MOUNTAIN VIEW NATURAL MEDICINE

Lorilee Schoenbeck, ND | Adriane Morrison-Taylor, ND | Lori Clarke, ND
Michael Gravett, ND | Nina Meledandri, ND, MSOM, Lac | Chelsey Koktavy, ND

PEDIATRIC REGISTRATION FORM (BIRTH-6 YRS)

Name:_____Preferred name: _____ Date of Birth:_____

Family Ethnicity:_____Parent(s)/Legal Guardian(s)_____

Street Address:_____City/State/Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email Address:_____

May we leave a medically related message at home?_____ at work?_____ on cell?_____

What is your birth sex? Male_____ Female_____ Other (specify)_____

What gender do you identify as? Male____ Female____ Other (specify)_____

Referred by:_____Pharmacy (include city):_____

How would you like to receive appointment reminders for your child: Email / Phone

Emergency contact: _____ Phone:_____

GUARANTOR

Name:_____Street:_____

City/State/Zip:_____Phone:_____

INSURANCE INFORMATION

Insurance Company:_____Subscriber:_____

Address:_____Subscriber DOB:_____

Patient ID#:_____ Subscriber ID#:_____

Group #:_____ Patient's Relationship to Subscriber:_____

Subscriber's Employer/Address/Phone:_____

I authorize the release of any medical or other information necessary to process claims to my child's insurance carrier. I also request payment of government benefits either to myself or to the party who accepts assignment: Mountain View Natural Medicine. I authorize payment of medical benefits to Mountain View Natural Medicine for services rendered at this clinic and submitted to my child's insurance carrier.

Sign/date/relationship to patient:

_____

Would you like us to be your child's primary care provider? Y/N

Name of other PCP if applicable: _____

Please list your child's health concerns in order of priority along with other practitioners they may be seeing for the condition:
1. _____
2. _____
3. _____
4. _____

What do you believe is causing your child's most important health concerns?

Please list any medications and supplements your child is currently taking, along with doses and the reason they are taking them:

Medications:	Reason:	Date began:	Dose:

Supplements:	Reason:	Date began:	Dose:

**Please list any drug allergies: _____

**Please list any food allergies_____

**Please list any environmental allergies: _____

Parents/gaurdians often desire communication between their healthcare providers. Do we have your permission to communicate verbally and in writing with your son or daughter's other providers regarding their healthcare?

___yes/no___

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no. of times _____
_____ Measles _____ Pneumonia _____ Ear infections, approx. no. of times __
_____ Mumps _____ Frequent colds _____ Strep throat, approx. no. of times ____
_____ Rubella _____ Rheumatic fever _____ Other: _____

Has your child ever had any of the following? when, where, results

Electroencephalogram (EEG): _____

Psychological evaluation: _____

Hearing test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations:_____

IMMUNIZATIONS (please supply dates, if known)

_____ MMR _____ H. influenza Others: _____
_____ DTaP _____ Annual Flu Adverse reactions: Y / N
_____ Chicken pox _____ Hep B If so, what? _____

BIRTH HISTORY

Did mother receive prenatal care? Y N Prenatal vitamins? Y N
Medications (type)? _____

_____

Did mother smoke cigarettes? Y N Drink alcohol? Y N
Illicit Drugs? Y N If yes, what type**?**_____

Any difficulties with the pregnancy (nausea, vomiting, bleeding, etc**):** _____

_____

Type of birth (eg. hospital, home, C-section)_____ Carried to term? Y N
If no, how premature? _____ Complications of labor or delivery**:** _____

_____

FAMILY HEALTH HISTORY: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Family Member	**Living?/Age**	**Major illness or chronic conditions**
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Office Manager
802-860-3366

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Mountain View Natural Medicine has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the **office manager at 802-860-3366.**

I also understand that I am entitled to receive updates upon request if Mountain View Natural Medicine amends or changes its Notice of Privacy Practices in a material way.

_____	_____
Signature	Relationship to Patient, if signed by someone other than patient.
_____	_____
Date	Patient's name if not signed by patient

THIS SECTION IS TO BE COMPLETED BY Mountain View Natural Medicine IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____	_____
Name and title of employee	Date

Financial Policy

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-Payments, deductible, co-insurance and private pay fees, where applicable are due upon check out.
- Any deductible is due as soon as the amount can be determined
- You are responsible for understanding what your insurance plan will cover or not cover
- As a courtesy, we will bill non-participating insurance companies
- Postage and handling will be added to dispensary items. We will mail and require payment prior to mailing.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changes, bring your new insurance card with you.
- Please contact your insurance company with insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a $25 service fee for any checks returned unpaid.
- If payment is not received within 21 days of the statement date your account will be considered delinquent

RETRUNED SUPPLEMENTS

- Any unopened item may be returned for a full refund within 30 days of purchase.
- Mail order items must be postmarked by 30 days of the original date of purchase. Return postage is nonrefundable.

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with our credit reporting agency. If we incur any collection costs, these will be added to the balance you owe.

NOTIFY US TO CANCEL AN APPOINTEMNT

- If you need to cancel an appointment, please notify us 24 hours before the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a $50.00 fee.
- If you frequently miss or cancel appointments, you may be discharged from the practice.

WE USE AND AUTOMATED SYSTEM FOR E-MAIL APPOINTEMNT REMINDERS

- An automated e-mail will be sent to the listed e-mail address prior to your appointment.
- Missed appointment fees apply regardless of whether a courtesy reminder was sent or not.

I've read the above financial policy of Mountain View Natural Medicine and agree to its terms. I am responsible for any balance due on my account or the patient I am responsible for.

Patient Name: _____
Responsibility party name: _____
Signature: _____ Date: ____/____/___