Monadnock Natural Medicine

Patient Registration Form

Patient Information

Last Name:_________________________ First Name:_________________________ MI: _______
Maiden Name:_________________________ Date of Birth: ______________________ Sex: _______
Street Address:____
City:___________________________ State:______ Zip:__________ SS#:__________________________
Employer/School:___________________________ E-mail Address:______________________________
Home Phone:__________________ Cell Phone:__________________ Work Phone:__________________
Mother's Name (minors only): _________________________ Father's Name: ______________________________
Emergency Contact: _____________________________ Contact's Phone #:_______________________________
Emergency Contact is my: (specify relationship) ____

How did you hear about us? (Circle one)
Newspaper Ad *News Story* *Mailer/Flyer* *Website*
Workshop/Event *Medical Referral* *Friend/Family* *Yellow Pages*

Responsible Party Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Name:____ Phone: _______________________________
Street Address: ____
City:____________________________ State:______ Zip:__________

Acknowledgement of Receipt

Monadnock Natural Medicine is required to provide you with a copy of our Notice of Privacy Practices and to obtain written acknowledgement, if possible, that you have received it. The Notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights, and explains how you may exercise those rights.

I hereby acknowledge that I have received a copy of Monadnock Natural Medicine's Notice of Privacy Practices. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

____
____
Patient's Name (PRINT)

____
Signature of Patient

____
Date

Patient's Guardian/Representative (PRINT)

____
Signature of Guardian/Representative

____
Relationship to Patient/Representative Authority

____
Date

Insurance Information:

Insurance Company: __________________________________ Insurance Phone: ______________________________
Address: _________________________________ City: ____________________ State: ______ Zip: _____________
ID Number: __________________________________ Group Number: ______________________________________
Subscriber's Name: __________________________________ Subscriber's Date of Birth: ______________________
Patient's Relation to Subscriber: (circle one) Self Spouse Child

FOR OFFICE USE ONLY: Unable to Obtain Acknowledgement of Receipt
This section serves as a record of Monadnock Natural Medicine's good faith effort to obtain written acknowledgement from the patient of receipt of the Notice of Privacy Practices.
Patient was given a copy of the notice on: ________________.

Patient refused to sign acknowledgement.

Patient is physically unable to sign acknowledgement.

Other: ____

Monadnock Natural Medicine
Pediatric Patient Profile

Last Name: ____________________________ First Name: _______________________ MI: ____
Nickname:_________________________ Date of Birth: ______________ Age:______ Sex: _____

Present Health Concerns

Please list your child's health concerns in order of priority, including date of onset and severity of symptoms.

1. ____
2. ____
3. ____
4. ____
5. ____

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

What goals do you have for your child's visit today?_______________________________________
____

Healthcare Practitioners: Please list your child's current medical practitioners with their contact information.

	Practitioner's Name	Office Name	City	Phone
Pediatrician				
Specialist				
Specialist				
Therapist				
Pharmacy				

Medications: Please list any prescription drugs, over-the-counter medications and supplements (vitamins, minerals, nutrients, herbs, homeopathic remedies, etc.) you child is currently taking.

Medication/Supplement	Reason	Date Began	Dose

Allergies: Please list and describe any severe or life-threatening allergies (medications, stings, foods, etc.):
____
____**(OVER)**

Past Medical History: Please list the date of or age at each event and describe:
Serious Illnesses and Injuries:____
Surgeries: ____
Hospitalizations: ____
Date of last physical: _________________________________ Date of last blood tests: ____________

Childhood Illnesses: Your child's health is: Good Fair Poor

Chicken Pox	Mononucleosis (Mono)	Rheumatic Fever
Diphtheria	Mumps	Tonsillitis
Ear Infections	Pertussis (whooping cough)	Scarlet Fever
German Measles (Rubella)	Pneumonia	Strep Throat (recurrent)
Measles	Polio	Positive TB test

Other: ____

Immunizations: Indicate which immunizations have been given to your child and any adverse reactions.
All immunizations up to date Delayed schedule Refused immunizations

DTP *or* DTaP______________________ Pneumococcus (PCV)___________________
MMR_____________________________ Hep B_______________________________
Polio (IPV *or* OPV)_______________ Varicella____________________________
Hib______________________________ Other _______________________________

Pregnancy History: Birth Mother: # of pregnancies: _____ # of children:______ Age at delivery:_____
Please check any factors during pregnancy. Health during pregnancy: Good Fair Poor

Alcohol Consumption	Nausea	Toxemia
Bleeding	Recreational Drugs	Trauma/Injury
High Blood Pressure	Smoking	X-Ray
Stress	Medications: ___________________	

Other health problems or complications during pregnancy:_______________________________________

Birth History:
Term: Early ____ weeks Full Term Late ____ weeks Length of labor:______hours
Place of Birth: Hospital Birth Center Home Other:_____________________________________
Birth Medications (if any): ____
Complications: ____

Newborn: Weight at birth: _____ lbs _____ oz Home from hospital in _____ days

Jaundice	Infection	Seizures
Cyanosis	Fever	Anemia

Other important conditions: ____
Feeding: Breast Fed______months Formula Fed_____ months Type of formula _______________

Developmental Milestones: Please indicate your child's age at each milestone:
Sit up _____ months First Tooth _____ months Toilet Trained _____ months
Crawl _____ months First Word _____ months
Walk _____ months First Sentence _____ months
Additional comments about social, cognitive, or physical development:_____________________________
____**(OVER)**

Personal and Family Medical History:

Please check the box next to each condition that applies to your child or his/her *biological* family members.

Key: P=Paternal; M=Maternal; GF=Grandfather; GM=Grandmother

				Grandparents				Siblings and Children				
	YOU	**Mom**	**Dad**	**PGM**	**PGF**	**MGM**	**MGF**					
Current Age or Age at Death												
Alcohol / Drug Abuse												
Allergies or Hay Fever												
Alzheimer's or Dementia												
Anemia												
Anxiety / Panic Attacks												
Arthritis / Joint Disease												
Asthma												
Autoimmune Disease												
Bleeding Disorder												
Cancer (**What Type?**)												
Celiac Disease												
COPD / Emphysema												
Depression/Suicide Attempt												
Diabetes												
Eczema												
Epilepsy or Seizures												
Glaucoma												
Gall Bladder Disease												
Migraines / Headaches												
Heart Attack												
Heart Disease												
High Blood Pressure												
High Cholesterol												
HIV / AIDS												
Inflammatory Bowel Disease												
Kidney Disease												
Liver Disease / Hepatitis												
Macular Degeneration												
Osteoporosis												
Schizophrenia												
Stroke												
Thyroid Disorder												
Other:												

Social History

Parents: Biological Adoptive Foster Step-parent(s)

Parents' Marital status: Single Married Divorced Re-married Widowed Significant Other

Mother's Occupation:_____________ Full *or* Part Time Father's Occupation:__________ Full *or* Part Time

Siblings: *Yes* *No* Please list their age(s) ____

Household: Parent(s) Sibling(s) Grandparent(s) Pet(s) ___________________________________

Other ____

Pre-School/Daycare/School:_____________________________ Hours per day:____ Days per week:____

Personality and Habits:

How does your child react to stressful events? ____

What are your child's primary sources of stress?____

How much does stress impact your child's life?____________________ Hours of play per day? __________

Favorite activities?____

Does your child:

Exercise regularly? Yes No What kind? ______________________________________

Sleep soundly and wake rested? Yes No If no, why?______________________________________

Sleep: _____ hours per night Naps: _____ hours per day

Play well with others? Yes No If no, why?______________________________________

Enjoy time alone? Yes No If no, why?______________________________________

Have sensory sensitivities? Yes No What kind? ______________________________

Have strong fears or phobias? Yes No What kind? ______________________________________

Have rituals/repetitive behaviors? Yes No What kind? ______________________________________

Diet:

Age Solid Foods Begun: ______ months First Foods: ____

Age of Introduction for: Dairy (cow's milk) ____ months Wheat:_____ months

Does your child have any dietary restrictions?____

Your child's favorite foods? ____

Foods your child refuses? ____

How is your child's appetite?_______________________ Thirst?___________________________________

Please describe a typical day below:

Breakfast Time:_______	Lunch Time:________	Dinner Time: ________	Snacks Times: ________

Water: ________ oz. per day Other beverages:____

What else would you like us to know about your child?

This form has been reviewed by the doctor with the parent.

_____________________________________ _______________________________________

Signature of Parent Date Signature of Doctor Date

174 Concord Street, Suite 250 Peterborough, NH 03458 • Phone: 603-924-6624 • Fax: 603-924-6679

Monadnock Natural Medicine

Consent for Treatment

The naturopathic doctors at Monadnock Natural Medicine may perform, order, or prescribe any of the following procedures and therapies as necessary to properly evaluate, diagnose and treat your health concerns:

- **General Diagnostic Procedures:** including, but not limited to, physical exams, diagnostic imaging (X-rays, ultrasound, etc.), venipuncture, pap smears and other specimen collection for diagnostic labwork.
- **Psychological and Lifestyle Counseling:** promotion of wellness using recommendations for exercise, sleep, stress management and balancing of work and social activities.
- **Botanical and Homeopathic Medicines**: use of therapeutic plant substances in oral and topical forms and homeopathic remedies (dilute quantities of naturally occurring plant, mineral and animal substances) in oral and topical forms.
- **Dietary Advice and Therapeutic Nutrition:** use of foods, diet plans or nutritional supplements. May include intramuscular vitamin injections and intravenous nutrient therapy.
- **Soft Tissue and Osseous Manipulation:** use of massage, neuromuscular techniques, muscle energy stretching, craniosacral therapy or visceral manipulation, and manipulations of the extremities and spine.
- **Prescription Items:** pharmaceutical medications contained within the New Hampshire naturopathic formulary, barrier contraceptives, and immunizations.

Potential Risks: including, but not limited to, pain, discomfort, blistering, discolorations, infection, burns, fainting or tissue injury from needle insertions, topical procedures, heat or frictional therapies; adverse reactions to prescribed herbs or supplements such as allergic reaction, headache, nausea; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: including, but not limited to, restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention and management of disease.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I hereby authorize the naturopathic doctors at Monadnock Natural Medicine to perform, order, or prescribe the above procedures and therapies as necessary to facilitate my diagnosis and treatment. I understand that I may ask questions regarding my individual treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic doctors at Monadnock Natural Medicine.

______________________ Patient's Name (PRINT)	______________________ Patient's Guardian/Representative (PRINT)
______________________ Signature of Patient	______________________ Signature of Guardian/Representative
______________ Date	______________________ Relationship to Patient/Representative Authority
	______________ Date

Monadnock Natural Medicine

Protected Health Information Management

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals have the right to request receipt of confidential communications from us by alternative means or at alternative locations.

I wish to be contacted in the following manner: (check all that apply)

Home Telephone ___________________________
- OK to leave message with detailed information
- Leave message with call-back number ONLY
- OK to fax _____________________________

Work Telephone ___________________________
- OK to leave message with detailed information
- Leave message with call-back number ONLY

Written Communication
- OK to mail to my home address
- OK to mail to my work/office address

Other (email, cell phone, etc.) _________________________
____

____
Patient's Name (PRINT)

____
Signature of Patient

____
Date

____
Date of Birth

____
Patient's Guardian/Representative (PRINT)

____
Signature of Guardian/Representative

____
Relationship to Patient/Representative Authority

____
Date

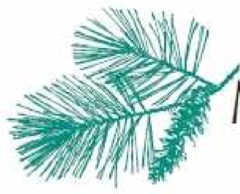
••

•••FOR OFFICE USE ONLY

Healthcare entities must keep records of PHI disclosures. Individuals have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

RECORD OF DISCLOSURES						
Date	Disclosed to Whom	Authorized	Purpose	By Whom Disclosed	Type	Method

Type key: E=Entire Record, P=Progress Notes, L=Lab/Imaging Reports



Monadnock Natural Medicine, PLLC

holistic health care for the whole family

Notice to all Cigna and Harvard Pilgrim insurance patients:

Naturopathic Doctors are considered to be specialists by Cigna and Harvard Pilgrim, and are therefore unable to act as a Primary Care Doctor for patients with these insurances. As a result, we are unable to submit insurance claims for Wellness Checks or for preventative appointments.

Please note: HMO insurance policies with either Cigna or Harvard Pilgrim DO NOT provide coverage for Naturopathic Services, and patients with these insurances must pay for services at the time of their appointment.

Please be aware that not all visits or procedures will be covered by insurance. ***Important: until we can verify your insurance coverage, payment is due in full at the time of your visit. If your insurance company denies payment for any portion of your bill for any reason, you are responsible for the cost of treatment at the current rates.***

We must know PRIOR to your appointment if you wish the visit to be covered by insurance in order to allow us time to verify your coverage. Unfortunately we are unable to submit claims for previous visits. We are unable to provide information regarding type, amount, or timing of insurance reimbursements.

Patients with insurance that requires a co-insurance (a percentage of the invoice total), MUST speak to their insurance company prior to an appointment in order to understand what their individual plan details are, especially as relates to deductibles.

Payment is due in full at the time of your visit. For your convenience we accept cash (exact change appreciated), check, Visa, Mastercard, Discover and American Express.

I have read, understand and agree to the above policies. I also agree that I have had the opportunity to discuss all fees and payment options, and understand my responsibility for payment of services rendered.

______________________________________ ______________________

Patient Signature **Date**

174 Concord Street, Suite 250 Peterborough, NH 03458 • Phone: 603-924-6624 • Fax: 603-924-6679

Monadnock Natural Medicine

How Do I Check My Insurance Benefits?

Patient Name ______________________ Insurance ID# ____________________
Insurance Company ____

Our clinic will happily bill your insurance for your visit; however, it is the patient's responsibility to be aware of her/his coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-6 when calling to find out benefits and eligibility.

First, Call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. When did my coverage begin and when is it valid thru?
Beginning Date of Coverage _______ Ending Date of Coverage ________

2. Do I need a referral from my primary care physician (PCP) for alternative services?
_____ Yes _____ No

3. What are my benefits for the following services? **Be sure to find out the benefits that apply to the doctor you are seeing; there will be different benefits depending on whether the doctor is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits.*
Naturopathic: % Covered_______ Co-pay/ Co-Insurance_______ Year Max_______

4. What is my *deductible for the year* and has any or all of it been met?
Deductible $________ Amount of Deductible met so far $_______ Date _____

5. What was the *name of the representative* I spoke with: **________________ Date______**

* **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. Thanks so much!

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