



PEDIATRIC REGISTRATION FORM

PATIENT/CLIENT INFORMATION

Date: _____

Name: _____ DOB: ___/___/___ Age: _____ Sex: ___F ___M

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ State: ___ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

Email: _____ Best way(s) to reach you: ___cell ___home ___work ___email

Would you like to subscribe to our email newsletter (updates, supplement discounts, etc)? ___Y ___N

Insurance Carrier: _____ SS#: _____

Emergency Contact Name & Relationship: _____ Phone #: _____

Last Physician Consulted: _____ Date: _____

Reason(s) for that visit: _____

Reason(s) for today's visit: _____

How did you hear about us? _____

OFFICE POLICIES

APPOINTMENT CANCELLATION

You must call **24 HOURS in advance** (during office hours) prior to appointment to cancel an appointment. Otherwise, you will be considered a “no-show” and charged a \$100 fee for new patients and a \$50 fee for established patients. We value our time and want to ensure our patients receive the care they deserve.

PAYMENT POLICY

- **Payment at Time of Service:** Payment for appointments, supplements, products, and lab tests is due in full at the time of service and/or purchase. For your convenience, we will provide you with a completed “superbill” for you to submit to your insurance company for reimbursement whenever services are rendered and paid for. **We do not bill for insurance in our office.**
- **Delinquent Accounts:** If a patient/client or guarantor’s check is returned due to non-sufficient funds, there will be a \$30 charge. In addition, if payment is not received within 30 days, finance charges will begin accruing at 1.5% per month. Excessively overdue accounts will be forwarded to an outside collection agency and the patient/client or guarantor will be responsible for any fees generated as a result of collection efforts.

PRICING

Mary Shackelton, MPH, ND

New Patient (60 mins) - \$250
Follow Up (45 mins) - \$145
Follow Up (30 mins) - \$100
Follow Up (15 mins) - \$65
Nutrient IV Therapy – starts at \$110

Damiana Corca, LAc, Dipl OM

New Patient (90 mins) - \$125 + herbs
Follow Up (60 mins) - \$75 + herbs
Follow Up Stress Relief (45 mins) - \$45
Follow Up Addiction (45 mins) - \$25
Herbal Consultation Only (60 mins) - \$65 + herbs
Facial Rejuvenation Initial Screening & Consultation (20 mins) - \$45
Facial Rejuvenation (75 mins) - \$135
Injection Therapy - \$45
Private Qi Gong Classes - \$55 (packages available)

Terri Rebibo Fox, MD, ABHIM

New Patient (60-90 mins) - \$250-\$375
Follow Up (40 mins) - \$185
Follow Up (30 mins) - \$125
Follow Up (15 mins) - \$65
School Physical - \$125
Sports Physical - \$100
Nutrient IV Therapy – starts at \$110

Note: Phone appointments are priced the same as in office visits.

RETURN POLICY

- **Supplements**
Un-opened product within 30 days of the purchase date – 100% of the purchase price
Opened product– No Refund (some exceptions may apply)
- **Skin Care Products** – returns decided on an individual basis; must have original receipt
- **Other Products** – must be unopened and come with the original receipt to receive a full refund.

TELEPHONE CALLS

Call 911 for emergency situations
Treatment Questions: call 303-449-3777 or email info@holisticacare.com

I hereby acknowledge that I have read and understand the above information and agree to the terms of payment.

Patient/Client's Signature: _____ Date: _____

Guardian's Signature (for minors only): _____ Date: _____

FINANCIAL RESPONSIBILITY (GUARANTOR) – PARENT/GUARDIAN

Name: _____ DOB: ___/___/_____ Sex: ___F___M

Address: _____ City: _____ State: ___ Zip: _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient/client and that I am subject to all financial terms listed below.

Guarantor's Signature: _____ Date: _____

TERMS OF ADMISSION

Financial Terms: I understand that I am responsible for all charges whether or not they are covered by my insurance. Holistica Integrative Care does not bill for insurance and accepts cash, check, VISA or MC for payment. I understand that payment for services, supplements, products, and lab tests are due in full at the time of service and/or purchase. I understand that a \$30 fee will be charged for returned checks (non-sufficient funds), and if payment is not received within 30 days, finance charges will begin accruing at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance, and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than me, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to other parties unless you direct us to do so or applicable laws authorize or compel us to do so. Holistica Integrative Care is required to provide you, at your request, with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information and describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic and wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our office at: 303-449-3777.

I hereby acknowledge that I have reviewed a copy of Holistica Integrative Care's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Holistica Integrative Care has made good faith effort to obtain my acknowledgement.

X _____ Date: _____
Patient/Client's Signature

X _____ Date: _____
Guardian's Signature

PATIENT/CLIENT INTAKE FORM

Patient/Client Name: _____ Date: _____

Please indicate symptoms you've experienced in the last 6 months with an **X** and throughout your life with a **P** for past symptoms.

FAMILY HISTORY

- Alcoholism
- Arthritis
- Cancer
- Diabetes
- Endometriosis
- Heart disease
- Other: _____
- Mental Emotional Disorder
- Osteoporosis
- Skin problems
- STD's
- Stroke
- Tuberculosis

GENERAL

- Weight change
- Fever/Chills
- Weakness
- Fatigue
- Sweating/night sweats
- Fainting
- Dizziness
- Forgetfulness
- Hair/nail changes
- Recurrent illness
- Chicken pox
- Lead poisoning

MOUTH/THROAT

- Sores
- Bleeding gums
- Teeth
- Hoarseness
- Difficulty swallowing
- Taste
- Strep Throat

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Murmurs
- Calf pain with walking
- Heart disease
- Edema
- Palpitations
- Chest pain/angina

SKIN

- Itching
- Rashes
- Bruise easily
- Hives
- Athlete's Foot
- Eczema/psoriasis
- Change in moles
- Sores that won't heal

EARS

- Ringing
- Earache/discharge
- Loss of hearing
- Ear infections

GENITOURINARY

- Low back pain
- Painful urination
- Blood in urine
- Frequent/urgent urination
- Loss of bladder control
- Nighttime urination
- Recurrent Infections
- Kidney stones
- Frequent URI's

EYES

- Glasses/contacts
- Blurring
- Pain
- Double vision
- Discharge
- Floaters
- Macular Degeneration

NOSE

- Sinusitis
- Bleeding
- Discharge
- Obstruction
- Postnasal drip
- Nasal polyps

PULMONARY

- Shortness of breath
- Wheezing
- Chronic Cough
- Coughing blood
- Sputum
- Asthma/reactive airway disease
- Bronchiolitis
- Croup

BLOOD/LYMPH

- Anemia
- Transfusions
- Bleeding tendency
- Lymph node enlargement
- Lymph node pain

GASTROINTESTINAL

- Poor appetite
- Constipation/diarrhea
- Indigestion/heartburn
- Ulcers
- Gas/bloating
- Lactose intolerance
- Bowel changes
- Nausea/vomiting
- Hemorrhoids
- Hernia
- Blood in stool
- Anal discomfort
- Excessive hunger
- Excessive thirst
- Mucus in stool

MUSCLE/JOINT/BONE

- Pain
- Numbness
- Swelling
- Bursitis/tendonitis
- Broken bones
- Sprains/strains
- Spasms/cramps
- Headache/head injuries
- Low back, hip, leg pain
- Neck/shoulder/arm pain
- Jaw pain/TMJ
- Arthritis

**BEHAVIORAL/
DEVELOPMENTAL**

- Bed Wetting
- Toileting problems
- ADHD
- Difficulty sleeping
- Developmental delay
- Speech delay
- Motor delay
- Lack of physical activity
- Socialization problems
- Behavior problems
- Learning disabilities

AUTO-IMMUNE

- Rheumatoid Arthritis
- Crohn's Disease
- Other

NEUROLOGICAL

- Fainting
- Seizures
- Gait/coordination
- Numbness/tingling
- Paralysis/weakness

ENDOCRINE

- Diabetes
- Thyroid
- Hypoglycemia
- Goiter
- Heat/Cold intolerance
- Hormone therapy
- Excessive thirst/hunger

PSYCHOLOGICAL

- Memory Loss
- Mood
- Sleep pattern
- Anxiety/depression
- Phobias
- Eating disorder
- Bipolar
- Schizophrenia

ALLERGIC

- Drug/vaccination allergy
- Asthma
- Eczema
- Rhinitis (runny nose)
- Hay Fever
- Hives
- Post-nasal drip
- Itchy or water nose/eyes
- Frequent sneezing

GENERAL INFO

Height: ___ ft. ___ in. **Weight:** ___ lbs. **Frame size:** ___ Small ___ Medium ___ Large

What are your top 3 health concerns?

Health Concern #1: _____

Health Concern #2: _____

Health Concern #3: _____

ALLERGIES (please describe type of allergy and your symptoms):

Seasonal Allergies (e.g. pollen, hay fever)	Medication Allergies (e.g. penicillin, rashes)

Besides the allergies listed above, are there any other substances to which your child has had a bad reaction?

SURGERIES/HOSPITALIZATIONS:

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

PREGNANCY HISTORY of MOTHER

Adopted? ___ Yes ___ No

Pregnancy history: _____

Complications?:

___ Gestational diabetes ___ Gestational hypertension ___ Pre-eclampsia ___ Other: _____

Medications during pregnancy (please specify): _____

Alcohol, tobacco or drug use during pregnancy? (please specify): _____

BIRTH HISTORY OF MOTHER AND CHILD

Full Term? ___ Yes ___ No **If not full term, how many weeks?** _____ **Birth weight?** _____

Vaginal/C-Section/VBAC: _____

Interventions/complications/antibiotics during birth? ___ Yes ___ No

Home Birth? ___ Yes ___ No **Hospital stay length?** Mom _____ (days) Baby _____ (days)

Breast fed or formula fed? _____ **How long?** _____

SOCIAL HISTORY

Mom's occupation: _____ How many hours per week? _____

Dad's occupation: _____ How many hours per week? _____

Any recent work changes?: _____

Any recent marital changes?: _____

Day care/preschool? _____ How many days per week? _____

Babysitter/nanny? _____ How many days per week? _____

School: _____ Grade/Year? _____

Problems at school? _____

Outside support (family, friends, etc): _____

How many people live in the home? _____

Siblings? _____ Names & Ages: _____

Any recent stressors at home? _____

How would you rate your stress level at home? ___ Low ___ Medium ___ High

What are your family activities? _____

Alcohol use in the home? How long? _____ How often? _____

Tobacco use in the home? ___ Yes ___ No

Other drug use? ___ Yes ___ No

Child abuse/neglect? _____

SPORTS, HOBBIES, INTERESTS

SPORTS, HOBBIES, INTERESTS (please include both current and past):

NUTRITION

How many meals does your child eat per day?

- One
- Two
- Three
- Four or more

How many snacks does your child eat per day? _____

What kind? _____

How much water does your child drink per day?

- None
- 8 – 24 oz
- Quart to half gallon
- More than a half gallon

Formula: Amount (oz) _____ Type _____

Milk: Amount (oz) _____ Type _____

Juice: Amount (oz) _____ Type _____

Soft Drinks: Amount (oz) _____ Type _____

Does your child eat foods containing large amounts of sugar? ___ Yes ___ No

If so, what kinds of foods? _____

Does your child eat artificial sweeteners (Equal, Sweet 'n' Low or Sucralose)?

- Yes ___ No

List any FOOD ALLERGIES (be specific and be sure to include ALL food allergies):

List specific FOOD DISLIKES (be specific and include all foods your child just won't eat):

NUTRITION, con't

Typical Daily Food Intake: List all the food your child has consumed in the last TWO days. If these days are not typical, pick two days that are most typical of his/her eating patterns. Please be specific, including amounts of foods, beverages, and supplements.

DAY 1

Meal	Time	Food & Amt	Beverage & Amt
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

DAY 2

Meal	Time	Food & Amt	Beverage & Amt
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

MEDICATION & NUTRITIONAL SUPPLEMENTS

Please list the name(s), dosage, frequency, and duration of all MEDICATION and/or SUPPLEMENTS, VITAMINS, MINERALS, HERBS, or HOMEOPATHICS your child is taking:

Name	Dosage	Frequency	Duration