CONSENT FOR TREATMENT

I, _________________________________, hereby request and consent to examination and treatment with Naturopathic Medicine by Dr. Abby Egginton.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Abby Egginton:

my suspected diagnosis(es) or condition(s)
the nature, purpose, goals and potential benefits of the proposed care
the inherent risks, complications, potential hazards or side effects of treatment or procedure
the probability or likelihood of success
reasonable available alternatives to the proposed treatment procedures
potential consequences if treatment or advice is not followed and/ or nothing is done

I recognize that Dr. Egginton is a licensed naturopathic doctor in the state of Washington, and that she has been trained as a primary care physician. I am aware that in the state of New York, there is no licensure regulating the practice of naturopathic medicine, therefore clinical diagnosis may not be made.

I confirm that I have read and fully understand the above prior to my signing.

____ __________________
Signature of Patient (Parent/Guardian if patient is a minor) Date

Dear New Patient,

Welcome to Westchester Center for Natural Medicine. We look forward to providing for your health care needs. Please read and initial the following statements:

__________ Payment for all services and medicinary items are due in full at the time of visit. We accept cash, credit card, and checks. We do not bill insurance directly, but you are more than welcome to submit the receipt for reimbursement. Some insurance companies cover naturopathic medicine while others do not. Returned checks will be subject to a $25 fee.

__________ Due to time constraints, you will be charged for scheduled and unscheduled phone consultations that exceed 10 minutes. Phone calls of 10 minutes or less are not charged. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment.

__________ Please give your physician 24 hours advance notice of cancellations. If you cancel within 24 hours of your appointment, you will be charged a fee of $50.

__________ Unless a specific payment plan has been agreed upon and put into writing, we reserve the right to charge interest on any outstanding balance on the account. After 2 months, a 5% compounded interest will accrue, after 6 months, 8% compounded interest will accrue.

I have read and understand the above-stated policies of Westchester Center for Natural Health and will comply with them in all respects.

____

Patient Name (Please print. Include parent/guardian if patient is a minor.)

____ ______________

Patient signature (Parent/guardian signature if patient is a minor) Date

Email Consent

Email offers us an easy and convenient way to communicate between office visits. In order for me to serve you best, I ask that you follow the below guidelines for email communication.

Conditions for email communication:

- Emails are great for asking general questions that do not require detailed discussion and for clarification of previous recommendations.
- Emails are not meant to replace in-person or phone appointments, nor are they meant to discuss new health concerns or receive new treatment recommendations.
- Although I do check my email regularly, I cannot guarantee that I will be able to answer your email right away nor can I guarantee that I will receive it. Call the office if the matter is urgent or if you do not hear back from me within a reasonable amount of time.
- Confidentiality is not guaranteed with emails! It is like sending a postcard in the mail.
- Email is never appropriate for emergency situations. Please call the office or your local emergency department.
- Emails may be added to your patient chart.

Finally, either one of us can revoke permission to use the email system at any time.

☐ **YES**, I would like the option to correspond via email. I agree to and understand the terms of email communication as detailed above.
☐ **NO,** I do not want to correspond via email.

Name:

Email Address:

Signature:
(type written name will serve as signature if filling out electronically)

Date:

YOUR HEALTH INFORMATION PRIVACY RIGHTS

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

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number:___________________
___Please do not phone me at work. Use this alternate phone number:____________________
___Please do not leave messages on my answering machine.
___Please do not contact me by email.
___Please send mail, including my bills, to this alternate address:_________________________
____
___Other request (please describe):____

____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

CHILD HEALTH HISTORY INTAKE

Name: ____

Parents' Name(s): ____

Who does the child live with? ____

Address:____

____

Phone: ________________ ____________________ ________________
Home Work Cell

Parent's Email: ____

Date of Birth: _________ Age: ________ Gender: ______________

Birth Weight: ___________

How did you hear about WCNH?____

Primary Care Physician: ______________________________ Phone #: _______________

Other Health Care Providers (including specialty or type of provider):

____

What are your child's most important health problems? List as many as you can in order of importance.

1.____

2.____

3.____

4.____

5.____

What has already been done for the above mentioned problems?

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Homeopathic and Naturopathic Care for the Whole Family

Please list anything your child is sensitive or allergic to and their reaction

____

Does your child have a contagious disease at this time? Y N

If yes, what?____________________________________

Birth History

List major patterns of illness present in the child's birth mother, father, or extended families:

____

Did mother receive prenatal care? _______ Prenatal Vitamins? _______ Medications (type)? _______

Did mother smoke cigarettes? _______ Drink alcohol? _______ Illicit drugs (type)? _______

Any previous pregnancies not carried to term? Y N How many? _______ When? _______

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

____

Type of birth (eg: hospital, home, C-section)

____

Carried to term? _______ If no, how premature? ______________________________

Complications of labor or delivery:

____

____

Describe difficulties during infancy (eg. Colic, skin or lung problems):

____

Has your child had (please circle one)?

Rheumatic Fever	Y	N	German Measles	Y	N
Chicken Pox	Y	N	Measles	Y	N
Whooping Cough	Y	N	Chronic Ear Infections	Y	N
Asthma	Y	N	Allergies	Y	N

How often does your child get:

N = never O = occasionally F = frequent C = constantly

Colds ______ Sore throat ______ Earaches ______ Cough ______ Diarrhea ______

Constipation ______ Abdominal aches ________ Other ____________________

Has your child had any of the following? When and Where?

Electroencephalogram? ____

Psychological evaluation? ____

Hearing tests? ____

Speech/Language tests? ____

What hospitalizations/surgeries/injuries has your child had? When?

____

____

Immunization History

U = Up to date P = Partial N = Not done

Pre-school: ______ HBV (hepatitis B) ______ Hib (hemophilus influenza)

______ HAV (hepatitis A) ______ DTap (diphtheria, tetanus, pertussis)

______ IPV (polio) ______ MMR (measles, mumps, rubella)

______ Varicella (chicken pox) ______ PCV (pneumoccal bacteria)

School age: ______ Td (tetanus, diphtheria) ______ MCV4 (meningitis)

Other ______ Influenza

Reactions to immunizations?

____

____

Allergies

Is your child hypersensitive or allergic to:
Any drugs? ____

Any foods? ____

Any environmental toxins? ____

Breast fed? _______ How long? _______ Formula? _______ Milk or Soy _______

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Medications/Supplements

Please list any prescription medications, over the counter medications, vitamins or other supplements your child is taking (with dosages if known):

Symptoms

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

Describe problems in the following areas:

Digestion: ____

Skin: ____

Respiratory: ____

Urinary: ____

Behavioral: ____

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How many hours of sleep does he/she get? ______________ From _______ pm to _______ am

What is the quality of your child's sleep? ______________________________________

Is there any information about your child's health that you would like to add?

____

What expectations do you have for your child from working with our clinic?

____

____

____

____