DEB BOSSIO, ND
100B Danbury Rd, Suite 102, Ridgefield, CT 06877
203-431-4443, fax: 203-431-6664
office@drdebbossio.com

PEDIATRIC INTAKE FORM Today's Date _____

Name _____ Nickname _____ Sex: M F

Date of Birth _____ Current Age _____ Home Address_____

City _____State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Type of Insurance _____ Policy Number _____ Group # _____

Name of parent: _____ Name of other parent: _____

Father's Occupation _____ Employer _____ Work Phone _____

Father's Work Address _____ Email _____

Mother's Occupation _____ Employer _____ Work Phone_____

Mother's Work Address _____ Email _____

Person to be notified in case of emergency _____Phone _____

Primary Pediatrician _____ Phone _____

Your Referral to the Office _____

HEALTH HISTORY QUESTIONNAIRE

Reason for Today's Visit _____

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

1)
2)
3)
4)

How does your child's condition affect him/her?

_____

What are your goals for today's visit, long-term health goals, and expectations of me as your Naturopathic Doctor?

_____

_____

_____

PLEASE LIST ANY PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, SUPPLEMENTS, AND VITAMINS

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8_____ 9. _____

PLEASE LIST ANY ALLERGIES TO THE FOLLOWING AND DESCRIBE REACTION:

Medications _____
Foods_____
Environmental _____

PLEASE LIST PRIOR HOSPITALIZATIONS, MAJOR ILLNESSES, OR SURGERIES WITH APPROXIMATE DATES:

_____
_____

CHILDHOOD ILLNESSES: Please list the significant childhood illnesses your child has experienced. Please note when they occurred, how severe they were, and what was used to treat them. (i.e. chicken pox, scarlet fever, frequent ear infections, pneumonia, tonsillitis, etc).

_____
_____

VACCINATION HISTORY: Please indicate whether your child has been vaccinated

_____ Diptheria	_____ Mumps	_____ Hib
_____ Pertussis	_____ Rubella	_____ Flu Vaccine
_____ Tetanus	_____ Polio	_____ Varicella (Chicken Pox)
_____ Measels	_____ Hepatitis B	_____ Other

ANY ADVERSE REACTIONS? Y N EXPLAIN:

FAMILY HISTORY

_____ Heart Disease	_____ Arthritis	_____ Tuberculosis
_____ Hypertension	_____ Allergies	_____ Mental Illness
_____ Cancer	_____ Asthma	_____Thyroid Disease
_____ Diabetes	_____ Birth Defects	_____Other

BIRTH OF YOUR CHILD Please tell the story of your child's birth, including:

- Vaginal or C-Section:
- Term: _____ full _____ premature _____ late
- Mother's age at child's birth:
- Any significant complications during the pregnancy:
- Any significant complications during the labor and delivery:
- Any significant complications postnatal:
- Is or was your child breastfed?
    - If yes, how long? _____
    - If no, what was source of nutrition? _____
- Birth weight _____ Birth length: _____

DEVELOPMENTAL HISTORY: answer accordingly to your child

- When did your child first sit up?
- When did your child first begin to crawl?
- When did your child begin walking?
- When did your child begin talking?
- When did your child begin to read?

DIET HISTORY:

- Onset of Food Introduction (when, how, and what): _____
- Any Known Allergies or Food Intolerances: _____
- Typical Daily Dietary Intake:
    - Breakfast: _____
    - Lunch: _____
    - Dinner: _____
    - Snacks: _____
    - Beverages: _____
    - Sources of Sugar: _____
    - Sources of Food Additives, Processed Foods, and Food Colorings: _____

PSYCHOSOCIAL HISTORY:

- Any Siblings? If yes, please indicate names, sex, and ages:

- School: Where is your child in school, when did they begin, and any difficulties?

- Family: Please tell me about the family make-up, indicating parent relationships and any additional traditions, values, stresses, and concerns.

SYMPTOMS (circle if current, underline if past)

Hives
Eczema
Bleeding gums
Nose bleeds
Acne
High fevers
Chronic rash
Hearing loss
Diarrhea
Sore throats
Headaches
Frequent colds
Wheezing
Cough
Burning of urine
Frequent urination
Heart Murmur
Vomiting
Anemia
Stomach aches
Jaundice
Easy Bruising
Flat feet
Constipation
Gas
Bleeding Tendency
Joint Pains
Dizzy Spells
Blood urine
Cries easily
Nervous
Sleep problems
Night Sweats
Sensitive to light
Body/breath odor
Motion/car sickness
No appetite
Nightmares
Canker sores
Unusual fevers
Excessive fatigue
Hair loss
Allergies
Ear infections
Attention deficit
Behavioral issues

OTHER INFORMATION: Please use the space below to describe your child's temperament, personality, likes and dislikes, and whatever else you believe to be important.

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Informed Consent for Naturopathic Medical Care:

I, _____ (Patient / Parent or Guardian Name), acknowledge that _____ (Patient Name) is accepting treatment from Dr. Deb Bossio. I understand that there are intrinsic differences between the care of Naturopathic practitioners and medical doctors. I also understand that Dr. Deb Bossio holds a current license to practice medicine in the state of Connecticut (license # 000395). At this time it is my decision to pursue Naturopathic Medical Care for any condition I have. Also, I understand that, as with medical treatment, there is no guarantee that this form of care will offer complete resolution to any or all conditions that I may have.

Consent to Pay for Services Rendered:

I have been informed that it is my responsibility to pay in full for services rendered at the time of the patient visit. I recognize that Dr. Deb Bossio currently accepts payment via cash, personal check, and credit card. She does not accept payment from insurance providers. At the end of the visit, I will be provided with a comprehensive invoice of services rendered for payment and method of payment. I understand that if I elect to have Dr. Bossio review my medical case and to provide the requested service, I must pay for this service in full at the time of the visit.

Insurance: Many insurance companies will reimburse "out of network" for my services. The office will provide you a form containing all the information needed to submit to your insurance carrier after each visit. In this way, you may then apply for reimbursement for some or all of the charges you've already paid. If you have any questions about how this process works, my staff and I will be happy to assist you.

Payment Fee Schedule for 2017

All office visits and telephone appointments are charged on a **$250.00 per hour prorated basis.**

Cancellation and Rescheduling:

Cancelling or rescheduling a New Patient appointment requires notice by 9:00am two full business days prior.
Cancelling or rescheduling without proper notice will result in a late fee of $75.
Cancelling or rescheduling a follow up appointment requires notice by 9:00am one full business day prior.
Cancelling or rescheduling a follow up appointment without proper notice will result in a charge of $50.

I, _____ (Patient or Parent/Guardian Name), have read the above policies of the private practices of Dr. Bossio

Patient or Parent/Guardian Signature: _____Date: _____

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Email Consultation Policy:

It is the policy of Dr. Bossio to do email consultations under the following conditions only:

1. Only for established patients of Dr. Bossio.
2. For non-emergency issues.
3. In cases where the doctor determines that an office visit is not necessary or possible.
4. For clarification of on-going treatment or treatment received within the past 30 days.
5. When the doctor can address the concern with a single reply, requiring 5 minutes or less.
6. Complicated or lengthy emails requiring more than 5 minutes response time will incur a charge.

No new health issues will be addressed by email consultation.
If the doctor receives an email about a condition that in her opinion cannot be properly assessed without an office visit, the patient will be notified by return email to schedule an appointment, with time frame recommended. In this case, no treatment advice will be given by email. Dr. Bossio generally responds to emails within 24-48 hours, Monday through Friday only. **If you have emailed the doctor and have not received a response within these parameters, please call the office and leave a phone message** stating your question and/or concern.

Supplement Returns:

As with prescription medication purchased at a pharmacy, we do not accept supplement returns.

Newsletter:

Would you like to receive a copy of our monthly newsletter? Yes ☐ No ☐

I, _____ (Patient or Parent/Guardian Name), have read the above policies of the private practices of Dr. Bossio

Patient or Parent/Guardian Signature: _____Date: _____

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Credit Card Consent Form

Complete this form only if you would like us to keep a credit card on file for ease of payment on visit fees, supplement refills, lab fees, etc.

I, _____, give Deb Bossio, ND LLC, permission to charge my credit card (specified below) for services rendered, laboratory fees, supplement purchases, shipping and handling fees and/or other charges.

This agreement commences on _____.
(Date)

This agreement includes charges for services rendered to:
☐ Myself
☐ Other (as indicated below)

1.) _____

2.) _____

3.) _____

4.) _____

Account to be charged: ☐ Mastercard ☐ Visa ☐ Discover

Name on credit card: _____

Account #: _____ Exp. Date: _____

Validation Code: _____

Signature: _____Today's Date: _____

Verbal Consent: Spoke to _____ on _____
(Date/Time)

Staff's Signature: _____ Date: _____

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HIPAA DISCLOSURE

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like patient reviews.

I have been informed that I may review the practice's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree with the request. If the practice agrees to my requested restrictions, they must follow the restrictions.

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

If signed by Patient Representative, please state relationship to Patient.

A Patient/Personal Representative:

- Has complete access to medical records and can discuss your condition with Dr. Bossio
- Picks up supplements and test kits
- Schedule medical appointments on your behalf

If you would like to appoint a Patient/Personal Representative, please indicate access and then sign and date form. If not, please sign and date this form.

Patient/Personal Representative(s):

Name:	Complete Access	☐
Relationship:	Supplements/Kits	☐
Phone:	Scheduling	☐

Name:	Complete Access	☐
Relationship:	Supplements/Kits	☐
Phone:	Scheduling	☐

Signature: _____ **Date**: _____