GIVINGTREE
NATURAL HEALTH

Margaux French, ND
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Newington, NH 03801

603.431.6677 ext. 242
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Dear Parent/Guardian,

Welcome to Giving Tree Natural Health! Thank you for choosing us for your family health care needs. We are here to serve your medical needs, help educate you about natural therapies and ways to optimize your overall health, and to answer your health care questions.

Enclosed in this packet are several forms that we will review at your first appointment. Your detailed and thoughtful responses will help us to utilize our time together more effectively. **Please bring these forms to your first appointment.** Your first visit will be a thorough assessment of your child's health and you should allow up to one and a half hours for this visit.

If you are unable to keep your scheduled appointment time, please let us know at least 24 hours prior to the scheduled time so that we may allow other patients to be seen during that time. We will be glad to reschedule your visit if it becomes necessary to do so.

Please remember to bring in copies of any recent lab work or medical records you may have and a complete list of medications and dosages your child is currently taking.

I look forward to meeting you and your family. My goal is to become a trusted partner in assisting your family with your health care needs.

Yours in health,

Margaux French, ND
Giving Tree Natural Health, LLC

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Consent for Treatment & Financial Policy Statement

Thank you for choosing Giving Tree Natural Health, LLC for your healthcare needs. We are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

Treatment:

Treatment at this clinic requires an agreement between you, the patient, and Dr. Margaux French, ND. Any therapy will proceed only with mutual consent. It is possible that certain adverse effects may result from treatments. These could include, but are not limited too, local skin irritation, bruising, temporary pain or discomfort, adverse reactions to prescribed herbs or supplements such as allergic reaction, headache, nausea; and the possible temporary aggravation of symptoms existing prior to treatment.

Because of the possibility of drug interaction with herbal formulas, we require our patients to inform the practitioner of any medications they may be taking, including any dietary supplements and herbs.

Notice to Pregnant Women:

All female patients must alert the doctor if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

Emergency Care:

Our clinic **does not** administer emergency medical care. In the case of an emergency, please see your medical or osteopathic doctor, the emergency room, or the nearest hospital.
After emergency care has been administered, patients often respond well to naturopathic care to accelerate the healing process.

Payment:

Giving Tree Natural Health, LLC is a fee for service clinic and payment is expected at the time of service. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

We accept cash, personal checks, Visa or Mastercard as payment. Returned checks are subject to $25 return fee and no further personal checks will be accepted.

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Phone Calls:

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. We would prefer that people call with questions rather than leave them unanswered. There is no charge for any call to clarify instructions given at a previous visit.

Phone support is not intended to take the place of an office visit. Phone consultations that cover *new material, require new information, take an extensive amount of time*, or *require a change in treatment plan* are considered substitutes for an office visit. These will be billed at the same rate as the visit for which they substitute.

Cancellation Policy:

We all have circumstances come up occasionally that make it difficult to keep appointments. With that in mind, we are happy to accept cancellations or postponements 24 hours in advance. There is no charge if an appointment is cancelled with 24 hours notice. A cancellation with less that 24 hours notice does not allow enough time for other interested patients to be scheduled and is an inconvenience.

This office requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. There is a $50 charge for new patient cancellations and a $25 charge for follow-up appointment cancellations that are made with less than 24 hours notice.

- I agree to pay for services rendered at the time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding my healthcare.
- I am aware that my practitioner may charge for telephone consultations.
- I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- I consent to treatment as agreed upon between the doctor and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the doctor.

_____
Patient's Name

_____
Patient's Guardian Signature

_____
Print Name

_____
Date

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Date:_____

Pediatric New Patient Information

Name of Child:_____ _____ DOB:___/___/___ Age:_____
(Last) ***(First)*** ***(Sex)***

Name(s) of parent/guardian(s):_____

Address:_____ City:_____ St:_____ Zip:_____

Home Phone:(___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Permission to leave detailed messages on answering machine/voicemail, if necessary? Y N

Social Security#_____ Parent's Email Address:_____

Additional Patient Information

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone: (___)_____

Does your child have a primary care physician? Y N

If yes, Physician's Name: _____ Physician's Phone:(___)_____

Address:_____ City:_____ St:_____ Zip:_____

Referral Information

How did you hear about us?_____

Whom may we thank for referring you?_____

Naturopathic Pediatric Intake Form

Reason for office Visit:_____

Please list your child's health concerns, in order of importance:

1)_____
2)_____
3)_____
4)_____
5)_____

Has child been seen by any other doctor(s) for this complaint? Yes No Past

List any surgeries, hospitalizations, or major accidents including date occurred:

1)_____ 4)_____
2) _____ 5) _____
3) _____ 6) _____

What is child's blood type:_____

List ALL medications child is currently taking (prescription and/or over-the-counter)			
Medications	**Dose/Frequency**	**Since**	**Adverse effects?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List ALL supplements child is currently taking			
Supplement	Dose, Frequency	**Supplement**	Dose, Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Any known allergies to medications? If so, which one(s) and what is child's reaction?_____
_____ _____
_____
Any other allergies to foods, animals, environment?_____
_____

Previous Medical History:

In the following section, **YES (Y)** indicates the child **currently** has or **regularly** gets the problem; **NO (N)** indicates the child **never** has had the problem; **PAST (P)** indicates the child had the problem in the **past, but not recently**. Please circle the correct one for your child.

Ear Infections: Y N P If has had, how many times total:_____
Colds: Y N P If has had, how many times total:_____
Strep Throat: Y N P If has had, how many times total:_____

How many times has the child taken antibiotics?_____ For what condition(s):_____
_____

Has child ever had any infectious disease from which s/he never fully recovered? _____
_____

What other medicines has the child taken and how often:
1)_____ 3)_____
2)_____ 4)_____

Hearing Test Normal: Yes No Not Tested **Speech Impediment:** Yes No Past
Vision Test Normal: Yes No Not Tested **Learning Difficulties:** Yes No Past

Vaccination History:

Yes, has had; **No**, has not had; **Some**, did not finish all shots:
MMR: Yes No Some **DPT:** Yes No Some **Hep B:** Yes No Some
Hib: Yes No Some **Chicken Pox:** Yes No Some **Polio:** Yes No Some
Hep A: Yes No Some **Influenza:** Yes No Some **Other:**_____
Any reactions to vaccinations: If so, please explain:_____
_____

Family History:

Allergies: Y N P **Obesity:** Y N P **Cancer:** Y N P
Tuberculosis: Y N P **Mental Illness** Y N P **Heart Disease:** Y N P
Diabetes: Y N P **Other Chronic Illness:**_____

Mother's age at conception:___ Mother's state of health at conception: poor fair good excellent unknown
Father's age at conception:___ Father's state of health at conception: poor fair good excellent unknown
Mother's state of health *during* pregnancy: poor fair good excellent unknown
Total number of pregnancies:_____ Total number of births:_____

Mother's Health During Pregnancy:

Smoking: Y N **Diabetes:** Y N **Coffee:** Y N **Nausea/Vomiting:** Y N
Preeclampsia: Y N **Emotional Stress** Y N **Recreational Drugs:** Y N
Vaginal Birth: Y N **Traumatic Birth:** Y N **Length of Labor:_____ If the birth was difficult, please explain:**_____
_____

Health of baby at birth:_____

Health History of Child:

Child Breastfed: Y N **For How Long:**_____ **Age when put on formula:**_____
What formula was used:_____ **When was child put on solid food:**_____
When did child walk:_____ **Talk:** _____ **Develop Teeth:** _____
Illnesses (include measles, mumps, chickenpox):_____
How was child's health the first year? Poor Fair Good Excellent
Jaundice as baby: Y N