



NEW PATIENT PACKET

• welcome to our clinic •



First Visit Checklist

- Completed Intake Form**
Please bring the completed intake forms with you to your appointment. If you would like to send us your forms *before the day of your appointment*, you may scan and email them to: **info@thegolgiclinic.com**.
- Bring Lab or Imaging Reports**
If you have notes or reports from previous doctors visits that you feel might help us in treating you, please bring them to your first appointment.
- Parking**
Parking is available in the Caras Park Lot behind our building or on Front Street.
- Don't Go Upstairs**
When you enter our building, **don't** go upstairs. Upon entering our building, we're located on the main level (second floor) of 113 W. Front Street. Upstairs is actually the third floor.
- Plan to Arrive on Time for Your Appointment**
There is complimentary tea available in our reception area.
- Payment is Expected at the Time of Service**
Cash, check, Mastercard, Visa and Discover are all accepted. We do not bill insurance.

Pediatric Health Intake (Birth - 12 years)
Patient Information

Name: _____

Date of Birth: _____ Age: _____ Gender: Male / Female Year/Grade in school: _____

Parent/Guardian's Name: _____

Address: _____
appt/unit

City: _____ State: _____ Zip: _____

Parent/Guardian's Email: _____
 (check box if you would like to receive our free clinic newsletter)

Phone: (home): _____ (mobile): _____ (work): _____
Please circle number(s) where we may leave messages.

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

Reason for referral or today's chief complaint: _____

Has any other family member been a patient at our clinic? Yes / No If yes, who?: _____

How did you hear of us? _____

MEDICATIONS

NOW PAST

_____ Aspirin
 _____ Tylenol
 _____ Antibiotics
 _____ Ibuprofen

NOW PAST

_____ Decongestants
 _____ Anti-histamine
 _____ Other: _____
 Allergies to medicines: _____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, number of times: _____
 _____ Measles _____ Pneumonia _____ Ear infections, number of times: _____
 _____ Mumps _____ Frequent colds _____ Strep throat, number of times: _____
 _____ Rubella _____ Rheumatic fever _____ Other: _____

Has your child ever had any of the following?

	WHEN	WHERE	RESULTS
Electroencephalogram (EEG):	_____	_____	_____
Psychological evaluations:	_____	_____	_____
Hearing test:	_____	_____	_____
Speech/language tests:	_____	_____	_____
Injuries/surgeries/hospitalizations (please list):	_____		

IMMUNIZATIONS

_____ MMR _____ DPT _____ Chicken pox Others: _____
 _____ Measles _____ Diphtheria _____ Small pox Adverse reactions: Y / N
 _____ Mumps _____ Tetanus _____ H. influenza If so, what? _____
 _____ Rubella _____ Polio _____ The flu _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
 _____ Hypertension _____ Arthritis _____ Tuberculosis
 _____ Cancer _____ Allergies _____ Asthma
 _____ Mental illness _____ Osteoporosis _____ Other significant: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

_____ Bleeding _____ Nausea _____ Physical or emotional trauma
 _____ Illnesses _____ Hypertension _____ Cigarettes, alcohol, drug consumption
 _____ Medications _____ Diabetes _____ Thyroid problems

BIRTH HISTORY

Term: _____ Full _____ Premature _____ Late Weight at birth: _____

Length of labor: _____ Complications: _____

Did your child have any of the following problems shortly after birth?

_____ Rashes _____ Birth injuries _____ Blue baby
 _____ Jaundice _____ Seizures _____ Cerebral palsy
 _____ Colic _____ Fever _____ Birth defects
 _____ Other: _____

HEALTH HISTORY

Child's sleep patterns (1st year): _____

Food intolerance?: _____

Breast fed: Yes / No How long: _____ Formula: Yes / No Type (milk, soy): _____

Age began solids: _____ Which foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

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

DIET

Please describe your child's *typical* daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

THANK YOU. WE LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY WE CAN.

the golgi clinic, LLC

Parent, Guardian, or Responsible Party, please **read** and **initial** the following statements:

Consent to Treatment

_____ I authorize The Golgi Clinic to treat my child. I understand methods of treatment used in this practice may include, but are not limited to: homeopathic, herbal, craniosacral, and/or physical medicine, as well as others deemed appropriate. I am at liberty to seek alternate opinions or care, and may discontinue treatment at any time. I will not hold The Golgi Clinic responsible for treatment outcomes should I choose to disregard the doctors medical advice and treatments.

Payment & Insurance Policy

_____ Payment for all services and pharmacy items is due at the time of the visit. We accept cash, check, Visa, MasterCard or Discover. The doctors at The Golgi Clinic are not contracted providers with any insurance plan. If your plan has coverage for out-of-network naturopathic care we will provide you with the appropriate paperwork and coding to submit your own insurance claim. During your visit, your health care provider may prescribe medication, which may be purchased at The Golgi Clinic or elsewhere. Most insurance companies *do not* cover the pharmacy items that we prescribe and dispense.

_____ I understand that no refunds are offered for services rendered or pharmacy items purchased.

_____ Returned checks are subject to a \$22 non-sufficient funds charge from The Golgi Clinic.

Appointment Cancellation Policy

_____ I recognize that scheduling an appointment involves the reservation of time specifically for set aside for my child, consequently The Golgi Clinic requires that a valid credit card be placed on file to hold your appointment. To avoid being charged, a minimum of **24 hours notice** is required to cancel or reschedule an appointment. *We do not recommend appointment cancellations by email as we check it infrequently.*

Credit Card Form

I authorize my credit card to be placed on file at The Golgi Clinic.

_____ I understand that the above card will be charged for appointment-based fees incurred via phone or Skype and/or for any medication I wish to order from the clinic.

_____ I understand that on the day of my appointment I may use another credit card to pay for my visit. I further understand that while I must keep a card on file at The Golgi Clinic, I may change the credit card on file at any time.

_____ For missed appointments or those cancelled with less than 24 hours notice, **I understand that my card will be charged the full cost of my office visit (for in-office, phone, Skype, and craniosacral visits).**

_____ I understand that my credit card information will be kept in a secure, digital format once I've submitted it and that should I cease to be a patient, The Golgi Clinic will destroy my credit card information immediately.

Name on Credit Card _____

Credit Card Number _____ - _____ - _____ - _____

Expiration Date _____

Security Code (3 digits on back of card) _____

Billing Address Zip Code _____

Signature of Cardholder _____

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Notice of Privacy Practices

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 healthcare.

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

- To give you medical treatment or other types of health care, multiple providers may be involved in your treatment, both directly and indirectly
- To bill you or a third party for payment for services provided to you
- To assist law enforcement officials in response to criminal activities and to avert a threat to an individual or to public health safety (as in outbreaks of communicable disease)
- In response to a court or administrative order
- We may share your health information with a person(s) that *you have named* to be involved with your health care: **I hereby authorize privileged, confidential information about my treatment to be shared with the following people:**

_____ print name(s) of authorized people

You have the following rights relating to the medical records we keep about you:

- Right to inspect your health record and to receive a copy of your health record upon request
- Right to amend information in your health record you believe is inaccurate or incomplete
- Right to know to whom we have disclosed your health information
- Right to ask for limits on the health information data we give out about you
- Right to receive communication from us about your health information in alternate ways
- Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge having received and read the above-stated policies of The Golgi Clinic and will comply with them in all respects. If my insurance company requires the release of medical records, I hereby give my permission by signing this form.

_____ Print Name of Responsible Party (parent/guardian)

_____ Signature (parent/guardian)

____/____/____
Date

How Do I Check My Insurance Benefits*?

The Golgi Clinic is not contracted (in-network) with any insurance company. Many insurance plans reimburse a portion of their member’s out-of-pocket expenses at our clinic. If you have insurance and would like to bill them for the cost of your office visit, we’ve attached this helpful questionnaire to assist in determining what will be paid.

Insured Patient Name _____ Insurance ID# _____

Call the number on your insurance card listed for patient customer service. Then follow steps 1-6 when calling to find out benefits and eligibility.

1. When did my coverage begin and when is it valid thru?
 Beginning Date of Coverage _____ Ending Date of Coverage _____
 Does my insurance plan follow a Fiscal or Calendar Year Schedule? _____
2. Do I need a referral from my primary care physician (PCP) for alternative services? Y N
3. What are my benefits for the following services? *Be sure to find out whether your plan includes Out-of-Network coverage for the following benefits.

Specialties:

Naturopathic: % Covered; Co-pay/ Co-Insurance _____; Year Max _____

Chiropractic: % Covered _____; Co-pay/ Co-Insurance _____; Year Max _____

Lab work/X-rays: % Covered _____; Year Max _____

4. What is the insured person’s **individual** deductible for the year and has any or all of it been met?
 Deductible \$ _____; Amount of Deductible met so far \$ _____ Date today _____
5. Does the insured person’s plan have a **family** deductible? Y N
 Deductible \$ _____; Amount of Deductible met so far \$ _____ Date today _____
6. Are the specialties listed above subject to either deductible? Y N
 If so, which specialties? _____

What was the name of the representative I spoke with? _____

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.

***Please be aware that this is not a guarantee of payment, if an insurance company gives you inaccurate information they may not honor the benefits that were quoted.**