

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

Dear Parent/Guardian,

Thank you for the opportunity to be a partner in your family's 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 1 ½ hrs for the visit.

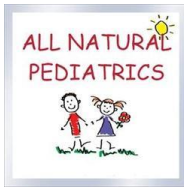
If you are unable to keep your scheduled appointment time, please let us know at least 48 hrs prior to the scheduled time so that we may allow other patients to have your appointment. We will be glad to reschedule your visit. Please help us to serve you better by keeping scheduled appointments.

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 meeting you and your family. Our goal is to become a trusted partner in assisting you with your family's health care needs.

Health and Blessings,

All Natural Pediatrics



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

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.

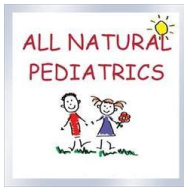
CANCELLATION POLICY

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



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

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.

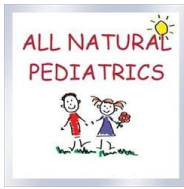
___ I **do** want to communicate with my doctor electronically. I have read the above information and understanding the limitations of security on information transmitted.

Patient Name: _____

Patient Signature: _____

Email Address: _____

Date: _____



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

PEDIATRIC PATIENT REGISTRATION FORM

Date: _____

New Patient Information

Name: _____ DOB: ___/___/___ Age: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Parent/Guardian Email: _____

Additional Patient Information

Pediatrician: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Mother's Name: _____ Occupation: _____ Phone: _____

Father's Name: _____ Occupation: _____ Phone: _____

Parents are (circle): Married Separated Divorced Living Together Other: _____

Whom may we contact in case of an emergency: _____

Relationship to patient: _____ Phone: _____

Referral Information

How did you hear of us? _____

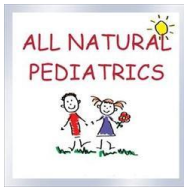
Were you referred by a physician? ___ Yes ___ No

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

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____



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

NATUROPATHIC PEDIATRIC INTAKE FORM

Patient Name: _____ DOB: _____

Sex: M F Grade in school: ____ Reason for office visit: _____

Has child been seen by any other doctor for this complaint? Yes No Past

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

List All Surgeries & Hospitalizations, including date occurred:

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

List All Medicines (from drugstore or prescription) child is on now:

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

List all supplements child is taking:

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

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

Previous Medical History

Yes (Y) indicates the child gets the problem regularly; NO (N) indicates the child never had the problem; PAST (P) indicates the child had the problem in the past, but not recently. Please circle the correct one for your child.

Ear Infections: Y N P If has had, how many total: _____

Colds: Y N P If has had, how many total: _____

Strep Throat: Y N P If has had, how many total: _____

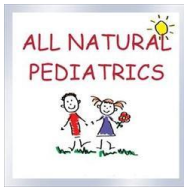
How many times has the child taken antibiotics? _____

What other medicines has the child taken and how often:

- 1) _____ 3) _____
2) _____ 4) _____

Hearing Tests Normal: Yes No Not Tested Speech Impediments: Yes No Past

Vision Tests Normal: Yes No Not Tested Learning Impediments: Yes No Past



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

Patients Name: _____

Vaccination History

Yes, has had **No**, has not **Some**, did not finish all shots

MMR: Yes No Some

DPT: Yes No Some

Hep B: Yes No Past

Hib: Yes No Some

Chicken Pox: Yes No Some

Polio: Yes No Past

Other: _____

Any reactions to vaccinations? If so, please explain: _____

Family History

Allergies: Y N P

Obesity: Y N P

Cancer: Y N P

Tuberculosis: Y N P

Mental Illness: Y N P

Cardiovascular Disease: Y N P

Diabetes: Y N P

Mother's Pregnancy History

Age at conception: _____ Did she have other children already? Yes No

Health During Pregnancy

Smoking: Y N

Diabetes: Y N

Coffee: Y N

Nausea/Vomiting: Y N

Recreational Drugs: Y N Emotional Stress: Y N Pre-eclampsia: Y N Length of labor: _____

Vaginal Birth: Y N Traumatic birth: Y N If the birth was difficult, please explain: _____

Place of birth: _____ Name of OB/Midwife/Doula: _____

Health of baby at birth: _____

Mom's Blood Type: _____ Baby's Blood Type: _____

Health History of Child

Baby's birth weight: _____ Birth length: _____ Head circum: _____

Did baby breathe/cry immediately? Y N Was baby jaundiced at birth? Y N

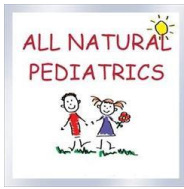
Was PKU Testing done? Y N Vitamin K? Y N Oral/Injection Hep B shot? Y N

Child breastfed: Y N For how long: _____ When put on formula: _____

What formula was used: _____ When was child put on solid foods: _____

And reactions/sensitivities with food introduction? _____

When did child walk: _____ Talk: _____ Develop teeth: _____



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

Name: _____

Jaundice as baby:	Y N	Colic:	Y N
Cradle Cap:	Y N	Anemia:	Y N
Eczema or Psoriasis:	Y N	Asthma:	Y N
Diarrhea:	Y N	Warts:	Y N
Constipation:	Y N	Nightmares:	Y N
Finicky Eating:	Y N	Bed-wetting:	Y N
Poor Teeth:	Y N	Tantrums:	Y N
Chronic Sniffles:	Y N	Disobedient:	Y N
Bad Foot Odor:	Y N	Fears/Phobia:	Y N
Very Sweaty Baby/Child:	Y N	Diaper Rash:	Y N
Hyperactivity:	Y N	Early Puberty:	Y N
Growing Pains:	Y N	Stomach Aches:	Y N

Has the child experienced, witnessed or gone through, any household stressors?

Social Development History

Mother's age _____ Father's age _____ Child has how many sisters? _____ Brothers? _____

Child is _____ in the family. (oldest, middle, youngest)

Other children's ages _____ / _____ / _____ / _____ / _____ / _____

Who spends the most time caring for child? _____

Does child go to daycare/babysitter/preschool on a regular basis? Y N

Are there any pets in the home? Y N How many? _____ Type? _____

Any smokers in the home? Y N

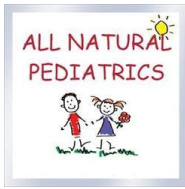
Concerns / Problems

Does your baby/child have any on-going problem(s) that concern you?

Please check all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> Eats too little | <input type="checkbox"/> Eats too much | <input type="checkbox"/> Speaks unclearly |
| <input type="checkbox"/> Cries a lot | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Wets bed |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Frequently constipated | <input type="checkbox"/> Small for age |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Sees poorly |
| <input type="checkbox"/> Doesn't always respond to noise / spoken words | | <input type="checkbox"/> Runny noses/cough |

Are there any other problems / concerns? _____



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

Patients Name: _____

Typical Day's Diet

Breakfast:

Lunch: _____

Dinner: _____

Snacks: _____

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?

