Dr. Amy Hawkins, ND

NATUROPATHIC FAMILY WELLNESS

natural health for the whole family

Thank you for scheduling your child an appointment with Dr. Amy Hawkins, ND.

Please be sure to set aside some time prior to your child's initial visit to complete the following forms and bring them with you to the first appointment. If you are unable to complete this packet prior to your child's visit, then please arrive 30-45 minutes prior to the appointment to allow yourself adequate time for completion. If you do not have your child's paperwork printed, then please find a printed packet waiting for you on the table in the waiting area and complete it prior to your child's appointment time.

It is extremely helpful to **bring any recent blood work, imaging results and any applicable assessments or reports with you.** If necessary, you can print the Authorization to Release Medical Information form from the website, fill it out and send it to your child's other doctors to have records sent directly to my office. Please note that this typically takes 2-4 weeks and plan accordingly.

Please bring with you a list of any vitamins and supplements that your child is taking.

If you are unable to keep your child's scheduled appointment time, please provide me with at least 48 hours notice so that other clients may utilize that appointment time.

Thank you for entrusting me with your child's health. I look forward to meeting you and working together!

Pediatric Client Registration

Pediatric Client Registration

Patient ..... Sex ❑ M ❑ F DOB ..... SS# .....

Mother ..... DOB ..... SS# .....

Address ..... Home # ..... Cell # .....

City/State/Zip ..... Email .....

Employer ..... Work # .....

Father ..... DOB ..... SS# .....

Address ..... Home # ..... Cell # .....

City/State/Zip ..... Email .....

Employer ..... Work # .....

Sibling ..... Sex ❑ M ❑ F DOB ..... SS# .....

Sibling ..... Sex ❑ M ❑ F DOB ..... SS# .....

Sibling ..... Sex ❑ M ❑ F DOB ..... SS# .....

Children live with: ❑ M ❑ F ❑ Guardian ❑ Grandparents ❑ Other .....

Emergency Contact ..... Relation ..... Phone # .....

Party responsible for Payment of Medical Services ❑ M ❑ F ❑ Guardian ❑ Grandparents ❑ Other .....

How did you hear about our practice? .....

Insurance Information

Primary ..... Claim Address .....

Policy # ..... Group# ..... Co-pay .....

Secondary ..... Claim Address .....

Policy # ..... Group# ..... Co-pay .....

Name of Insured ..... DOB ..... Relation .....

Primary Care Physician ..... Phone # ..... City .....

Dr. Amy Hawkins, ND

Naturopathic Family Wellness

PEDIATRIC INTAKE FORM

PATIENT INFORMATION

Name_____Date of 1st Visit _____

Date of Birth_____Age_____Gender: M F

HEALTHCARE PROVIDERS

Primary Health Care Physician:_____Phone: _____

When was your child's last physical exam? _____

Is he/she currently under the care of a specialist? _____

Name:_____Specialty:_____Phone: _____

Name:_____Specialty:_____Phone: _____

List your child's primary health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH HISTORY

How would you describe your child's general state of health? Excellent Good Fair Poor

Is your child currently being treated for a health concern by other healthcare practitioners? Please explain.

_____

_____

Does your child have any known contagious diseases at this time? Y N If yes, what?

_____

List any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has experienced, along with the approximate date.

	Date		Date

List any X-rays, CT scans, blood work or other studies (hearing, vision, etc.) that your child has had, along with the approximate date.

Study	Date	Study	Date

MEDICATIONS

Vitamins and Supplements

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand)	Total daily dose	Reason for Use	Duration of Use

Prescription Medications

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

How many times has your child received antibiotics in the past three years? _____

Prescription Medications

Is your child sensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental agents? _____

Any chemicals? _____

Any supplements? _____

Has your child ever had an anaphylactic reaction? _____

Illnesses

What illnesses has your child had?

Scarlet fever____Diphtheria_____Rheumatic fever_____Mumps_____Measles_____German measles (rubella) _____

Chicken pox____Impetigo_____Tuberculosis_____Mononucleosis_____Strep throat_____Ear infections _____

Immunizations

What immunizations has your child had?

Hep B	Rotavirus
DTaP	Hib
PCV	IPV
MMR	Varicella
Hep A	HPV
MCV	Hep C
Smallpox	TB
Influenza	Other:

Please indicate if any immunizations caused adverse reactions _____

Family History

Does your child have a family history that includes any of the following? (Please circle and note Father, Mother, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather, Sibling, etc.)

Alcoholism or Drug Addiction_____

Cancer (list type)_____

High Blood Pressure_____

Heart Disease_____

Heart Attack_____

Stroke_____

Anxiety or Depression_____

Other Mental Illness_____

Diabetes_____

Thyroid Disorder_____

Other Endocrine Disorder_____

Asthma_____

Tuberculosis_____

Other Respiratory Disorder_____

Allergies_____

Autoimmune Disease_____

Other Immune Disorder_____

Osteoporosis_____

Other Bone Disorder_____

Does your child have any other significant family history that Dr. Hawkins should consider?

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

Did the mother experience any of the following during pregnancy:

Bleeding____High blood pressure_____Nausea_____Vomiting ____

Diabetes____Thyroid problems_____Physical/emotional trauma ____

Other _____

Did the mother use any of the following during pregnancy? If so, please list amounts, frequency:

Medications Y N _____

Tobacco Y N _____

Recreational drugs Y N _____

Prescription medications Y N _____

Supplements Y N _____

Birth History

Term length: Full Premature:_____wks Late:_____wks

Length of labor:_____Weight at birth: _____

Any complications? _____

Was the birth: Vaginal/C-section_____Induced_____Forceps_____Anesthesia used _____

In the first few weeks, did the child experience any of the following (circle all that apply)?

congenital birth defects colic constipation vomiting

jaundice rashes seizures other _____

Age at first: sitting_____crawling_____teething_____walking_talking _____

Diet

Was your child breast fed? Y N If, so for how long? _____

At what age did you introduce solid foods? _____

Are there any foods you exclude from your child's diet? If so, for what reason?

_____

Are there any foods your child craves (chocolate, sweets, salty, rich/fatty, breads, spicy)? _____

How much water does your child drink daily? _____

How often does your child have a bowel movement? _____

Lifestyle

How is your child's energy?_____Stress level? _____

Does your child exercise regularly?_____How often?_____What type? _

_____

Is your child regularly exposed to toxins or other hazards (school, home, hobbies, etc.)? Please describe.

How many hours of sleep does your child typically get? _____ Any problems with sleep? _____

_____

Describe your child's temperament:

How does your child feel about school/day-care?

What are your child's main interests and hobbies?

How would you describe the emotional climate of your home?

Is there anything else that you would like to share that has not been covered?

Dr. Amy Hawkins, ND
Naturopathic Family Wellness

Informed Consent for Naturopathic Consultation

Welcome to the office of Dr. Amy Hawkins, ND. This document serves to educate you on Naturopathic care and obtain your consent. Dr. Amy Hawkins, ND is a Naturopathic Doctor. She works to identify obstacles to healing and recommend natural therapies that promote your inherent ability to achieve a natural state of health.

Naturopathic care offers a customized approach to health care. Naturopathic care providers assess the whole person and recommendations are tailored to suit individual needs. Gentle, non-invasive techniques are generally used to stimulate the body's inherent healing ability. Under current North Carolina law, Naturopathic care is not deemed the practice of medicine and is not regulated by state law. However, Naturopathic care is considered a complement to traditional Allopathic medicine. Your Naturopathic care may include:

Lifestyle counseling involves identifying obstacles to health and helps patients to make informed choices to achieve and maintain optimal health.

Nutritional counseling examines the relationship between diet and health. Special diets may be recommended. Other recommendations may include nutritional supplements such as vitamins, minerals, enzymes and other nutraceuticals.

Botanical medicine (herbal medicine) uses plant substances for their healing effects and nutritional value. Plant substances may be used as teas, tinctures, capsules or decoctions (strong teas) to be taken internally or used externally as a wash, poultice, or salve.

Homeopathic medicine is based on the principle of "like cures like" and uses minute amounts of natural substances (plant, animal, or mineral) to stimulate the self-healing ability of the body.

Hydrotherapy refers to the use of water applications to the body.

Physical Medicine includes the use of hands-on techniques. Therapeutic use of light, heat and cold, massage and ultrasound may be incorporated into treatment. This often involves a referral.

Dr. Amy Hawkins, ND will take a thorough case history. Assessment of each patient's physical, mental, emotional, spiritual and environmental well-being is required to facilitate this work. A basic complaint-oriented physical exam and specific urine and/or blood laboratory tests and/or reports may be considered as part of your work-up.

Declaration and Informed Consent for Naturopathic Consultation

I understand that Dr. Amy Hawkins, ND is not a Medical Doctor (MD). _____ (Initials)

I, _____, hereby authorize Dr. Amy Hawkins, ND to act as a natural health consultant on my (or my child's) behalf. I understand that Dr. Hawkins is NOT a licensed healthcare provider in North Carolina and, as such, she does not diagnose or treat any condition or conditions. I understand that if I choose to follow-through with any recommendations set forth by Dr. Hawkins, I should consult with my primary care or specialist medical doctor, nurse practitioner or physician assistant first. _____ (Initials)

I understand that Dr. Hawkins requests that I maintain a relationship with a medical doctor, nurse practitioner or physician assistant licensed in North Carolina to serve as my primary healthcare provider. _____ (Initials)

I understand that North Carolina does not regulate the practice of Naturopathic Medicine and, as such, Dr. Hawkins cannot hold a license to practice medicine in North Carolina. I understand that Dr. Hawkins holds a current medical license in Washington State but that she is NOT a licensed healthcare provider in North Carolina. _____ (Initials)

Furthermore, I understand the following:

Dr. Hawkins does not offer diagnosis for any condition or conditions
Dr. Hawkins does not offer treatment for any specific condition or conditions
Dr. Hawkins does attempt to restore balance to the whole body and the whole person by analyzing the negative environmental or lifestyle factors (food, movement, sleep, mental health, etc.) that may be an obstacle to healing and optimal health. Additionally, Dr. Hawkins does attempt to support the body's own inherent healing wisdom with natural therapies.

To that end, Dr. Hawkins utilizes the following modalities:

Lifestyle Counseling
Nutritional Counseling and Therapeutic Nutrition
Botanical Medicine
Homeopathic Medicine
Hydrotherapy
Metabolic and Functional Profiling

Potential risks: allergic reactions to recommended herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of dis-ease, assistance in injury and dis-ease recovery, and prevention of disease or its progression.

I recognize the potential risks and benefits of the procedures above and have had them explained to me to my full satisfaction. ___ (Initials)
I recognize that even the gentlest therapies may cause complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly patients, those on multiple medications, or those with specific diseases such as heart, liver, kidney or diabetes. I therefore confirm that I will inform, and will continue to inform, Dr. Hawkins of my medical history, family history, medications and/or supplements I am currently taking (prescription and over-the-counter), or was previously taking. If female, I will advise Dr. Hawkins immediately if I am pregnant, suspect I am pregnant, am trying to become pregnant, or if I am breast-feeding and will continue to do so. _____ (Initials)

I understand that a basic complaint-oriented physical exam and specific urine and/or blood laboratory and/or imaging tests and/or reports may be considered in my care. I understand that Dr. Hawkins is not licensed to order labs in the state of North Carolina. I understand that if laboratory studies are recommended, then I have the option of utilizing direct-pay patient-ordered lab services or requesting recommended laboratory studies from my primary care or specialist medical doctor, nurse practitioner or physician assistant. _____ (Initials)

I understand Dr. Hawkins is not licensed to order prescriptions in the state of North Carolina. I understand that if these services are necessary, then I will request them from my primary care or specialist medical doctor, nurse practitioner or physician assistant. _____ (Initials)

I understand that inherent health risks associated with laboratory studies, imaging studies and prescriptions include, but are not limited to:

- Risks specific to any procedure that may be performed. _____ (Initials)
- Risks specific to pharmaceutical medications that may be prescribed. _____ (Initials)

I agree not to hold liable Dr. Amy Hawkins, ND for any laboratory studies that may be recommended or performed, nor for any laboratory studies, imaging or prescriptions discussed with Dr. Hawkins that are ordered by another primary care or specialist healthcare provider involved in my care. _____ (Initials)

I understand that Dr. Hawkins will answer any questions that I have to the best of her ability. With this knowledge, I voluntarily consent to the assessment, consultation, therapeutic recommendations and procedures mentioned above. I realize that no guarantees have been given to me regarding cure or improvement of my condition or conditions and understand that, as with any type of treatment, results cannot be guaranteed. I do not expect my care provider to be able to anticipate and explain all risks and complications. _____ (Initials)

Additionally, I acknowledge that I have been informed and understand that:

- Any care provided to me as a client by Dr. Amy Hawkins, ND should not obviate any treatment or advice that I may now be receiving, or may in the future receive, from any other health care provider including but not limited to my primary care or specialist medical doctor, nurse practitioner or physician assistant. _____ (Initials)
- I am at liberty to seek and/or continue medical care from any other health care provider including but not limited to my primary care or specialist medical doctor, nurse practitioner or physician assistant. _____ (Initials)

- No employee or other practitioner associated with Dr. Hawkins or Dr. Hawkins herself are suggesting or advising me to refrain from seeking or following the directions of any other health care provider including but not limited to my primary care or specialist medical doctor, nurse practitioner or physician assistant. _____ (Initials)

I have read and understand the above stated policies and information. I have received a full and complete explanation of the services that I may receive from Dr. Amy Hawkins, ND. I hereby authorize and consent to treatment. I intend this consent form to cover the entire course of treatment I receive from Dr. Amy Hawkins, ND. I also confirm that I am free to revoke this authorization for treatment at any time but will be financially liable for all treatment rendered. I also represent that I am not an agent of any private, local, county, state or federal agency attempting to gather information without so stating.

I understand that a record will be kept of the health consultation provided to me by Dr. Amy Hawkins. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my consultation record at any time and can request a copy of it by paying the appropriate fee. I understand that my consultation record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my consultation record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by Dr. Hawkins to the best of her ability.

Patient Name (Please print):

First _____ Middle _____ Last _____

Date of Consent: Month _____ Day _____ Year _____

Name of Parent (or Legal Guardian):

Signature of Patient (or Parent or Legal Guardian):

Dr. Amy Hawkins, ND

Financial Policy

PAYMENT FOR SERVICES

Fees are based on a rate of $45 per 15 minutes until September 30, 2017:
Initial visit brief (60 mins) $180
Initial visit standard (75 mins) $225
Initial visit extended (90 mins) $270
Initial visit complex (>90 mins) >$270
Return visit 15-60 min $45-$180

Fees are based on a rate of $65 per 15 minutes beginning October 1, 2017:
Initial visit brief (60 mins) $260
Initial visit standard (75 mins) $325
Initial visit extended (90 mins) $390
Initial visit complex (>90 mins) >$390
Return visit 15-60 min $65-$260

As the patient, you are responsible for the total charges incurred for each visit. Payment by cash, check or credit card is accepted. Returned checks will be subject to a $25 return fee. If your insurance plan covers Naturopathic Medicine, Dr. Hawkins can provide you with receipts to submit for reimbursement. It is your responsibility to determine if your insurance plan will provide reimbursement.

Fees are paid at the time of each visit, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees and other applicable fees.

Telephone support is to assist in clarifying recommendations made during an office visit. Telephone conversations that cover new material or require extended time beyond very brief Q&A will be considered "phone consults" and will be billed at the same rate as an office visit. This applies to after-hours phone consults regarding acute illness (as such is typically needed in pediatric care).

Email communication is to assist in clarifying recommendations made during an office visit. Email conversations that require extended time beyond very brief Q&A will be billed at the same rate as an office visit. Please see detailed email policy on the following page.

Naturopathic recommendations may include certain herbal, homeopathic, vitamin or mineral supplements. Know that Dr. Hawkins has spent time researching and identifying well-made supplement brands and that these can be purchased from Emerson Ecologics or from the in-house dispensary. Payment for supplements is your sole responsibility. Please note that you are free to choose where you purchase the recommended products.

CANCELLATION POLICY

Please give at least 48 hours notice if you need to cancel or reschedule an appointment. This will allow for consideration of other patients who may be waiting for appointments. Please understand that your appointment time is reserved for you alone. Dr. Hawkins does not double book as is customary in other medical practices, so observation of the cancellation policy is very much appreciated.

I have read, understand and agree to the above financial and cancellation policies.

Patient Name (Please print): _____Date: _____

Signature of Patient (or Parent or Legal Guardian): _____

Dr. Amy Hawkins, ND

Email Policy

There is an expanding reliance on electronic communication (e-mail) motivated by the convenience, speed, cost-effectiveness and environmental advantages of its use. If you choose to communicate with Dr. Hawkins via e-mail, know that e-mail is considered an official means of communication and, if used, your e-mails will be included in your patient file.

This policy outlines appropriate use of e-mail communication with Dr. Hawkins.

Email communication is ideal:

- To schedule a return office visit.
- To clarify instructions or ask a brief question about previous recommendations.
- To ask brief questions as noted above that do not require discussion.

Email communication is not ideal for:

- Scheduling a first office visit.
- Cancelling an office visit with less than 48 hours notice.
- Communicating urgent or emergent information.
- Time-sensitive issues.
- Asking for an opinion or discussion of a new health issue not yet evaluated via office visit or phone consult.

Dr. Hawkins does understand that there are instances outside of the examples above when email communication can be very helpful. Please be aware that email communication beyond very brief Q&A and clarifications as listed above will be considered an "email consult" and will be billed at the same rate as an office visit based on the amount of time spent reviewing and responding to your email.

Other points to be aware of:

- Email communication does not take the place of an office visit. If you think you need to be seen, please book an appointment.
- Staff other than Dr. Hawkins may check the inbox to handle routine matters and may read your email communication.
- It is important to keep in mind that although you may send an email at a certain time, it may not arrive immediately at Dr. Hawkins' email inbox, and there may be a delay before either the doctor or other staff member can check and read the email you sent.
- Email is generally not checked over the weekend or holidays.
- Email IS NOT A CONFIDENTIAL METHOD OF COMMUNICATING OR SENDING MEDICAL INFORMATION.

I would like to use email communication with Dr. Hawkins. I have read the above and understand the security limitations with electronic communication. I agree to use email communication in accordance with the above policies.

Patient Name (Please print): _____

Date of Consent: Month_____Day_____Year _____

Signature of Patient (or Parent or Legal Guardian): _____