Natural Care MD
Caring for your health naturally!

Dr. Nagaratina Salem, M.D, P.A.
Adriane Nelson, CPNP
Shelly DeLisle, CPNP

Phone (214) 383-4400 Fax (214) 383-4403
www.NaturalCareMD.com

New Patient Enrollment

Welcome! We thank you for choosing us to serve your healthcare needs. The information requested on this form will enable us to serve you better. Thank You.

PLEASE FILL OUT FORM COMPLETELY, INITIAL, SIGN AND DATE

Patient's Name _____D.O.B._____ M / F
Home Address_____
City_____ State_____ Zip Code_____
Cell Phone#_____ Home Phone#_____
Email Address_____
Pharmacy _____ Ph. _____
Emergency Contact Name: _____Ph._____

SIBLING INFORMATION

Name_____ D.O.B._____ M / F
Name_____ D.O.B._____ M / F
Name_____ D.O.B._____ M / F

PARENT INFORMATION

Mother's Name_____ Father's Name_____
Cell #_____ Cell #_____
Occupation _____ Occupation_____
Employer_____ Employer _____
Driver's Lic. State/#_____ Driver's Lic. State/#_____
SSN: _____ DOB: _____ **SSN: _____ DOB: _____**
Please Circle Parents Status: Married Single Widowed Separated Divorced
PRIMARY Insurance Holder Name: _____
How did you hear About Our Office? _____

Craig Ranch Pediatrics will not provide health care to minors without a parent/legal guardian*, parent's written consent or contact from the parent/legal guardian giving said consent. I give consent to the following people to seek medical treatment and receive information regarding my child in my absence:

Name _____ Relation _____Tel _____
Name _____ Relation _____Tel _____

Medical History Form

A. Birth History: Birth Weight:_____ Birth Length:_____ Obstetrician:_____

Prenatal Problems? __No __Yes (e.g. diabetes, high blood pressure)
Labor/Delivery: __Normal Vaginal Birth __C-section
__Other Problems_____

Newborn Problems? __No __ Yes (e.g. premature, jaundice, infection)
Hearing Screen: __Pass __Fail
Newborn Screen: __Normal __Abnormal:_____

B. Past Medical History:

Date of last check-up: _____ Where? _____
Date of last dental check-up: _____ Where? _____
Previous Hospitalizations: _____
Previous Surgeries: _____
Medical Illnesses: (e.g. asthma) _____
Allergies: (medications, foods) _____
At what age did your child: Sit alone____ Walk____ Talk____ Toilet (potty) train_____
Grade in School: _____ Where: _____

C. Social & Family History

MEMBER	NAME	AGE	SEX	HEALTH	OCCUPATION
Mother					
Father					
Siblings					

Family Medical History: Are any family members with the following diseases? (Please circle)
Asthma, Allergies, Cancer, Seizures, Birth Defects, Heart Disease, Liver Disease, Diabetes, High Blood Pressure.
Other? If so, who & which disease _____
_____

Home Environment:
Live in: __own house __own apartment __shared home __shared apartment
Smokers in household: __no __yes:_____
Animals in household: __no __yes:_____
Is child in daycare: __no __yes:_____

Natural Care MD Policies

Below are the standard policies that every Parent/Guardian of the patients must be aware of and follow. The same information is also available as a soft copy on our website under Patient Forms. Before providing health care, a signed consent to Privacy, Treatment, Appointment, Payment policies, Patient Medical information/history and authorization for release of records are mandatorily required.

1. Privacy Consent

I understand that as part of my healthcare, **Natural Care MD** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

The *HIPAA Privacy Rule at* **www.hhs.gov/ocr/privacy/** provides specific information and complete description of how personal health information may be used and disclosed. I understand that I have access to the *HIPAA Privacy Rule* and have reviewed the notice prior to signing this consent. Natural Care MD will be using the Patient Portal to communicate with the patient to maintain HIPAA compliancy and I agree to use the same.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. Consent to Treatment

Natural Care MD will not provide health care to minors unless accompanied by a Parent/legal guardian, or have a parent's written consent or there is a way to contact the Parent/legal guardian and obtain consent.
Exceptions: (1) Child abuse (2) Patient seeking counseling/family planning services (3) Treatment for drug/alcohol abuse. (4) Treatment for STDs (5) Suicidal ideation (6) All routine pediatric immunization

If parent cannot be contacted, the following may consent in this order: **Grandparents, adult sibling, aunt, uncle**. For questions regarding this, contact Texas Department of Health, Adolescent Health Promo at 512-458-7111 Ext 2021. You can provide consent to up to three people to bring my child to **Natural Care MD** for medical treatment in your absence. Please note that Legal guardians should bring all related documents to prove guardianship, before patient can be seen.

As the Parent/legal guardian of the child designated as patient, I hereby authorize **Natural Care MD** to perform the required medical treatment considered advisable for the patient. I understand that no guarantees can be made as to the eventual outcome of medical treatment advised or performed. I also understand that written authorization is required before allowing anyone other than parent or legal guardian to bring child to the office to be examined.

3. Advertising/Promotion of goods or products Policy

Based on the Provider's prior experience with certain health related products, Patient's feedback on the product's effectiveness, direct observations of health improvements and Supplier's Supplemental facts/information, we promote/sell certain health related products such as Dietary Supplements, Oils and Vitamins at the office and/or on our website as a normal course of business. While we do receive financial remuneration, the products are sold at a reasonably low cost and are primarily for the convenience of our Patients. The same or equivalent products are available at the local stores/online. The Patient/Customer is under no obligation to purchase these products from us. Purchasing or not purchasing products from us will not change how we treat them.

I have read, understand and hereby agree with the Promotion/Sale of goods/products policy. I understand that purchasing products at the office or their website is completely optional. I also understand that I am not being forced nor required to purchase in order to receive any special treatment or provide favors to the Providers. If I do purchase, it is out of my own free will and decision.

4. Consent to Payment/financial Policy

- Patient or Person responsible (Guarantor) must present insurance card at the time of visit. It is your responsibility to ensure that the insurance (incl Medicaid) is valid/active and all patients including newborns are covered under the insurance plan.
- While we will put in our best effort to validate eligibility, it is your responsibility to ensure that the providers are in-network with your insurance plan incl Medicaid and if necessary chosen as "Primary Care Provider (PCP)" prior to the visit.
- If you do not have ANY insurance or we are unable to validate eligibility, payment in full is required at the time of service.
- Co-payments, deductibles, other office fees and any outstanding balance are due upon check in.
- Based on the services provided, additional money may be due at check out.
- If office is not notified of insurance changes within 30 days of service, payment in full is required.
- For claims denied by insurance incl Medicaid for ANY reason, patient or responsible party is accountable and is required to pay the denied amount for the services already provided.
- Payments can be made in the form of cash, debit cards or credit cards only. Personal checks are not accepted.
- Forms of payment (credit card, health savings card etc.) will be stored on file to charge for payments due.
- There is a 2% interest fee for all balances over 60 days.

I understand that I am financially responsible for all charges for our services not reimbursed or reimbursed inadequately from my insurance company including Medicaid.
I have read and agreed to the above financial policies. I assign insurance benefits to be paid directly to Natural Care MD. I authorize release of all medical information to the insurance company for purposes of filing insurance claims. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional / medical services rendered. I have read all the information on this Sheet and have completed the forms (portal or paper) to the best of my knowledge. I will notify you of any changes in my health insurance status or patient information within 3 business days.

5. Late/Missed Appointment/No Show Policy

If you arrive for your appointment more than 15 minutes late, there is a chance that we will not be able to accommodate you due to the length of time it takes to provide service. If you are running late, please call us ahead of time so that we will be able to determine if your child can still be seen despite a late arrival or if it is necessary for us to reschedule your appointment.

Our No Show policy is for all patients. Each confirmed appointment that you miss or arrive late over 15 mins, you will be charged $25 per child per visit. This charge is not covered by insurance and is patient responsibility. To avoid these charges PLEASE call us to cancel your scheduled appointment 24 hours in advance before the appointment. If your appointment is early in the morning, please call the previous day to avoid the NO Show charge. This will allow us time to fill the appointment time with other children who need to be seen. For any unscheduled appointments (Walk Ins) that we accommodate there will be a $15 charge out of respect for our scheduled patients.

6. Release of Patient Medical Information (PHI)

I authorize release of all medical information to the insurance company for purposes of filing insurance claims. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

I have read, understand, agree and provide consent to Natural Care MD
(Initial here)_____ Privacy Consent
(Initial here)_____ Consent to Treatment
(Initial here)_____ Advertising/Promotion of Goods or Products Policy
(Initial here)_____ Missed/Late Appointment/No Show Policy
(Initial here)_____ Consent to Payment/financial Policy
(Initial here)_____ Release of Patient Medical Information (PHI)

I will abide by the policies, uses and disclosures stated herein. I assign insurance benefits to be paid directly to Natural Care MD (also known as Craig Ranch Pediatrics) and/or Dr. Nagaratina Salem.

Printed name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date: _____