Kelly Austin, ND
Natasha Monterey, ND
Email: austin.nd@gmail.com
858.675.7072

Pediatric Confidential Health Record

Contact Information

LAST NAME	FIRST NAME		TODAY'S DATE MM DD YY
HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	EMAIL ADDRESS
Permission to leave messages: Y N	DATE OF BIRTH - -	GENDER: FEMALE MALE	AGE

EMERGENCY CONTACT NAME	PHONE
Who is filling out this form? (name & relation)	Who does the child live with?
How did you hear about our clinic?	PRIMARY MEDICAL PHYSICIAN NAME / PHONE

List other healthcare providers with office phone numbers:

CURRENT STATUS

MOST IMPORTANT HEALTH CONCERNS, STARTING WITH THE MOST IMMEDIATE

1	4
2	5
3	6

Usual Health: Excellent Good Fair Poor	Time of highest energy during the day: Morning Afternoon Evening
Energy: Good Fair Poor Varies	Time of lowest energy during the day: Morning Afternoon Evening

Medications: please list prescription medication, over-the-counter medications and supplements taken regularly:

NAME	REASON	DOSE	START DATE	SIDE EFFECTS

PRIME WELLNESS

Kelly Austin, ND
Natasha Monterey, ND
Email: austin.nd@gmail.com
Phone: 858.675.7072

DIET

How was your infant fed?

☐ Breast fed. How long? _____

☐ Formula. Milk/Soy/Other: _____

Veg: _____ Fruit:_____

Grain: _____ Bean/meat: _____

Sweets: _____ Concerns: _____

_____

Did your child ever experience colic? Y N

How severe? mild moderate severe

Describe a typical day's diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages (and total quantity)_____

_____

ELIMINATION

BM Freq: _____ Appearance: _____

Urinary freq:_____ Toilet training: _____

Concerns: _____

SLEEP

Hrs/night: _____ Naps freq: _____ Amt: _____

Where: _____ Habits: _____

Concerns: _____

_____

GROWTH & DEVELOPMENT

Stand	Y N	Scribble:	Y N
Walk:	Y N	Feed Self:	Y N
Run	Y N	Wave bye bye:	Y N
Dada/mama specific:	Y N	Drink from cup:	Y N
Number of words:	___	Use spoon /fork:	Y N
Imitate speech:	Y N	Remove clothes:	Y N

BEHAVIOR/PERSONALITY

Has your child's genetics been tested? Y N

Do you give our office permission to run genetics? Y N

Describe child: _____

_____

Temper tantrums: Y N How managed? _____

_____

Discipline (reasons, methods) _____

_____

Adaptable Y N Plays well w/others Y N Shares: Y N

Aggressive: Y N How managed: _____

TV/day: _____ Read to daily: Y N

Concerns: _____

How would you describe your child's behaviour and performance at school? _____

FAMILY/SOCIAL

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

Does anyone in the child's household drink? Y N Who?____

Dental care: Y N

Concerns: _____

DAY CARE

Y N Where: _____

Freq/Length: _____

Concerns: _____

VACCINATION STATUS

1. Is your child up to date on their vaccinations? Y N
2. If not, what vaccinations (if any) have they received?

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

_____ Date Received:_____

Environment

What are your child's favorite activities?

_____

_____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?

Please describe: _____

How was your child's health in the first year?

Poor Fair Good Excellent Unknown

Kelly Austin, ND
Natasha Monterey, ND
Email: austin.nd@gmail.com
Phone: 858.675.7072

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? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting

☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma

Other _____

_____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements: _____

☐ Other: _____

Birth history

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries _____

☐ Birth defects _____

☐ Other _____

Is there anything that you feel is important that has not been covered?

_____

_____

Dr. Kelly Austin, ND
Dr. Natasha Monterey, ND
atmyprime.com 858.675.7072

OFFICE POLICIES

Hours Rancho Bernardo
Monday- Friday 9am-5pm

Hours Solana Beach
Monday / Tuesday / Thursday 9am-4pm
Wednesday & Friday 9am-1:00pm

Office visits are by appointment only.
B12 walk-ins welcomed!

Fees

$375 Initial Appointment (55 min)
$375 1st follow-up (55 min)
$200 follow-up (45 min)
$125 follow-up (25 min)
$90 follow-up (15 min)

Payment

• Payment is due at the time of service. Please discuss any fee questions with the doctor before your visit so you can know what to expect.
• We accept cash, check or credit cards.
• Lab testing is not included in the fee. If you have a PPO, we will use a lab facility that is covered by your insurance company. If you have a HMO, we can ask your HMO MD to run the labs we need.
• Fee schedules can be arranged with the doctor prior to a visit if you are in financial need.

Insurance

- Insurance does not directly cover naturopathic doctors.
- However, we can provide you with a superbill after every visit which you may submit to your insurance company to request out-of-network reimbursement. Some services may not be covered by certain health insurance plans.
- It is your responsibility to know what your insurance plan covers.
- We are not responsible for unpaid claims by your insurance company for services we provide.

Phone Consults

- We will call you for your scheduled appointment. Please allow a 5 to 10 minute window of buffered time.
- All appointments are scheduled for the Pacific Standard Time.

Cancellations

- As a courtesy, our office will e-mail or call you to confirm your appointment 1 business day in advance.
- If you cannot keep a scheduled appointment, please notify us at least 24 hours prior to your scheduled time.
- If you miss your appointment without cancelling, you will be charged for the missed appointment.

Appointments

- First appointment: Please fill in the new patient forms prior to your appointment. You may bring them with you to your appointment or fax them in.
- Please arrive 15 minutes before your scheduled appointment.
- Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, perfumes, cologne and hair spray.
- Follow-up consults may be scheduled in 15, 30, 45, or 60 minute blocks, depending on your needs.
- All consultations are charged for the time used, not the time blocked.
- Research requested by the patient is a billable service and will be charged at the hourly rate.
- Follow-up visits: We generally recommend that all patients have a follow-up every 3 months at minimum.

Prescriptions

- Prescriptions need to be obtained at your appointment. We do not mail prescriptions or lab orders.
- We require 24-hour notice for refills.
- Hormone prescriptions are done on a 3 month basis, and require a follow up to renew them.
- Please come to all appointments prepared with a complete medication list and let us know which require refills.
- No prescription dose change will be made without an appointment.
- If you are sick or have side effects, please contact us immediately.
- The doctor cannot prescribe medications to those who are not his or her patient.

Tests

- If you misplace an order for testing, we require 24-hour notice to rewrite the order. You can pick it up at the office or we can e-mail it to you.
- Tests will not be discussed via phone unless it is a phone consult.
- Results are only discussed at appointments and not outside the office to prevent unsafe disclosure of the confidential health information.

Medical Letters

- Medical letters (for schools, insurance companies, etc) can be provided. The charge for generating these will be billed at the doctor's hourly rate.

Follow-Up Questions

- You can contact the doctor with follow-up questions, but please keep these brief. If a question is more involved, a consult may be required.

General

- Please keep all health concern discussions to office visits.
- Please avoid discussing other people's health concerns at the visit. You have limited time with the doctor and we want to make sure you get the time and attention needed to make you feel better.

The policies listed above have been established to ensure quality care for our patients. Should you have any questions, please contact our office.

Dr. Kelly Austin, ND
Dr. Natasha Monterey, ND
atmyprime.com 858.675.7072

DECLARATION AND CONSENT TO TREAT

Name: _____ Date: MM DD YY

please print

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, and treat the cause of the illness by taking into consideration physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

It is very important therefore, that you provide such information as any medications or over the counter drugs you are currently taking, disease processes you are currently suffering from or if you suspect that you are pregnant.

This is to acknowledge that I have been informed and I understand that:

1. I have read all the foregoing information and that I understand that the ultimate responsibility for my health is my own.
2. I am receiving treatment from a Naturopathic Doctor, not a Medical Doctor.
3. All treatments offered are within the Naturopathic scope of practice.
4. Any treatment or advice given to me as a patient is not mutually exclusive from any treatment or advice that I may receive now, or in the future, from another licensed health care provider.
5. I am at liberty to seek or continue medical care from a physician, surgeon or other health care provider.
6. I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
7. There are some slight health risks to treatment by Naturopathic medicine. These include, but are not limited to:
    - Allergic reactions to supplements or herbs
    - Side effects of medications (eg. Hormone Therapy, Antibiotics)
    - Pain, bruising, infection or injury from injections

PLEASE NOTE: There is a 24-hour cancellation policy at the clinic. If you are unable to make your appointment, please notify the clinic at least 24 hours in advance to ensure you are not charged the initial visit fee. _____ ← *please initial here*

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Signature / Signature of Guardian _____

Dr. Kelly Austin, ND
Dr. Natasha Monterey, ND
atmyprime.com 858.675.7072

Notices of Privacy Practices and Electronic Consent

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of the protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - o the right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - o the right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - o the right to receive confidential communications of protected health information.
    - o the right to inspect and copy protected health information.
    - o the right to amend protected health information.
    - o the right to receive an accounting of disclosures of protected health information.
    - o the right to obtain a paper copy of the Notice of Private Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Private Practices and to make new provisions effective for all protected health information it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Email:

I acknowledge the by electing to receive my health information via email in an unsecure manner, that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Prime Wellness is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.
Receive my health information through email: Yes _____ No _____

Telemedicine:

Telemedicine involves the use of electronic communications to enable our patients to choose whether they would like their consultations to be in person or over the phone, this helps to improve patient care. The information may be used for diagnosis, therapy, follow-up and/or education.
Confidentiality: At Prime Wellness all reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation.
Rights: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.
Consultations over the phone: Yes _____ No _____

My signature below signifies that I have read and understand the Privacy Practices of this clinic and that I have marked my consent preferences for emails and telemedicine.

Signature _____ Date _____

Dr. Kelly Austin, ND
Dr. Natasha Monterey, ND
atmyprime.com 858.675.7072

Cancellation Policy/No Show Policy for Appointments

1. *Cancellation/ No Show Policy for Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged the full price for your service.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment and you will be charged the full price for your service.

3. Account Balances

We do require that patients to pay their account balances to zero prior to receiving further services by our practice. Patients who have questions about their bills may call and ask to speak to a business office representative

_____ _____ ____/____/____

Print Name Signature Patient/Guardian Date