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: MALE / FEMALE

Address: _____

City: _____ State: _____ Zip: _____

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

Relationship: _____ (if patient is a minor)

Cell Phone: _____ (Used for appointment reminders via text)

Home Phone:_____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 if 'yes' and include dates if able):

Cancer _____ **Diabetes (Type I or II)** _____ **HIV/AIDS** _____

High Blood Pressure _____ **Heart Disease** _____ **Ulcers** _____

Lung Disease _____ **Arthritis** _____ **Hepatitis** _____

Rheumatic Fever _____ **Seizures** _____

Surgeries (types & dates) _____
_____

Other _____

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

Cancer _____ **(type)** **Diabetes (Type I or II)** _____ **Stroke** _____ **Arthritis** _____

High Blood Pressure _____ **Heart Disease**_____ **Ulcers** _____ **Allergies** _____

High Cholesterol _____ **Hepatitis** _____ **Mental Illness** _____ **Seizures** _____

Alcoholism _____ **Asthma** _____ **Autoimmune Disorder** _____

Inherited Blood Disorder _____ **Other** _____

Lifestyle:

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

Diet (food restrictions or sensitivities, sweet/salt cravings):

_____

Exercise (type & number of times per week) _____

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:** _____

PRIVACY PRACTICE NOTICE

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: _____

Date: _____

Printed Name of Patient or Patient Representative: _____

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:_____

FINANCIAL POLICY

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 for any payment due 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 reminders', 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: _____

CVV: _____

Name of Patient: _____

Signature of Patient or Guardian: _____

Date: _____

SELF PAY ONLY – PHONE/ZOOM/SKYPE for Dr. Skowron

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.

Eff 2/1/20 the self-pay rate will increase to $500 for the initial visit and $250 for follow ups.

Patient / Legal Guardian signature: _____

Date _____