers and/or mailing addresses provided to Momentum Health. I give consent to Momentum Health to leave messages at my contact number. In the case of a change in address or telephone number, I give Momentum Health consent to release information as needed so that I may be contacted.

c. Signature

Momentum Health requires the patient to agree to the above consents (Consent to Collect and Disclose personal information, Consent for the cost of our services, Consent for payment) prior to the initial treatment consultation. I hereby give Momentum Health my permission and consent for all of the above.

Patient Signature

 Date

Witness Signature

 Date

BILLING OPTIONS & CREDIT CARD AUTHORIZATION FORM

Billing and Payment:

- ✓ **OPTION 1** – You will pay Momentum Health directly for treatments received at the time of each visit.
- ✓ **OPTION 2** – Momentum Health will bill the insurance company (if on our list of direct billing insurance companies)
 - You are responsible for any portion of the bill that the insurance company does not pay.
 - If the account is overdue by 3 months, you are responsible for the bill and will be reimbursed by the clinic if the insurance company pays.
 - **As Momentum Health may carry an outstanding patient balance for a period of time, a credit card in trust is required for security.** Credit card information/slips will be shredded upon request.
 - You will need to complete a Credit Card Billing Authorization below if you choose Option 2.
 - It can take up to 3 months for insurance companies to inform the clinic of any treatments or portions of treatment not covered.
- ✓ Please be aware that if your claim is denied, you are responsible for any and all charges accrued for your treatment at our facility.

Extended health insurance ** Please provide your policy and ID numbers		
Insurance Company:	Policy Number	Employee ID Number:
Physiotherapy Coverage:	Massage Therapy Coverage:	Chiropractic Coverage:
Yearly Max:	Yearly Max:	Yearly Max:
<input type="checkbox"/> Doctor's note required?	<input type="checkbox"/> Doctor's note required?	<input type="checkbox"/> Doctor's note required?
Details:	Details:	Details:

I, _____, hereby authorize Momentum Health to debit my MasterCard/Visa for charges and all overdue accounts.

a. Credit card information

Card Type:

Card #:

Expiry Date (mm/dd/yyyy) :

b. Consent for Payment and Cancellation Policy

I agree that in the event I cannot attend my scheduled therapy appointment(s) that I will make every effort to notify and inform Momentum Health at least 24 hours prior to my scheduled appointment. If I am unable to give appropriate notice of cancellation, I agree to pay the **FULL VISIT FEE** for missed or late therapy cancellation. Treatment may be suspended until the account has been paid in full.

c. Signature

PLEASE BE AWARE THAT ALL ACCOUNTS NOT PAID BY THE INSURANCE COMPANY, WCB OR THIRD PARTY PAYER FOR WHICH DIRECT BILLING IS POSSIBLE IS THE RESPONSIBILITY OF THE PATIENT. WE ASK THAT YOU SIGN THE SPACE BELOW IN ACKNOWLEDGMENT AND UNDERSTANDING OF YOUR LIABILITY OF ANY COSTS INCURRED BY YOU AT THIS CLINIC.

Signature of Patient _____ Date _____

Printed Name of Patient _____ Date _____