Head to Toe Holistic Healthcare

Patient Legal Name: _____ Date of Birth: _____ Gender: **M F Other**

Patient Preferred Name: _____ Marital Status: **Married Single Other**

Is the patient a minor? **Yes No** If yes, parent / guardian name(s): _____

Mailing Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred phone? (circle one) **Home Cell**

Preferred reminder method? (circle one or more) **Call (Home) Call (Cell) Text Cell Email**

Email address(es): _____ Is it okay to contact you via email? **Yes No**

Employer: _____ Work Phone: _____

Spouse: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number (s): _____

Is this a workers comp or personal injury claim? Yes No

PRIMARY INSURANCE INFORMATION:

Company Name: _____

Primary Policy Holder Name: _____ DOB: _____

Primary Policy Holder Relationship to Patient: **Self Spouse Child Other:** _____

ID #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Company Name: _____

Primary Policy Holder Name: _____ DOB: _____

Primary Policy Holder Relationship to Patient: **Self Spouse Child Other:** _____

ID #: _____ Group #: _____

Please provide the Front Desk with your insurance card(s) including any Medicare / Medicaid cards, as well as an ID Card.

121 W Fireweed Lane, Suite 100, Anchorage, AK 99503
P (907) 222-6887 F (907) 222-6877

PAYMENT FOR SERVICES:

Please read, initial where indicate, and sign below.

PATIENT RESPONSIBILITY: (please initial on each line)

_____ Insurance is not a guarantee of payment.

_____ We cannot accept Tri Care, Denali Kid Care, Medicare, Medicaid, or AARP Supplemental Plans.

_____ It is your responsibility to call your insurance company prior to your appointment to determine if your visit will be covered.

_____ We will try to let you know if you have an insurance company that will not cover naturopathic visits (these include UMR, Aetna Conoco Phillips and Aetna Tesoro). If your company does not generally reimburse for naturopathic visits, you may be asked to pay up front while the claim is being filed.

_____ We will bill your insurance if you present your insurance cards at the time of your appointment. It is important for you to know that we are not always contracted with your insurance carrier. This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered.

_____ If you have a personal injury or workers comp claim, you will be responsible for the charges at the time of the visit. We will give you the paperwork so you can file for reimbursement with your insurance company.

_____ Any co-payments or "patient responsibility" percentages must be paid at the time of service.

_____ If we do not receive a response from your insurance company within 45 days from the date we bill them, the balance will become your responsibility.

_____ You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time.

_____ If we do not receive your payment in full within 90 days from the date of the first statement or have not heard from you about setting up a payment plan by that time, your account may be turned over to a third-party collection agency.

_____ Injections and dispensary items are not covered by insurance and must be paid in full at the time of the visit.

We accept cash, checks, and all major credit cards. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment in full at the time of service is required in the following circumstances:

- You do not have insurance coverage, or are covered by a plan we are unable to accept
- You are covered by a personal injury or workers comp claim
- You have not brought your insurance cards with you
- You have not met your deductible
- A contract is required by your insurance policy and we are not contracted with your insurance carrier
- For dispensary items, injections, or other procedures or treatments not covered by insurance

LAB WORK:

If you are a Blue Cross / Blue Shield Patient, we CANNOT bill labs for you. You will be responsible for dealing with the lab and insurance company directly for these, and will need to contact them with any questions. If you have other insurance, we will bill labs for you, but any amount not covered by your insurance company will be your responsibility and we will bill you directly for that.

By signing below, you acknowledge that you have read and understood the above statements and are willing to accept responsibility for services rendered if not covered by insurance. You also understand that you are responsible for laboratory charges not covered by insurance. This authorization is not limited in time.

_____ _____

Patient Signature (or responsible party) *Date*

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PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

This consent form, when signed, gives us permission to release necessary medical information to your medical insurance provider to process your claim, as well as to the pathologist, lab, or other doctor(s) who may be consulted in your diagnosis and treatment. Each of the above will also treat your information with the strictest confidence. This signed consent form gives us authorization to provide your information to a specific person other than yourself. Your information is otherwise confidential.

By signing below, you understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Head to toe Holistic Healthcare (HTTHH) has a Notice of Privacy Practices and you have the opportunity to review this Notice.
- HTTHH reserves the right to change the Notice of Privacy Practices. If we change our Notice, you may obtain a revised copy by contacting our office.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- HTTHH may alter provision of services upon the execution of this Consent.
- In addition, you acknowledge receipt of the HTTHH Notice of Privacy Practices provided to you today.

Do we have your permission to:	(please circle)	
Leave a message on your cell phone?	Yes	No
Leave a message on your answering machine at home?	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your medical condition with any member of your household?	Yes	No
If yes, whom: _____		
Relationship: _____		
Consult within Head to Toe Holistic Healthcare?	Yes	No

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient or Personal Representative | Relationship / Description of Personal Representative's Authority

_____ _____

Signature of Witness | Date

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PEDIATRIC INTAKE
(0 –12 years)

Name_____ Age_____ Birthdate _____

Birth weight _____ Sex _____ Race _____Today's Date _____

Name of parent(s) / caretaker(s) _____

What are the child's chief complaints or reason for the visit?

1)

2)

3)

What treatment (if any) has been undertaken?

Birth history:
If this child was adopted, please provide details (age at adoption, country of origin, etc.):

Did the mother receive prenatal care? _____ Prenatal vitamins?_____

Any difficulties with pregnancy (nausea, vomiting, bleeding, etc.)?_____

_____

Did mother smoke cigarettes?_____Drink alcohol? _____Take drugs?_____

What type of birth (eg. hospital, home, C-section) _____

How long was the labor? _____ Complications of labor or delivery? _____

Carried to term? _____ If no, how premature _____

Family background:

Who does the child live with? _____

Are the parents divorced or separated? _____

If so, what, if any, arrangements are made with the other parent (eg. visitation): _____

_____

Please list age and gender of siblings; indicate half, step or deceased where applicable.

Health history:
Describe difficulties during infancy (e.g. colic, skin rashes or lung problems)?

How often does your child get (never, occasionally, frequently, constantly):

Colds_____Sore throats_____Earaches_____Coughs_____

Diarrhea_____Constipation_____Tummy aches_____

Other_____

Describe any problems in the following areas:

Digestion:

Skin:

Respiratory:

Urinary:

How much sleep does he/she get? From_____p.m. to_____a.m. Quality?_____

Serious illnesses or hospitalizations (include dates and reason):

Allergies:

Please list any medications (including antibiotics) your child is taking or has taken in the past. Please indicate reason.

Please list any supplements your child is taking:

Immunizations	Dates					
Hepatitis B						
Diptheria, Tetanus, Pertussis (DTaP)						
Haemophilus Influenzae Type B (Hib)						
Polio (IPV)						
Measles, Mumps, Rubella (MMR)						
Varicella (chicken pox)						
Pneumococcal (PCV)						
Hepatitis A						
Influenza						

Any adverse reactions to immunizations?

Diet:

Was/is the child breastfed?_____ For how long?_____

At what age were solid foods introduced?_____ What were they?_____

_____

What foods does he/she typically eat?_____

_____

Environmental:

Do you have indoor pets?_____ If so, what type?_____

What type of dwelling do you live in?_____How old?_____

How do you heat your home?_____

Does anyone in your house smoke?_____

Development:

Was this child early or late in rolling over, teething, walking or talking?_____

_____

Any difficulties with school (describe)? _____

_____

How would you describe the child's:

personality _____

intelligence _____

Is there anything not covered in this questionnaire that you feel is important for the doctor to know about?

Please complete family health history on page 4

Please indicate any conditions that exist in the child's birth mother or father or their families.

Condition	Child	Mother	Father	Brothers	Sisters	Grndprnts	Others
Alcoholism							
Allergies							
Anemia							
Anorexia/Bulimia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Cancer/Leukemia							
Depression							
Diabetes							
Drug Abuse							
Emphysema							
Epilepsy or Seizures							
Gallbladder Disease							
Glaucoma/Cataracts							
Gout							
Heart Attack							
Heart Disease-circulatory problems							
Hepatitis or Liver Disease							
High Blood Pressure							
Hypoglycemia							
Kidney or Bladder Disease							
Kidney Stones							
Malaria							
Mental Illness							
Migraine Headaches							
Mononucleosis							
Multiple Sclerosis							
Muscular Dystrophy							
Obesity							
Osteoporosis							
Physical Abuse							
Rheumatic Fever							
Sexual Abuse							
Scoliosis (curvature of the spine)							
Stroke							
Suicide							
Thyroid Problems, Goiter							
Tuberculosis (TB)							
Ulcers							
Sexually Transmitted Diseases							
Other:							

Thank you for taking the time to fill out this questionnaire