

Tahoe Center of Natural Medicine, 600 N. Lake Blvd., POB 5024, Tahoe City, CA 96145  
 Phone: 530.583.0002 Fax : 530.583.0044

**PEDIATRIC INTAKE FORM**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nickname(s):** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Sex:** *Male Female*

**Home Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Father's Name:** \_\_\_\_\_

**Sibling(s) {names and ages}:** \_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

*Besides mother and father, does anyone else take care of the child?* No Yes Who? \_\_\_\_\_

*Has the child received healthcare elsewhere?* No Yes Where? \_\_\_\_\_

*Has the child been immunized?* No Yes Which ones? \_\_\_\_\_  
 When? \_\_\_\_\_

*How would you rate this child's health in general? (Circle)* Excellent Good Fair Poor

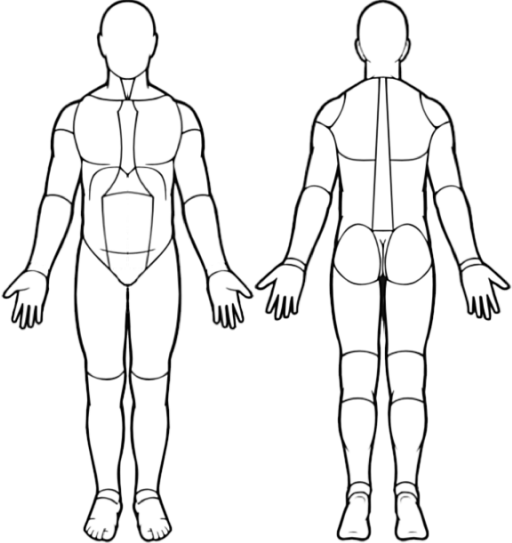
*Do you have concerns about the child's behavior or development?* No Yes What? \_\_\_\_\_

*Do you have any concerns about the child's nutrition or growth?* No Yes What? \_\_\_\_\_

*What goals do you have for your visit at the clinic today?* \_\_\_\_\_

*Do you have any questions about our clinic or care?* \_\_\_\_\_

**PRESENT HEALTH CONCERNS**

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Indicate painful or distressed areas:
1.		
2.		
3.		
4.		

Date of last physical/annual exam: \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

Please list any prescription medications, over the counter drugs, supplements, vitamins, herbs, homeopathic remedies, etc that the child is currently taking with dosages: \_\_\_\_\_

Please list any allergies to medication or life threatening allergies and reaction \_\_\_\_\_

**Family health habits:**

How often does your child use a seatbelt (car seat)? Never Rarely Sometimes Often Always

How often does your child wear a helmet when participating in sports such as bike riding, skiing, skateboarding, etc.?

Never Rarely Sometimes Often Always

Does your home have smoke detectors? Yes No Does your home have a fire extinguisher? Yes No

Does your home have carbon monoxide detectors? Yes No Do you feel that you live in a safe place? Yes No

Do you have guns in your house,? Yes No

If yes, what kind(s)? Handgun Shotgun Rifle Other: \_\_\_\_\_ Are they kept locked up? Yes No

Does anyone in your household smoke? Yes No If yes, who \_\_\_\_\_ how much daily? \_\_\_\_\_

Do you follow any particular diet regimens or restrictions? If yes, please describe: \_\_\_\_\_

**Past history: Please circle those that apply to child**

- Frequent Ear Infections
- Allergies, Hayfever
- Eczema, Psoriasis
- Anemia
- Heart Murmur
- Vision Problems
- Kidney, Bladder Infections
- Seizures
- Broken Bones
- Hearing Problems
- Bed Wetting
- Injury or Abuse
- Asthma
- Frequent Bronchitis
- Pneumonia/ Persistent cough

**Family Medical History:**

Please check the 'yes' box next to each condition that applies to the child's mother, father or other family members. Please note whether the condition is in the past or currently by denoting a 'P' for past, or 'C' for current. Indicate who had the condition in the 'Relation' column.

	YES	RELATION	DATE RESOLVED Past (P)/Current(C)		YES	RELATION	DATE RESOLVED Past (P)/Current(C)
Alcoholism/ Drug Addict'n				High Blood Pressure			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				Headaches			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			

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**INFORMED CONSENT FOR NATUROPATHIC TREATMENT**

I acknowledge that I am accepting treatment from a licensed Naturopathic Doctor (N.D) at the Tahoe Center of Natural Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors (N.D.'s) and Medical Doctors (M.D.'s).

Stephenie Riley is licensed by both the States of Washington and California as a Naturopathic Doctor. In the State of California, Naturopathic Doctors are licensed to diagnose and treat disease and have limited prescriptive rights.

I hereby authorize the Naturopathic Doctors of Tahoe Center of Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Common diagnostic procedures:** e.g. venipuncture, Pap smears, urine analysis.

**Minor office procedures:** e.g. ear lavage, skin scraping, skin cryotherapy.

**Medicinal use of nutrition:** e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

**Botanical medicine:** e.g. botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.

**Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

**Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

**Physical medicine:** e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.

I recognize the potential risks and benefits of these procedures as described below:

*Potential risks include but are not limited to:* allergic reactions and other side effects to prescribed herbs and supplements; aggravation of pre-existing symptoms; discomfort, pain, infection, burns, nausea, light headedness; inconvenience of lifestyle changes, injury from injections, venipuncture, or other procedures. Please notify Tahoe Center of Natural Medicine if you experience any symptoms which may be secondary to the above procedures.

*Potential benefits include but are not limited to:* restoration of health and the body's maximal functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

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

At this time, it is my decision to pursue Naturopathic treatment. I do understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all of the conditions I may have.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Tahoe Center of Natural Medicine, or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself, or my representative, or unless it is required by law.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician/Witness

\_\_\_\_\_  
Date



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**PATIENT CARE FINANCIAL POLICY**

**We are a cash-based practice.** At this time we are unable to accept, nor do we bill, insurance for any of our in-house services. Full payment of all charges is required at time of service. We accept payment by cash, check, and credit card. Checks denied for insufficient funds will incur a fee of \$35.00.

At this time we are not contracted with any insurance providers, and our services are not covered by insurance in California. As a courtesy, we will provide you with a Super Bill for services rendered. This can be submitted to your insurance company for review of possible benefits. The provided Super Bill, and any insurance submission for possible reimbursement, are the sole responsibility of the patient. ***Copies of Super Bills can not be reproduced if lost, please maintain copies for your own files.***

In the cases of financial hardship, special circumstances for payment may be considered. Such arrangements must be made in advance with the front office.

**First Office Call:** \$225 - 250 (This does not include required tests or supplements.)  
*Chiropractic Only Visit: \$90*

**Return Office Call:** 15-minute: \$60                      *Chiropractic Follow-up Only: \$50*  
30-minute: \$85  
45-minute: \$115  
60-minute: \$155

**Re-establishing Care:** \$175 - 225  
*Patients not receiving care for a period greater than 2 years will require an extended return office call to re-establish healthcare baselines.*

**Phone Consultations:** Charged accordingly with in-office visits.  
*The phone consultation fee is not charged if you are calling for clarification of an on-going medical therapy, or when the doctor has specifically requested you call with a treatment status. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call. Insurance does not reimburse for phone appointments.*

**Emails:** At this time we do not conduct patient communication via email.

**Cancellations:** We require a minimum of 24 hours for any changes to your scheduled appointment. *We reserve the right to charge for missed appointments, or appointments cancelled with less than 24 hours notice.*

**Supplements:** Nutritional supplements, herbs, homeopathics and other products are often recommended as a part of your treatment plan. We do carry most of the products we recommend at competitive prices, although you are free to purchase from any source you choose. However, products available to health care providers are often of a higher quality not found in many of over-the-counter brands.

**Other Tests:** We do not mark-up any outsourced testing services offered through our offices. For all out-of-office tests you will pay the lab directly, providing you with the lowest cost possible.

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Patient/Guardian Signature

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Date



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**FINANCIAL DISCLAIMER**

I claim full responsibility for services rendered at the Tahoe Center of Natural Medicine (TCNM). I understand that payment is required within full at the time of service, unless other arrangements have been made.

If other arrangements have been made, I am held responsible for making monthly payments until my bill is paid in full.

A Super Bill with diagnostic and procedural information is provided for you to submit to your insurance company for possible reimbursement. At this time I understand there is no official insurance reimbursement for naturopathic care. TCNM does not submit to insurance on the behalf of the patient, it is the sole responsibility of the patient. The Super Bill is provided at the time of service, they can not be reproduced later and should be maintained for your own records.

**It is our policy we receive 24-hour cancellation notice. If we do not, we reserve the right to charge the full fee for a missed appointment.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**PRIVACY RULE CONSENT**

By signing this form, you are giving Tahoe Center of Natural Medicine permission to use and disclose your protected health information for the purposes of treatment and payment associated with your care.

We have a “Notice of Privacy Practices” that provides more detailed information regarding how we may use and disclose your health information. You have the right to review this document I detail at any time. You have the right to request restrictions on how we may use and disclose your health information. We are not required by law to agree with your request, but we will do whatever we can to accommodate requests that are reasonable. You also have the right to revoke this consent in writing at any time, unless your health information has already been used or disclosed in reliance on this consent for the diagnosis, treatment or payment for the medical services for which you sought treatment.

A copy of our “Notice of Privacy Practices” may be obtained by contacting our offices at 530-583-0002, or in writing at POB 6869, Tahoe City, CA 96145. Please note that our “Notice of Privacy Practices” may be changed as needed to comply with Federal Law.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date