CYNTHIA PRESTON
NATUROPATHIC DOCTOR

562-794-9027

Pediatric Intake Form

Congratulations on taking the first step towards your journey of Health. Dr. Preston's goal is to provide you with the highest level of personalized care. She is committed to helping you on your path to health and healing.

It is important to read all the enclosed information carefully. You may mail or fax completed forms prior to your appointment. This will allow Dr. Preston to help solve your problems more efficiently and enhance the quality of your care. Alternatively you may bring the forms in with you to your first appointment.

Appointment Scheduling

The charge for Late Cancelled Appointments and NO show appointments are **charged 50% for appointment of your scheduled visit time.** This means that we will charge you 50% of your scheduled fee, so if you had a 30 minute consults booked you would be billed 40 dollars (visit is 80). Due to the overwhelming requests for consultations, there is a 24-hour cancellation policy. We encourage patient responsibility with their appointment schedule. Scheduling reminder calls are a courtesy and are NOT meant to replace your management of our appointment schedule. Please don't depend on the reminder calls as your only means of arriving at your appointment. 24 hours advance notice is required and cancellation for a next day appointment left on voicemail after business hours will be charged as a late cancellation. If you are cancelling a Monday appointment you are required to call on Sunday. You may cancel your appointment by calling Beachside Naturopathic Clinic & IV Bar at 562-794-9027. If calling after hours, please leave a message.

I acknowledge 24 hour cancellation policy: PATIENT INITIALS _____Date_____

Phone and Email Policy

For your safety all questions or emails to Dr. Preston will be charged. Should you have **one brief question regarding clarification of treatment from previous visit** the message must be left with staff and Dr. Preston is available to return answers to staff during those clinic hours when she is not actively providing direct patient care. Any other questions must be scheduled with Dr. Preston as a phone/email or office consult. Considerable effort is made to respond to phone messages within 24 hours of their receipt; however, with a busy schedule and the only doctor on staff, telephone time is limited. It is preferable and safe that the evaluation and treatment of medical questions or reccomendations be conducted during a scheduled office visit with Dr. Preston where you can receive adequate care and attention. We appreciate your understanding and consideration in this regard. Our phone and email policy is below:

- **1-10 minute phone call - $40**
- **Emails –$55 per email.**

PATIENT INITIALS _____ Date_____

Insurance and Payment Information

CYNTHIA PRESTON
NATUROPATHIC DOCTOR

562-794-9027

Cynthia Preston, ND, **does not accept insurance or** Medicare and we cannot assure you that services (office visits, phone consultations or lab tests) will be reimbursed. You will be provided with diagnosis and procedure codes to assist you with possible insurance reimbursement. You can request a bill of services rendered that you can submit to your insurance provider who may reimburse you for some or the entire fee at their discretion. Please note that phone visits and supplements will not be reimbursed by your insurance carrier.

Payment for the office visit or phone appointment is expected at time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day of the visit or phone call.
You will receive an invoice receipt and superbill with the medical codes at the completion of your visit.
Dr. Preston does not accept insurance or Medicare. If you are using a health savings account all supplements and visits can be used towards this. Please save your superbill for tax filing purposes.

Please be prepared to pay for your visit in full. Please be aware that any conversation regarding your health treatment

PATIENT INITIALS _____ Date_____

LAB TESTS

After your initial or follow–up consultations, lab tests and/or diagnostic tests may be ordered.
Testing recommendations and cost(s) per test will be reviewed at time of visit. Fees for such tests are billed directly by the lab to the patient, meaning that payment must always be sent with test kits at time of administration. In many cases, the lab will work directly with the patient's insurance care provider. We cannot guarantee that your labs will always be covered and will not reimburse your fees for any reason.
With specialty testing kits there is a $45 dollar fee depending on each test for shipping and processing of the test kits. This must be paid at time of visit when kit is given.
All specialty lab tests take up to 3 weeks to be finalized and sent to the office. Your appointment will be scheduled at 3 weeks for this reason.

Dr. Preston does provide phlebotomy services at Cynergetics. This is a convenient service we offer for patients that includes a $15 draw fee & a $45 Processing Fee

PATIENT INITIALS _____Date_____

.

Patient Contact Information

Name of Patient _____ Date of First Visit _

Name of Parent(s)/Guardian(s) (ifapplicable)_____ _____

Relationship to patient _____

Address_____

City _____ State _____ Zip Code

_____

Telephone # (cell) _____

(home) _____

(work) _____

Email address_____

Age _____ Date of Birth _____ Gender: Female ___Male

Married _____ Separated _____ Divorced___ Widowed ___ Single _____ Partnership

Live with: Spouse _____ Partner____ Parents ___ Children_ Friends ____ Alone _____

Occupation _____ Hours per week _____ Retired

Employer _____

(Work address) _____

How did you hear about our clinic?_____

Next of Kin or other to reach in an emergency

_____

Relationship _____ Phone_____

Address_____

I authorize employees or agents of Newport Integrative Health to leave a detailed message for me on a voice message device associated with the phone number listed below regarding my:

Laboratory reports ___Yes (initials) _____No (initials)
Protected Health Information ___Yes (initials) _____No (initials)

If you answered yes please list number to call:

Consent To Treat

I understand that the treatment provided is determined by the professional discretion of my naturopathic doctor. Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. It is very important that you inform Dr. Preston immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant or you are breast-feeding please inform me as well. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I will immediately notify the doctor if I become aware that I am pregnant.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to temporary aggravation of pre-existing symptoms, allergic reactions to herbs or supplements, bruising and bleeding from injection therapies.

I will immediately inform the doctor if I experience any gastrointestinal upset, allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur.

I have read, or have had read to me, the above information and I consent to receiving naturopathic medical care from the above mentioned naturopathic doctor I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment. Signing below means I consent to treatment

PATIENT INITIALS _____Date_____

Notice of Privacy Practices

This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPAA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. To correctional institutions or law enforcement officials, if you are an inmate

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care
3. You have the right to inspect and obtain a copy of the health information that, but not including psychotherapy notes.

I have also read and understand the attached NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996

REPRESENTATIVE or PATIENT INITIALS _____

Consent Regarding E-mail Use or Disclosure of Health Information

Cynthia Preston, ND provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail however, has a number of risks:

1. Risks:
    a. e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily copy information
2. It is the policy of Cynthia Preston, ND that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that's patients protected personal health information. We cannot guarantee the security and confidentiality of e-mail or internet communication.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks with the following conditions:
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Cynergetics staff, insurance coordinators and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Cynthia Preston, ND will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore e-mail must not be used in a medical emergency.
    c. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable or communicable diseases such as syphilis, gonorrhea and the like; behavioral health, mental health; or alcohol and drug abuse.
    d. Cynthia Preston, ND cannot guarantee that electronic communications will be private. Dr. Preston, ND is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct and is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time be e-mail or written communication to Cynthia Preston, ND. I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail

PATIENT INITIALS_____ Date_____

Release of Records

REQUESTING PARTY: Today's Date_____

Printed Legal Name _____ Date of Birth_____

I, the undersigned, hereby authorize:

Name of Agency or doctor _____

Address_____

City, State, Zip_____

Phone_____ Fax_____

TO RELEASE MY INFORMATION TO:

Dr. Cynthia Preston, ND
16601 PCH Sunset Beach, Ca 90742

Tel: (562)794-9027
Fax: (562)470-9660

Information to be released:

_____ALL MEDICAL RECORDS
_____OTHER_____

Initial next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes_____	No_____
Mental Health Information	Yes_____	No_____
AIDS/HIV Testing & Results	Yes_____	No_____
Sexually Transmitted Diseases Testing & Results	Yes_____	No_____
Communicable Diseases	Yes _____	No_____
Genetic Testing	Yes_____	No_____

and is limited to the time period from _____ to_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise specified, this authorization will automatically expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or receive copies of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. A copy of this authorization shall be as valid as the original.

SIGNATURES: _____

Requesting Party_____ Date_____

For_____ Relationship_____

Last Name: _____ First: _____ Age: _____ DOB:_____
Date: _____

List child's medical problems:
1) _____
2) _____
3) _____
4) _____

Last time blood work was done and with what doctor:_____

BIRTH HISTORY

Was child born full term: Y N
Was child born premature: Y N if yes how early: _____
Vaginal or Caesarian delivery?
Were there complications with delivery? Y N if yes, please explain:
_____
_____Were there complications with pregnancy?: Y N if yes, please explain:
_____
Are there any genetic or inheritable disorders? Y N if yes, please explain: _____
_____
Are there any growth delays? If yes please explain:_____
_____
Are there any and developmental delays? If yes please explain: _____
_____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparents
Age if living	_____	_____	_____	_____
Age when died	_____	_____	_____	_ _____
Reason for death	_____	_____	_____	_____
Cancer (type)	_____	_____	_____	_____
Heart Attack/stroke	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please Note When and Why Each of The Following:
X-rays: _____
MRI/Cat Scans:_____
Ultrasounds:_____
Accidents:_____

Please List All Sensitivities/Allergies/Reactions
Drugs: _____
Foods: _____
Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diptheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions:_____

List all Prescription Medicines, Supplements, & Herbs Taken: INCLUDE DOSAGE

_____

_____

_____

Exercise:
How often?:_____ What type?(s):_____
For How long:_____
Hobbies:_____
_____

Sleep:
How long per night: _____ frequent wakening? Y N if yes, what is the reason?: _____
Nightmares: Y N P Wake refreshed: Y N P Naps during the day: Y N P
Sleep walk: Y N P Grind Teeth: Y N P Snore: Y N P

Infant Feeding:
Was child breast feed? Y N If so, for how long? _____
Was child formula feed? Y N If so, what type and for how long? _____
Has solid food been started? Y N If so, at what age was solid food began? _____

Typical Days Diet:
How much water dose child drink? _____
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Food aversions: _____
Food cravings: _____

Toxin Exposure:

Did child grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____
Have child been exposed to solvents, heavy metals, fumes, or other toxic materials?:_____
_____
Have there been health problems experienced when new carpeting, paint, cabinets, or did other refurbishing was performed?:_____
Is there sensitive to perfumes, gasoline, or other vapors?:_____
Are pesticides, herbicides, or other chemicals used around your home?_____
_____

Social Life:
Quality of most significant relationship?_____
History of sexual, mental/emotional, physical abuse?: Y N P
If so, at what age and by whom?: _____

REVIEW OF SYSTEMS

Present Weight:_____ Weight one year ago: _____
Height: _____ Maximum weight and when:_____
Ideal Weight:_____

Regarding the Next Section: Please Circle Y if you have the problem **now**, **N** if you've **never** had the problem, **P** if you had the problem in the **PAST**.
If two symptoms are listed, circle the one (s) you have.

Frequent Infections: Y N P If yes, what types: _____
Frequent Antibiotic usage: Y N

SKIN
Rash: Y N P
Lump: Y N P
Psoriasis/eczema: Y N P
Hives: Y N P
Itchy: Y N P
Cancer: Y N P

HEAD
Headache: Y N P
Head Injury: Y N P
Migraine: Y N P

EARS
Ear Pain: Y N P
Ear tubes Y N P
Drainage: Y N P
Dizziness: Y N P

NOSE
Frequent colds: Y N P
Nosebleeds: Y N P
Congestion: Y N P
Post nasal drip: Y N P
Polyps: Y N P
Seasonal allergies: Y N P

EYES
Dry/Watery: Y N P
Blurry vision: Y N P

Styes: Y N P
Strain: Y N P
Decreased Hearing Y N P
Double vision: Y N P
Discharge: Y N P
Dark under eyelid: Y N P
Itchy: Y N P

MOUTH/THROUT
Canker sores: Y N P
Cold sores: Y N P
Sore throat: Y N P
Gum disease: Y N P
Cavities: Y N P
Loss of taste: Y N P

Hoarseness: Y N P

NECK

Stiffness: Y N P
Swollen glands: Y N P
Full movement: Y N P
Tension: Y N P

RESPIRATORY

Cough: Y N P
Shortness of breath with exertion: Y N P
Tuberculosis: Y N P
Bronchitis: Y N P
Pneumonia: Y N P
Asthma: Y N P
Wheezing: Y N P

:

GASTROINTESTINAL

Heartburn: Y N P
Bowel movement frequency:_____
Colic : Y N P
Indigestion: Y N P
Recent change in BM: Y N P
Bloating: Y N P
Diarrhea: Y N P
Constipation: Y N P
Nausea: Y N P
Ulcer: Y N P
Vomiting: Y N P
Pancreatitis: Y N P

URINARY

Frequent infections: Y N P
Pain with urination: Y N P
Discharge/blood: Y N P
Urgency: Y N P

ENDOCRINE

Change in Appetite: Y N P
Diabetes: Y N P
Heat/Cold intolerance Y N P
Thyroid problem Y N P
Difficulty maintaining weight: Y N P

HEMATOLOGIC

Anemia: Y N P
Easy bruising/bleeding Y N P
Transfusions: Y N P

MALE

Genital malformation: Y N P
Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P

FEMALE

Menstruation: Y N P
Age periods began:_____
How long periods last: _____
How often periods occur:_____

NERVOUS

Tingling/numbness: Y N P
Seizures: Y N P
Leg cramps: Y N P
Fainting: Y N P
Pain: Y N P

MENTAL/EMOTIONAL

Tantrums: Y N P
Anger/irritability: Y N P
Anxiety: Y N P
Panic: Y N P
Inattention: Y N P