NEW PATIENT INTAKE FORM - CHILD

Welcome to Core Vitality Clinic. We will do our best to serve your healthcare needs, provide natural and safe treatments, and serve as a resource for natural health education. It is important to us that you read and understand our clinic policies. If you have questions about the policies, please be sure to ask. We encourage you to communicate any issues, complaints or special needs with us.

CLINIC POLICIES

Services. We offer an array of Naturopathic and Regenerative services, most of which are insurance-friendly.

Office Hours.

Mondays 8-5, closed for lunch from 12-1

Tuesdays 9-6, closed for lunch from 1-2

Wednesdays 9-5, lunch from 1-2

Thursdays 8-5, closed for lunch from 12-1

Fridays 9-6, closed for lunch 12-1

Contacting us. Telephone contact is available during office hours at **(541) 602-0260.** If you get voice mail, leave a message and our staff will return your call as soon as they can. If it is urgent, please let them know so there won't be a delay. If you prefer to email, the office email is info@corevitalityclinic.com. If you have an urgent matter outside of office hours, you can call the emergency cell of Dr. Thom Rogers at (360) 929-2550, or text Dr. Alicia Rogers at 360.969.5452. Note: there will be a charge for calls taken at the emergency number, minimum $40. If you have several questions, or want to speak directly to the doctor, our staff will recommend scheduling an appointment.

Payment. Payment is due at the time of service for procedures, office visits (non-insurance), copays and dispensary items. We accept cash, checks, Visa, and Mastercard.

Insurance. We are credentialed with BC/BS (Regence), Providence, PacificSource, Aetna, Cigna (Dr. Thom), United (Dr. Thom), Moda, and certain Samaritan plans. We use a billing company to bill your insurance & then bill you for balances. It is helpful if you have a general knowledge of your insurance coverage when you come in (whether you have coverage to see a naturopath, lab coverage, deductibles, etc.) We are not Medicare or Medicaid providers, but we offer a discount for payments at time of service, and a sliding scale.

I understand that I am financially responsible for all charges and agree to pay for the services and products I receive. If applicable, I authorize the provider to release to my insurance company any information necessary to process a claim. I authorize the insurance payment be made directly to the provider. Initials_____Date _____

Prescription Refills. Refills are best obtained by contacting the pharmacy and having them fax us a formal request. When a refill is requested, the doctor is required to review the chart and in some cases, may need to perform an exam prior to refilling the prescription. Allow 24-48 hours to refill all prescriptions. There is a $30 charge for same day refills.

Form Completion. If you have any forms to be filled out by the doctor outside of an office visit, please allow 1-2 days for completion. There will be a $20 charge to fill out paperwork outside of a visit (i.e. camp/sports/college physicals, medication forms for schools, HSA accounts, return to work, etc.). Special letters for insurance, pharmacy, reports, etc. will have a minimum charge of $30.

Cancellation policy. We appreciate if you give us at least 48 hours notice before canceling an appointment so we have sufficient time to fill that spot. If you cancel your appointment with less than 24 hours notice, there is a $50.00 charge for your empty time slot. The charge will only be waived in emergency situations.

I have read and understand that if I cancel within 24 hours of an appointment, I will be liable for a $50.00 cancellation charge. Initials _____Date _____

No Show Policy. If you make an appointment and don't call or show up for that appointment (barring emergency situations in which a call cannot be made) there is a charge of $50.00. This is charged to you and not your insurance. We provide courtesy reminder calls about appointments, but it is still your responsibility to keep track of your appointment times even if you do not receive a reminder call. We reserve the right to discontinue care to patients who do not keep their appointments.

I have read and understand the "No Show" policy and understand that if I fail to show up at my appointed schedule time, I will be charged $50.00. Initials _____Date _____

Confidentiality. You have the right to know how your privacy is being protected in accordance with the HIPAA Act of 1996. Your healthcare information is private and cannot be shared with anyone else without your signed consent. Your records are kept in your chart and secured in our clinic at all times. If charts are in the open, names are covered. Access to the clinic is limited to practitioners, employees, and supervised guests.

I have read and understand my right to privacy, as stated above, and agree to allow CVC to maintain my records confidentially in accordance with the law. Initials _____Date _____

Supplements. We stock a moderately large dispensary in our office and will prescribe items that you can buy here. When you need refills, it's best if you call a few days ahead to make sure we've got your items in stock. Sometimes, due to vendor backorders or other circumstances, we will not be able to get the same item and will give you a similar product as a substitute. We can also order directly from distributors to send items to your house if we are out.

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I hereby authorize Dr. Thom Rogers, ND, and Dr. Alicia Rogers, ND, to perform the following procedures as necessary to facilitate my diagnosis and treatment, including, but not limited to:

- **General Diagnostic Procedures:** general physical exams, blood draws and laboratory evaluation.
- **Herbal/Natural Medicines:** prescribing of various therapeutic substances, including plants, vitamins, minerals, hormones and animal materials. Substances may be given in the form of teas, pills, powders, tinctures – may contain alcohol; topical creams, pastes, suppositories, and other forms.
- **Homeopathic Remedies:** often highly dilute quantities of naturally occurring substances to gently stimulate the body's healing processes.
- **Dietary Advice and Therapeutic Nutrition:** use of foods, diet plans, or nutritional supplements for treatment.
- **Physical Therapy:** massage, muscle energy stretching, hot and cold therapies, and manipulations, and injection therapy may be used.
- **Lifestyle Counseling:** promotion of wellness, including recommendations for exercise, sleep, and stress reduction.
- **Pharmaceutical Drugs:** the appropriate use of prescription drugs.

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

Potential Risks: adverse reactions to prescribed substances, including interactions with certain medications or lab evaluations, aggravation of pre-existing symptoms, pain or lack of improvement of symptoms, injury from physical therapy, inconvenience of lifestyle changes.

Potential Benefits: restoration of health and the body's optimal functional capacity, 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, since some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by my Naturopathic Doctor regarding cure or improvement. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of procedure and treatment, based on the information known at the time and in my best interest. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue care at any time.

I intend this consent form to cover the entire course of treatment for my present condition/s, and for any future condition/s for which I seek treatment here.

Patient Name (Printed) Patient/Guardian Signature Date

Core Vitality Clinic T(541) 602-0260 F (541) 753-4217
650 SW 3rd St. Corvallis, OR 97333

NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Name (Child)_____Name (Parent/s)_____

Parent email_____ Phone_____Text Ok? Y N

Address _____City _____State _____Zip _____

Date of Birth _____ Social Security Number _____ Age_____

Emergency Contact/other parent _____ Phone _____

How did you hear about us? _____

_____

EMPLOYMENT/SCHOOL INFORMATION

What do you do for work (Parent)?_____

Employer _____

If child is in school, where, & which grade level_____

INSURANCE INFORMATION

Insurance Company/Plan Name _____

ID Number/Claim Number _____ Group Number _____

Who is the Main Policy Holder?_____

CONFIDENTIALITY

You have the right to confidentiality when receiving care from providers. We will not disclose medical information to anyone unless directed to do so in writing by you. If you would like us to leave messages regarding your health care on an answering machine or with another person, please list them below and indicate which voice mail or email we may leave messages on: _____

What are your concerns today?

From the following list of problems, please circle those that pertain to him or her:

Fatigue	Runny nose	Cough	Diarrhea
Constipation	Dizziness	Shortness of Breath	Stomach aches
Frequent Colds	Chest Pain	Depression	Anxiety
Headaches	Heart Palpitations	Disturbed Sleep	Excess Stress
Allergies	Aches and Pains	Eating problems	Rashes
Irritability	Nervousness	Learning problems	Weight issue

Other:

Please list any medical problems your child has or has had in the past:

Please list any injuries, accidents, surgeries or hospitalizations he or she has had:

Is he or she allergic to any medications? Yes No

If yes, please list medications he or she is allergic to:

_____

_____

Please list any medications and supplements he or she is currently taking:

_____

_____

Briefly describe his or her diet on a typical day:

_____

_____

_____

_____

Please list any health problems of members of your immediate family (mother, father, brothers, sisters and children):_____

_____

_____

X_____

Parent Signature/Date