BIG SKY INTEGRATIVE HEALTH, PC

8707 N. JACKRABBIT LN. STE. E,

BELGRADE, MT 59714

(406)-388-6676

New Born Intake to 5 Years Old

Name _____ Date _____

Age _____ Date of birth _____ Sex F M

Mother _____ Father _____

Telephone: (Mother) _____ (Father) _____

Address _____

City _____ State _____ Zip code _____

Insurance

Insurance: _____ Primary Holder's Name: _____

Subscriber ID#:_____ Group #: _____

Primary's DOB: _____ Primary's Phone: _____Relationship:_____

Primary's address: _____

Primary's City, St, Zip: _____ Primary's SS#: _____

How did you hear about the clinic? _____

Name and address of Dr.'s office/hospital/clinic where your child's health records are kept._____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

1)_____

2)_____

3)_____

4)_____

Medications

	Now	Past		Now	Past
Aspirin	___	___	Antibiotics	___	___
Decongestant	___	___	Tylenol	___	___
Anti-histamine	___	___	Ibuprofin	___	___
Inhalers	___	___	Asthma meds	___	___
Topical steroids	___	___	Others	___	___

Allergies to medications: _____

_____

Medical History

____chicken pox ____scarlet fever ____bronchitis ____mumps
____frequent colds ____eczema ____measles ____pneumonia
____croup ____rubella ____mumps ____asthma
tonsillitis, number of times _____ ear infection, number of times _____

other_____

X-rays and Special Studies

	When	Where	Results
Electroencephalogram			
Psychological			
Hearing			
Speech/Language			

Family History

____heart disease ____diabetes ____hay fever ____mental illness
____hypertension ____cancer ____tuberculosis ____allergies ____arthritis
____eczema ____birth defects
Previous pregnancies by natural mother, miscarriages or complications:

_____

Mother's age at child's birth_____
Mother's health during pregnancy:
____bleeding ____hypertension ____cigarettes, alcohol, drugs ____diabetes
____nausea ____thyroid problems ____physical or emotional trauma ____illness

Birth History

Term: Full____ Premature____ Late____ Weight at birth_____
Length of labor_____
Complications_____
_____
As a baby, did your child have any of the following problems?
____jaundice ____diarrhea ____birth defects ____rashes ____colic
____fever ____cerebral palsy ____allergies ____blue baby ____seizures
____birth injuries____ other_____
Feeding: Breast fed_____ How long?_____ Formula_____ Milk/soy _____
Age began: Solid foods_____ Sitting_____ Crawling_____
Walking_____ First words_____
Child's sleep patterns first year _____
_____

Injuries/Surgeries/Hospitalizations

_____
_____

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Any adverse reactions?	Y N	If yes, what ? _____	

Symptoms

Please circle: Y = current condition N = never had. P = past condition

Hives	Y N P	Burning of urine	Y N P	Dizzy spells	Y N P
Eczema	Y N P	Bloody urine	Y N P	Cries easily	Y N P
Flat feet	Y N P	Frequent urination	Y N P	Nervous	Y N P
Nose bleeds	Y N P	Motion/car sick	Y N P	Easy bruising	Y N P
Acne	Y N P	Vomiting spells	Y N P	Night sweats	Y N P
High fevers	Y N P	Sensitive to light	Y N P	Unusual fears	Y N P
Chronic rash	Y N P	Stomach aches	Y N P	Jaundice	Y N P
Hearing loss	Y N P	Body/breath odor	Y N P	Heart murmur	Y N P
Diarrhea	Y N P	Sleep problems	Y N P	No appetite	Y N P
Sore throats	Y N P	Bleeding gums	Y N P	Nightmares	Y N P
Gas	Y N P	Frequent headaches	Y N P	Canker sores	Y N P
Anemia	Y N P	Excessive fatigue	Y N P	Constipation	Y N P
Wheezing	Y N P	Bleeding tendency	Y N P	Joint pains	Y N P
Cough	Y N P	Frequent colds	Y N P	Hair loss	Y N P

Any other condition not mentioned?_____

Diet

Please describe your child's typical daily diet: _____
_____
_____
_____

Food intolerances (if known) _____

Big Sky Integrative Health, PC

8707 N Jackrabbit Ln. Ste. E Belgrade, MT 59714
Phone: 406.388.6676 Fax: 406.388.2170

Clinic Policies

Welcome to Big Sky Integrative Health. Our mission is to serve your needs and to provide safe, effective, quality healthcare. We work in conjunction with other health care practitioners to optimize your health. We welcome any ideas you have to better serve you and enhance our services.

Insurance

It is your responsibility to make sure your insurance policy covers the treatment you are receiving. If any treatment is not covered by your policy, you are responsible for payment. You are responsible for in-house pharmacy and other supplies purchased in the office.

Payment

Full payment is due at time of service for office visits, co-pays, and supplements. We accept cash, check, credit, and debit cards. Checks denied for lack of funds will be assessed a $25.00 fee. Payment plans are available upon request.

Appointments

For visits cancelled with 24-hours notice there is no fee. For a missed appointment OR cancellation with less than 24-hours notice the charge is $90 or equal to the appointment that has been scheduled ($175 for a new patient and $100 for a return patient).

Phone Calls/Email

There is no fee for brief questions over the phone or by email. Phone consultations can be arranged if you cannot make it to the office. These are the same price as our office visits.

In the event you default on your account, you will be responsible for all third party collection fees, legal fees, and court costs. Any accounts not paid past 60 days will have a 1.5% interest rate applied to the monthly balance. I have read and understand that I am financially responsible for, and agree to pay for, all charges and services at Big Sky Integrative Health. I give permission for the release of information to my insurance company to process a claim. I am responsible to notify the office of any insurance carrier or policy changes if they arise.

Signature:_____ **Date:** _____

Printed Name: _____

Patient Name (if signed by someone other than patient): _____

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Informed Consent for Naturopathic Treatment

I,_____,hereby authorize the physicians of Big Sky Integrative Health to perform with my approval and consent the following procedures for my diagnosis and treatment:

Physical Exam: e.g. general, cardiac, lung, EENT, neurological, musculoskeletal.

Common Diagnostic Procedures: e.g. venipuncture, diagnostic imaging, laboratory.

Physical Medicine: e.g. muscle release techniques, osseous manipulation, therapeutic ultrasound, massage, trigger point therapy.

Dietary Advice and Therapeutic Nutrition: e.g. lifestyle and nutritional counseling, diet plans, nutritional supplements (with vitamins, minerals, and amino acids), botanical medicine (with teas, tinctures, capsules, tablets, and creams), intra-muscular and intravenous vitamin or mineral injections.

Homeopathic Medicine: e.g. using highly dilute quantities of naturally occurring plants, animals, or minerals for healing.

Immunizations: e.g. thimerosol-free vaccines, vaccine schedules on an individual basis.

Minor Surgery: e.g. biopsy, wounds, lacerations, cryotherapy, suturing.

Chelation: e.g. heavy metal detoxification, intravenous therapy.

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

Potential Risks: allergic reactions to prescribed supplements, medications, and herbs, side effects of natural medications, inconvenience of lifestyle changes, injuries from injections, venipuncture, or other procedures.

Potential Benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, and prevention of disease and its progression.

Notice to Women: all female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by Big Sky Integrative Health or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

Signature **Date**

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HIPPA Notice of Privacy Practices

Please review this notice carefully. It describes how medical information about you may be used *and disclosed and how you can get access to this information.*

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object

unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on November 7, 2007.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature Below is only an acknowledgment that you have received this notice of our Privacy Practices:

Print Name_____Signature_____Date_____