NEW PATIENT PACKET

• welcome to our clinic •

First Visit Checklist

☐ **Completed Intake Form**

Please bring the completed intake forms with you to your appointment. If you would like to send us your forms *before the day of your appointment*, you may scan and email them to: **info@thegolgiclinic.com**.

☐ **Bring Lab or Imaging Reports**

If you have notes or reports from previous doctors visits that you feel might help us in treating you, please bring them to your first appointment.

☐ **Parking**

Parking is available in the Caras Park Lot behind our building or on Front Street.

☐ **Don't Go Upstairs**

When you enter our building, **don't** go upstairs. Upon entering our building, we're located on the main level (second floor) of 113 W. Front Street. Upstairs is actually the third floor.

☐ **Plan to Arrive on Time for Your Appointment**

There is complimentary tea available in our reception area.

☐ **Payment is Expected at the Time of Service**

Cash, check, Mastercard, Visa and Discover are all accepted. We do not bill insurance.

Pediatric Health Intake (Birth - 12 years)

Patient Information

Name: _____

Date of Birth: _____ Age: _____ Gender: Male / Female Year/Grade in school: _____

Social Security Number:

Parent/Guardian's Name: _____

Address: _____
apt/unit

City: _____ State: _____ Zip: _____

Parent/Guardian's Email: _____

☐ (check box to receive clinic newsletter)

Phone: (home): _____ (mobile): _____ (work): _____

Please circle number(s) where we may leave messages.

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

_____

Reason for referral or today's chief complaint: _____

Has any other family member been a patient at our clinic? Yes / No If yes, who?: _____

How did you hear of us? _____

Medications

	Now	Past		Now	Past	
Aspirin	☐	☐	Decongestants	☐	☐	
Tylenol	☐	☐	Anti-histamine	☐	☐	
Ibuprofen	☐	☐	Antibiotics	☐	☐	List: _____

Other ☐ ☐ List: _____

Does your child have allergies to medications? ☐ No ☐ Yes

If **yes**, list medication & reaction: _____

Does your child have **food allergies** or **environmental sensitivities?** ☐ No ☐ Yes

If **yes**, please list allergy and reaction:

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Your Child's Medical History

☐ Chicken pox	☐ Scarlet fever	☐ Tonsillitis, *number of times*: _____
☐ Measles	☐ Pneumonia	☐ Ear infections, *number of times*: _____
☐ Mumps	☐ Frequent colds	☐ Strep throat, *number of times*: _____
☐ Rubella	☐ Rheumatic fever	☐ Other: _____

Has your child ever had any of the following procedures?

	Date	Where	Results
Electroencephalogram (EEG):			
Psychological evaluations:			
Hearing test:			
Speech/language tests:			
Hospitalizations (*please list*):			
Surgeries (please list):			

Immunizations

☐ MMR	☐ DPT	☐ Chicken pox	☐ Pneumococcal
☐ Measles	☐ Diphtheria	☐ Polio	☐ Rotavirus
☐ Mumps	☐ Tetanus	☐ H. influenza type B	☐ Hepatitis A or B (*circle*)
☐ Rubella	☐ Pertussis	☐ Seasonal flu shot	☐ Others: _____

Any adverse reaction with any shot? ☐ No ☐ Yes If so, what? _____

Family History

☐ Heart disease	☐ Diabetes	☐ Birth defects
☐ Hypertension	☐ Arthritis	☐ Tuberculosis
☐ Cancer	☐ Allergies	☐ Asthma
☐ Mental illness	☐ Osteoporosis	☐ Other: _____

Prenatal History

Number of previous pregnancies by natural mother: _____ Miscarriages: _____

Any complications? _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

☐ Bleeding	☐ Nausea	☐ Physical or emotional trauma
☐ Illnesses	☐ Hypertension	☐ Cigarettes, alcohol, drug consumption
☐ Medications	☐ Diabetes	☐ Thyroid problems

Birth History

Term: ☐ Full ☐ Premature ☐ Late Weight at birth: _____
Length of labor: _____ Labor complications: _____
Did your child have any of the following problems shortly after birth?

☐ Rashes	☐ Birth injuries	☐ Blue baby
☐ Jaundice	☐ Seizures	☐ Cerebral palsy
☐ Colic	☐ Fever	☐ Birth defects

☐ Other: _____

Health History

Child's sleep patterns (1st year): _____
Food intolerances: _____
Breast fed: ☐ No ☐ Yes, how long: _____ Formula: ☐ No ☐ Yes, type (milk, soy): _____
Age began solids: _____ Which foods: _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

Current Symptoms

☐ Hives	☐ Burning urine	☐ Bloody urine	☐ Eczema
☐ Cries easily	☐ Bleeding gums	☐ Heart murmur	☐ Nervous
☐ Nose bleeds	☐ Vomiting spells	☐ Sleep problems	☐ Asthma
☐ Acne	☐ Allergies	☐ Night sweats	☐ High fevers
☐ Jaundice	☐ Sensitive to light	☐ Chronic rash	☐ Stomach aches
☐ Diarrhea	☐ Hearing loss	☐ Easy bruising	☐ Sore throats
☐ Flat feet	☐ No appetite	☐ Body/breath odor	☐ Constipation
☐ Nightmares	☐ Frequent colds	☐ Bleeding tendency	☐ Unusual fears
☐ Wheezing	☐ Joint pains	☐ Excessive fatigue	☐ Cough
☐ Dizzy spells	☐ Hair loss	☐ Frequent urination	

Diet

Please describe your child's *typical* daily diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.

Please **initial** in the spaces provided after reading the following:

Consent to Treatment

_____ I authorize The Golgi Clinic to treat my child. I understand methods of treatment used in this practice may include, but are not limited to: homeopathic, herbal, craniosacral, and/or physical medicine, as well as others deemed appropriate. I am at liberty to seek alternate opinions or care, and may discontinue treatment at any time. I will not hold The Golgi Clinic responsible for treatment outcomes should I choose to disregard the doctors medical advice and treatments.

Payment & Insurance Policy

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, check, Visa, MasterCard or Discover. The doctors at The Golgi Clinic are not contracted providers with *any* insurance plan except Healthy Montana Kids. If your plan has coverage for out-of-network naturopathic care we will provide you with the appropriate paperwork and coding to submit your own insurance claim.

_____ During your visit, your health care provider may prescribe medication, which may be purchased at The Golgi Clinic or elsewhere. Most insurance companies *do not* cover the medicinary items that we prescribe and dispense.

_____ I understand that no refunds are offered for services rendered or pharmacy items purchased.

_____ Returned checks are subject to a $25 non-sufficient funds charge from The Golgi Clinic.

Credit Card Policy

The Golgi Clinic requires that patients keep a valid credit card on file. Please initial in the spaces provided indicating you have read the ways in which the clinic may use your credit card.

_____ I authorize my credit card to be kept on file at The Golgi Clinic. I understand that my credit card information will be kept in a secure, digital format once I've submitted it and that should I cease to be a patient, The Golgi Clinic will destroy my credit card information.

_____ My credit card will be charged for office visits via phone or Skype and any other appointment-related costs, including medicinary and shipping costs.

After Hours Appointments Policy

For pediatric patients, The Golgi Clinic doctors may provide after-hours contact information for use in situations where your child requires urgent care outside regular office hours. For these appointments, the clinic reserves the right to charge for the visit based on time and complexity.

Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your healthcare.

It is important that you understand that your information can be used and shared in the following ways:

- To give you medical treatment or other types of health care, multiple providers may be involved in your treatment, both directly and indirectly
- To bill you or a third party for payment for services provided to you
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease)
- In response to a court or administrative order
- We may share your health information with a person(s) that *you have named* to be involved with your health care: **I hereby authorize privileged, confidential information about my treatment to be shared with the following people:**

_____

print name(s) of authorized people

You have the following rights relating to the medical records we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge having received and read the above-stated policies of The Golgi Clinic and will comply with them in all respects. If my insurance company requires the release of medical records, I hereby give my permission by signing this form.

_____

Print name of responsible party

_____ ___/___/_____

Signature of responsible party Date

How Do I Check My Insurance Benefits*?

The Golgi Clinic is not contracted (in-network) with any insurance company. Many insurance plans reimburse a portion of their member's out-of-pocket expenses at our clinic. If you have insurance and would like to bill them for the cost of your office visit, please use this helpful questionnaire to assist you in determining what will be paid.

Insured Patient Name_____ Insurance ID# _____

Call the number on your insurance card listed for patient customer service. Then follow steps 1-6 when calling to find out benefits and eligibility.

1. When did my coverage begin and when is it valid thru?

   Beginning Date of Coverage_____ Ending Date of Coverage_____

   Does my insurance plan follow a Fiscal or Calendar Year Schedule? _____

2. Do I need a referral from my primary care physician (PCP) for alternative services? Y N

3. What are my benefits for the following services? *Be sure to find out whether your plan includes Out-of-Network coverage for the following benefits.

   Specialties:

   Naturopathic: % Covered; Co-pay/ Co-Insurance _____;Year Max _____

   Chiropractic: % Covered _____; Co-pay/ Co-Insurance _____;Year Max _____

   Lab work/X-rays: % Covered _____; Year Max _____

   Female Annual Exam/Well-Woman Exam or Male Annual Exam: % Covered _____

4. What is the insured person's **individual** deductible for the year and has any or all of it been met?

   Deductible $ _____; Amount of Deductible met so far $ _____ Date today _____

5. Does the insured person's plan have a **family** deductible? Y N

   Deductible $ _____; Amount of Deductible met so far $ _____ Date today _____

6. Are the specialties listed above subject to either deductible? Y N

   If so, which specialties? _____

What was the name of the representative I spoke with? _____

Please bring this form with you to your appointment. If you have trouble getting the information you need, please feel free to call the clinic for assistance.

***Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.**