

Pediatric & Family Center for Natural Medicine

857 North Main Street Ext Unit 2 Wallingford CT 06492

Phone: 203-265-0444

Fax: 203-265-0472

Patient Name: _____

Patient Date of Birth: _____

Patient Sex: M / F

Address: _____

City: _____ **State:** _____ **Zip:** _____

Guardian's Name: _____ (if patient is a minor)

Relationship: _____ (if patient is a minor)

Cell Phone: _____ **Home Phone:** _____

Used for appointment reminders via text

Email: _____

Emergency Contact: _____ **Relation:** _____

Phone: _____

How did you learn about us? _____

Submission of claims is not confirmation of insurance reimbursement. Please understand that insurance companies will not guarantee medical/naturopathic benefits. As your insurance company processes claims and notifies us of any patient balance, you will be billed accordingly. Please contact your insurance company to verify coverage. All payments are due at time of service for office visit charges and nutritional supplements, which are not covered by insurances.

A \$50 return check fee will apply to all returned checks.

Cancellations (with less than 24-hour notice) and missed appointments will be subject to a \$50 charge.

I understand and agree to the above criteria.

Signature _____ **Date** _____

If patient is under 18: I hereby authorize medical treatment for my child to be received by PFCNM. I understand I have the responsibility of my child's healthcare, and have legal control of their medical records until the age of 18.

Guardian's Name (print) _____ Guardian's Signature _____

Please list current medical condition & health concerns (*Reason for today's visit*):

Current medications & supplements (*Please include dosage if able*):

Allergies: _____

Past Medical History (*Please check boxes if 'yes' and include dates if able*):

- Cancer _____
- High Blood Pressure _____
- Lung Disease _____
- Rheumatic Fever _____
- Surgeries (types & dates) _____
- Diabetes (Type I or II) _____
- Heart Disease _____
- Arthritis _____
- Seizures _____
- HIV/AIDS _____
- Ulcers _____
- Hepatitis _____

Other _____

Family History (*Please check the box if an immediate family member – mother, father, sibling, aunt, uncle, grandparent or child – has any of the following conditions*):

- Cancer _____ (type)
- High Blood Pressure
- High Cholesterol
- Mental Illness
- Alcoholism
- Inherited Blood Disorder
- Diabetes (Type I or II)
- Heart Disease
- Arthritis
- Seizures
- Asthma
- Other _____
- Stroke
- Ulcers
- Hepatitis
- Allergies
- Autoimmune Disorder

Life Style:

Cigarettes _____ (*packs per day*) Coffee Tea Soda
Alcohol _____ (*glasses per week*) Sweets Salt

Exercise (*type & number of times per week*) _____

Diet (*food restrictions or sensitivities*) _____

Women Only:

Age menses began: _____ First day of last period: _____ Length of Cycle: _____
Date of last Pap smear: _____ Any abnormal paps? Y / N Date/Year: _____

**Acknowledgement of Receipt of Notice of Privacy Practices for
Pediatric & Family Center for Natural Medicine**

Patient Name: _____ DOB: _____

Address: _____

I have been given/viewed a copy of Pediatric & Family Center for Natural Medicine Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Pediatric & Family Center for Natural Medicine has the right to change this Notice at any time. I may obtain a current copy by contact the facilities privacy official.

My signature below acknowledges that I have been given/viewed a copy of the Notice of Privacy Practices for Pediatric & Family Center for Natural Medicine. Please ask front desk if you would like a copy.

Signature of Patient or Patient Representative

Printed Name of Patient or Patient Representative

Date: _____

I _____, give the following people permission to speak to office staff/doctors regarding my care and treatment/financial care.

Name	Relationship	Phone #
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Signature of Patient/Representative: _____

Print name: _____ Date: _____

Please read and sign the following acknowledging our No Show Policy for missed appointments and for paying any balance due upon Insurance EOB receipt.

There is a \$50 No Show Fee for missed appointments. We require a credit card to be kept on file and your card will be charged the No Show fee if you fail to show for your appointment.

Our electronic scheduling system, Charm, sends two text reminder's, one when your appointment is booked and one 2 days prior to the appointment. Confirmations are a courtesy and do not negate the No Show policy if you do not receive a text message. To protect your information, no hard copy of your credit card will be kept, but will be stored electronically.

Also, any patient balance will be charged to the credit card on file upon receipt of the insurance EOB if patient responsibility differs from what was signed for any copay's, co-insurance, deductibles or insurance denial. We verify your insurance benefit as a courtesy and cannot be held responsible for any incorrect benefit information obtained. Receipts of any charges will be mailed to you along with explanation.

Credit Card number: _____

Expiration Date: _____

Thank you for your understanding.

Name of Patient

Signature of Patient or Guardian

Date

SELF PAY ONLY - NOT IN OFFICE VISIT

Your visits will be at an out- of- pocket cost to you of \$400.00 for initial visit then \$200.00 for follow up visits not including supplements. **Phone or Zoom appointments will be charged 24-48 hours prior to appointment.** (Dr. Skowron.)

Patient / Legal Guardian signature

Date