

ALL NATURAL PEDIATRICS, PLC
The office of Terri L Barrett, ND

Dear Patient,

Thank you for the opportunity to be a partner with you in your health care.

We have included several important forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time more effectively. Please bring these forms in at your first office visit. The first visit will be a thorough assessment of your child's health and you should allow up to 2 ½ hrs for the visit.

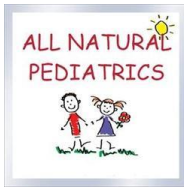
If you are unable to keep your scheduled appointment time, please let us know at least 48 hrs prior to the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in copies of any recent lab work or medical records as well as all the bottles of supplements and/or medications that your child is currently taking.

We look forward to seeing you. Our goal is to become a trusted partner in assisting you with your health care needs.

Health and Blessings,

All Natural Pediatrics



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FINANCIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing All Natural Pediatrics for your healthcare needs. Our healthcare provider and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

All Natural Pediatrics is a fee for service clinic. *Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.*

For your convenience, we accept cash, personal checks, Visa, MasterCard, and Discover. No personal checks will be accepted for your first visit. Returned checks are subject to a \$25 return fee and no further personal checks will be accepted.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that cover new material, require new information, take an extensive amount of time, or require a change in the treatment are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a standard follow up visit will be billed at \$70.

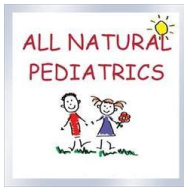
CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hrs of the appointment. There is no charge if an appointment is cancelled within 48 hrs. A cancellation with less than 48 hrs notice does not allow enough time for other interested patients to be scheduled and is a great inconvenience for our center. Thus, for naturopathic visits there is a \$100 charge for a new patient and a \$50 charge for follow up cancellations. Full service fees will be charged if no notice is given.

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I, the undersigned, have read, understand and accept the information and conditions specified in this document.

Patient or Parent/Guardian Signature

Date



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PATIENT – PROVIDER EMAIL AGREEMENT

Email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember, there are important differences. Email is not the same as calling the office; there is no person at the other end of the email – just a computer. You can't tell for certain when your message will be read or even if the doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication email affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us via email:

- Email is never appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Room for emergencies.
- Email is great for asking those little questions that don't require a lot of discussion.
- Email should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **Email is not confidential!** It is like sending a postcard through the mail. Our staff may read your emails to handle routine, non-clinical matters. You should also know that if sending emails from work, your employer has a legal right to read your email if he or she chooses.
- Email may become part of the medical record when we use it; a copy may be printed and placed in your chart.
- **Email is not a substitute for seeing your physician.** If you think that you need to be seen, please call and schedule an appointment!
- Emails may be forwarded to our staff for handling, if appropriate.

Finally either party can revoke permission to use the email system at any time.

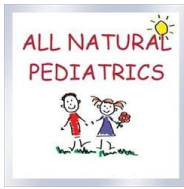
___ I **do** want to communicate with my doctor electronically. I have read the above information and understanding the limitations of security on information transmitted.

Patient Name: _____

Patient Signature: _____

Email Address: _____

Date: _____



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PATIENT REGISTRATION FORM

Date: _____

New Patient Information

Name: _____ DOB: ___/___/___ Age: _____ Sex: _____
Address: _____ City: _____ Zip: _____
Home Phone: (____) _____ Cell Phone: (____) _____
Email Address: _____

Additional Patient Information

Primary Care Physician: _____ Phone: (____) _____
Address: _____ City: _____ Zip: _____
Employer: _____ Phone: _____
Marital Status (circle): Single Married Separated Divorced With Partner Widow(er) .
Number of Children: _____
Name of Spouse/Partner: _____
Whom may we contact in case of an emergency: _____
Emergency Contact Phone: _____

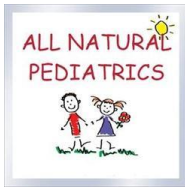
Referral Information

How did you hear of us? _____

Were you referred by a physician? ___ Yes ___ No

If "Yes" could you provide us with as much information as possible for the referring Physician?

Name: _____
Address: _____ City: _____ Zip: _____
Phone: _____



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NATUROPATHIC PATIENT INTAKE FORM

Patient Name: _____ DOB: _____

List in order of importance what your health concerns are:

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

When was the most recent lab work and with what physician? _____

Family History (Mark only if something significant)

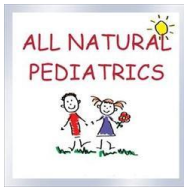
	Father	Mother	siblings	grandparents	spouse	children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer type	_____	_____	_____	_____	_____	_____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

Please note when & why you have had each of the following:

x-rays: _____ MRI/Cat Scans: _____
 Ultrasound: _____ Accidents: _____
 TB Test: _____ Hepatitis C: _____
 HIV: _____ Last Dental Visit: _____
 Last Eye Exam: _____



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Patient Name: _____

Did you have the following Disease (D), Get Immunized (I) or Neither (N):

Measles: D I N Chicken Pox: D I N Mumps: D I N Rubella: D I N
Tetanus: D I N Whooping Cough: D I N Homophilus (Hib): D I N Hep B: D I N
German Measles: D I N Any vaccination reactions? _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs/day & number of years: ____
Analgesics : Y N P Laxatives : Y N P Coffee : Y N P Cups per day : _____
Soda Pop: Y N P How much & how often: _____
Alcohol: Y N P How much & how often: _____
Any alcohol addition: Y N P Any Alcohol Treatment: Y N P When: _____
Recreational Drugs: Y N P Any Drug Additions: Y N P What: _____

List All Medicines (from drugstore or prescription) currently taking:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

List all supplements currently taking:

- 1) _____ 4) _____
- 2) _____ 5) _____
- 3) _____ 6) _____

Any known allergies to food, drugs, environment, animals: _____

Typical Day's Diet

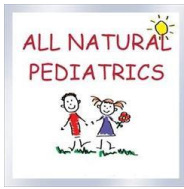
Breakfast:

Lunch: _____

Dinner: _____

Snacks: _____

Bowel Movements, how often? _____ Tend to be: Constipated Loose



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Patients Name: _____

Exercise

How often do you exercise? Daily ____ Times per wk _____ Never _____

What type of exercise? _____ For how long? _____

Sleep

How long per night? _____ Wake during night? Y N How many times? _____

Why? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep Walk: Y N P Grind Teeth: Y N P Snore: _____

Rate each of the following, on average, using a scale of 1-10 with 0 being none.

Energy level: _____ / 10

Stress level : _____ / 10

If you have fatigue, when is it worst? Morning afternoon evening

If you have fatigue, can you do what you need to get done during the day? Y N

Weight Management

Present Weight: _____ Weight one year ago: _____ Height: _____ BMI: _____

Maximum weight and when: _____ Minimum weight as adult & when: _____

Ideal Weight: _____ (weight at which you feel good)

Social Life

Enjoy job: Y N P Hours worked per week: _____ Highest Level of Education: _____

Active spiritual practice: Y N P Quality of significant relationship: _____

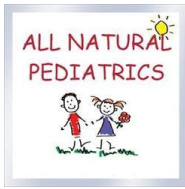
History of sexual/mental/emotional/physical abuse: Y N P

If so, at what age and by whom: _____

What is your greatest health concern: _____

How does it limit you the most: _____

How committed are you towards making valuable changes: Little Moderately Very



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Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what was the child exposed to? _____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? _____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors?

Do you spray pesticides, herbicides or other chemicals around your home?

