Banyan
Wellness Center

PEDIATRIC INTAKE FORM (Birth- 18 years)

Patient's name _____ Date of first visit _____
Age _____ Date of Birth _____Gender: female _____male_____
Mother's name_____Father's name _____
If parents are separated or divorced who has custody of the child and power to make medical decision? _____
Address _____ City _____
State _____ Zip code _____
Tel: (c) _____ (h) _____ (w) _____
How did you hear about this clinic? _____
Health insurance: Company _____
Policy/I.D. No. _____ Group # _____
Name policy is in _____
Policy holder date or birth:_____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept _
_____

Reason for referral or presenting problems _____
_____

Next of Kin or other to reach in case of an emergency?

_____

Relationship:_____ Phone: _____

Address:_____

_____

Please list with whom, other than yourself, we may discuss your child's personal medical information:

1.) Name:_____

Tel: _____

Relationship: _____

2.) Name: _____

Tel: _____

Relationship:_____

In the event that we cannot speak to you directly do you wish for us to leave medical information on your voicemail or message system?

Yes_____ No _____

If yes, what number may we leave medical information?

(c) _____ (h) _____ (w) _____

Do you wish to receive newsletters in the form of e-mails from our office?

Yes _____ No _____

Do you wish to receive text messages about appointment reminders?

Yes _____ No _____

What are your child's most important health problems? List them in order of importance.

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

MEDICATIONS Now Past Now Past

Aspirin _____ _____ Antibiotics _____ _____
Tylenol _____ _____ Anti-histamine _____ _____
Decongestant _____ _____ Ibuprofen _____ _____
Any other medications _____

Please list any medications, over the counter medications, vitamins or supplements that your child is currently taking:

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

ALLERGIES

Is your child allergic or sensitive to any of the following:
Any foods? _____
Any drugs? _____
Any environmental? _____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no ___
_____ Measles _____ Pneumonia _____ Ear infections, no ___
_____ Mumps _____ Frequent colds _____ Rheumatic fever
_____ Rubella _____ Other (explain) _____

Has your child had any of the following tests? When Where Results

Electroencephalogram _____
Psychological evaluation _____
Hearing _____
Speech/Language _____
Injuries/Surgeries/Hospitalizations (please list): _____
_____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox
_____ Mumps _____ DPT _____ Tetanus _____ Influenza

Others (list) _____
Any adverse reactions? Y N
What ? _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?
Mother's age at child's birth? _____
Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Medications _____ Hypertension (pre-eclampsia)
_____ Thyroid problems _____ Diabetes (gestational)

BIRTH HISTORY (children birth to 5yo)

Term: Full _____ Premature _____ Late _____Weight at birth _____
Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain)
_____

Child's sleep patterns (first year)

_____

Food intolerances (if any)

_____

Feeding: Breast fed? _____ How long? _____
Formula? milk / soy How long? _____

Age began solids _____ Which foods? _____
Sitting _____ Crawling _____
Walking _____ Talking

Review of Systems (mark **Y** if current, **P** for past symptoms, **N** for none)

MENTAL/ EMOTIONAL

Treated for emotional problems	Y P N	Depression	Y P N
Mood Swings	Y P N	Anxiety or nervousness	Y P N
Unusual fears	Y P N	Irritability	Y P N
Poor concentration	Y P N	Memory problems	Y P N
Hyperactivity	Y P N	Introvert/Extrovert	Y P N
Motion sickness	Y P N	Cries easily	Y P N

ENDOCRINE

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Low blood sugars	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N		

IMMUNE

Chronic infections	Y P N	Slow wound healing	Y P N
Chronically swollen glands	Y P N		

NEUROLOGIC

Seizures	Y P N	Muscle weakness	Y P N
Loss of memory	Y P N	Easily stressed	Y P N
Vertigo or dizziness	Y P N	Loss of balance	Y P N

SKIN

Rashes	Y P N	Eczema, Hives	Y P N
Acne, Boils	Y P N	Itching	Y P N
Color Change	Y P N	Perpetual Hair Loss	Y P N
Lumps	Y P N	Night Sweats	Y P N

HEAD

Headaches	Y P N	Head Injury	Y P N

EYES

Impaired vision	Y P N	Glasses or contacts	Y P N
Blurriness	Y P N	Tearing or dryness	Y P N
Color blindness?	Y P N		

EARS

Impaired hearing	Y P N	Ringing	Y P N
Earaches	Y P N		

NOSE AND SINUSES

Frequent colds	Y P N	Nose Bleeds	Y P N
Stuffiness	Y P N	Hayfever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH AND THROAT

Frequent sore throat	Y P N	Copious saliva	Y P N
Teeth grinding	Y P N	Sore tongue/lips	Y P N
Gum problems	Y P N	Hoarseness	Y P N
Dental cavities?	Y P N	Jaw clicks	Y P N

RESPIRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N
Pneumonia	Y P N	Pleurisy	Y P N
Shortness of breath	Y P N	Tuberculosis	Y P N

CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N
High/Low Blood Pressure	Y P N	Fainting	Y P N

GASTROINTESTINAL

Trouble swallowing	Y P N	Heartburn	Y P N
Change in thirst	Y P N	Change in appetite	Y P N
Nausea	Y P N	Vomiting	Y P N
Vomiting blood	Y P N	Bowel Movements:	
Blood in stool	Y P N	Number/day_____	
Is this a change_____			
Pain or cramps	Y P N	Constipation	Y P N
Belching or passing gas	Y P N	Diarrhea	Y P N
Black stools	Y P N	Gall Bladder disease	Y P N
Jaundice (yellow skin)	Y P N	Ulcer	Y P N
Liver Disease	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination	Y P N	Increased frequency	Y P N
Bed wetting	Y P N	Inability to hold urine	Y P N
Frequent infections	Y P N		

BOY'S HEALTH

Hernias	Y P N	Testicular masses	Y P N
Testicular pain	Y P N	Prostate disease	Y P N
Venereal disease	Y P N	Discharge or sores	Y P N
Are you sexually active	Y N	Chlamydia	Y P N
Sexual orientation: _____		Gonorrhea	Y P N
Condyloma	Y P N		
Premature ejaculation	Y P N	Herpes	Y P N
Birth control? Type? _____		Syphilis	Y P N

GIRL'S HEALTH

Age of first menses? _____		Age of last menses? _____	
Are cycles regular	Y N	Length of cycle	_____days
Bleeding between cycles	Y P N	Duration of menses	_____days
Pain during intercourse	Y P N	Painful menses	Y P N
Clotting	Y P N	Heavy or excessive flow	Y P N
Discharge?	Y P N		
PMS?	Y P N		
If yes, what are your symptoms?			
_____			
Birth control?	Y P N		
What Type? _____			
Number of years? _____			
Number of pregnancies? _____		Number of live births _____	
Number of miscarriages?_____		Number of Abortions_____	
Endometriosis?	Y P N	Ovarian cysts?	Y P N
Difficulty conceiving?	Y P N	Menopausal symptoms?	Y P N
		If yes, what?_____	
Cervical Dysplasia	Y P N	Abnormal PAP	Y P N
Sexual difficulties	Y P N	Chlamydia	Y P N
Gonorrhea	Y P N	Condyloma	Y P N
Herpes	Y P N	Syphilis	Y P N
Are you sexually active	Y N	Sexual orientation: _____	
Do you do breast self exams	Y P N	Breast lumps	Y P N
Breast pain/tenderness	Y P N	Nipple discharge	Y P N

MUSCULOSKELETAL

Joint pain or stiffness	Y P N	Arthritis	Y P N
Broken bones	Y P N	Weakness	Y P N
Muscle spasms or cramps	Y P N	Sciatica	Y P N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising	Y P N	Anemia	Y P N
Deep leg pain	Y P N	Cold hands/feet	Y P N

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Is your child on any special diet?

Gluten Free _____ Dairy/Lactose Free _____

Wheat Free _____ Yeast Free _____

Vegan _____ Vegetarian _____

Other: _____

Exercise:

What form: _____

How often: _____

Is there any additional information that you feel is pertinent to better understanding your child's health?

_____

_____

_____

_____

Thank you, we are honored that you have entrusted Banyan Wellness Center to assist in the health and wellbeing of your child and we look forward to helping you child achieve optimum health and wellness

BANYAN WELLNESS CENTER
1646 N. Litchfield Road, Suite 200
Goodyear, AZ 85395

Terms of Agreement

Patient Name: *Last*_____ *First*_____ *M.I.*___

Age:_____ Date of Birth:_____/_____/_____ Social Security #:_____/_____/_____

Welcome to *Banyan Wellness Center* and thank you for choosing us for your health care needs. We look forward to helping you recapture your life.

Office Hours: Our hours of operation are currently Monday-Thursday 8:30am - 5pm and Friday 8:30am - 4pm. We are closed daily from 12:00pm - 1:30pm. We reserve the right to change our office hours at any time without prior notification.

Active Patient: To be considered an active patient in the practice you must have been seen by one of the doctors within the last 3 years. If it has been over 3 years since you have had an appointment your chart will be moved to storage. After 3 years you will be starting as a new patient within the practice. We are required by law to maintain your records for 6 years, after 6 years we reserve the right to dispose of your medical information. If you would like to have a copy of your chart please see the records policy below. We will forward your information to another provider at no expense via fax, however, if a hard copy is required by your new physician there will be an applicable copy fee.

Visits: All visits with the providers at Banyan Wellness Center are based on time. Time blocks are based on 15 minute increments. Our staff tracks each appointment starting from the moment your doctor closes their office door, ending when all questions have been answered at the front of the office with your doctor. Once your appointment has gone 7 minutes past the 15 minute increment your visit will be billed at the next higher 15 minute increment. The staff tracks the duration of the visit to ensure that you are being charged appropriately, and only for the time spent with your doctor. This is to avoid any confusion as to why you are being charged more or less then the scheduled appointment time. We want to ensure that you are only charged for the time you spend with your doctor. The appointment charge is non-negotiable and will not be adjusted.

We do not take walk in appointments, however, we will do everything we can to accommodate urgent visits including same day visits, as long as a provider is available. Please understand that in the event of an urgent visit your appointment will be with the first available doctor which may or may not be your "regular" doctor, however, you will be given options.

Initial appointments: If you should go over the allotted time for your initial appointment there will be an additional charge based on the additional amount of time spent with your doctor, again, based on 15 minute increments.

Follow up appointments: Follow up appointment are scheduled in 15 minutes increments. In the event that your appointment should go over your allotted time by 7 minutes you will be charged at the next 15 minute increment. For example, if you are scheduled for a 30 minute follow up appointment and your follow up lasted 38 minutes you will be charged for a 45 minute follow up appointment. Accordingly, if you are scheduled for a 45 minute appointment and you only spend 30 minutes with the doctor you will only be charged for the time that you spent with the doctor, in this case, 30 minutes. Rates are subject to change without notice, although we will do our best to make our patients aware of any changes to our fee structure in advance.

Phone consults: For your convenience we offer phone consults to existing patients. When it is time for your appointment our office staff will call you and collect a credit card for the payment of your appointment prior to being transferred to your doctor. Your card will only be charged after you have finished your appointment at which time we can ship out any supplements that may be needed as well. Phone consults are billed at the same 15 minute increment and rate as a face to face to consult.

Late for your appointment: In the event that you are 15 minutes late for your appointment you may be asked to reschedule your appointment, this will be at the discretion of your doctor. In the event that you are late and your doctor is able to see you, you may not be seen for the original scheduled follow up time as there is traditionally another patient scheduled after you. Thus, you may only get 30 minutes of your allocated 45 minute appointment. You will be billed for the amount of time spent with your doctor.

HCG follow up appointments: HCG follow up appointments are scheduled for 15 minutes with the doctor and is included in the price of your HCG program. In the event that your follow up should go over the allocated 15 minutes you will be charged for the additional time spent with the doctor.

After Hours Calls: All after hours calls made to any of the providers will be assessed a $95 fee and will be called upon to be collected the following business day.

Cancellations:
Initial appointment: If you should need to reschedule your initial appointment please be sure to provide us with 24 business hours notice prior to your scheduled appointment time. This means that if you are scheduled for a Monday you would need to cancel on the Friday before, same applies for holidays. You will receive a courtesy phone call reminding you of your initial appointment at the number provided at the time of booking your appointment, 48 hours prior to your scheduled time. If we do not receive notice of cancellation of your initial appointment 24 hours prior and you need to change your appointment or if you do not show up for your appointment the $25 deposit is forfeited.

If you reschedule your initial appointment 24 business hours in advance of your scheduled time the initial $25 deposit is honored. The deposit will be held on your account for 3 months, if you do not reschedule your initial appointment within 3 months, the deposit is forfeited and a new deposit will be required to schedule an initial appointment. In the event that you are a no show for your initial appointment and you would like to reschedule your initial appointment, we will retain the original $25 deposit and require a non-refundable deposit for the full amount of the initial appointment at the time we reschedule your appointment. Our office does not double book patients, the scheduled hour is time dedicated solely to you.

Follow up appointment:
If you fail to give 24 business hours notification for your scheduled follow up visit or do not show up for your appointment you will be responsible for to the full amount of your allotted appointment time. This will be invoiced to your account and it will be necessary for this invoice to be paid prior to scheduling another follow up. We give every patient the grace of one missed follow up appointment understanding that things happen in life, this visit is not invoiced, however, any future missed appointments will be.

HCG follow up:
If you do not show up for your HCG follow up visit (part of your package) or fail to cancel within 24 hours of your scheduled HCG follow up you will forfeit your complimentary follow up appointment.

IV therapy:
One of the treatments offered at Banyan Wellness Center is IV therapy. The IVs that we administer are vast and for a variety of conditions which may be recommended to you by your doctor. All IVs are custom made for you specifically. IVs are made the day of your appointment. You will receive a courtesy reminder of your scheduled IV appointment 48 hours prior to your IV. If you do not show up or do not cancel your IV appointment within 24 business hours of your scheduled time you will be charged for the full amount of your IV, even if you did not receive the infusion, as we must now discard the mix.

Fees & Financial Policy: Payment of fees is the direct responsibility of the patient. *Banyan Wellness Center* does not bill insurance, however we will provide you upon request with the necessary form so that you may submit directly to your insurance provider. You are responsible for contacting your insurance provider to verify your benefits. We cannot guarantee reimbursement. We are currently not recognized by Medicare, AHCCCS, HMO plans or TriCare and therefore are unable to provide any claim forms to submit for reimbursement for the aforementioned plans.

Health Insurance Claim Form:
Currently the health care providers at Banyan Wellness Center are not contracted with any health insurance providers. As the health care field is constantly changing, this also may change in the future. If you have a PPO plan and you would like to submit for reimbursement for your office visit, please inform one of our staff members at the time of your appointment. We cannot guarantee reimbursement, however, if you have a PPO plan and your deductible has been met there is a good possibility that your visit will be

be reimbursed at an out of network provider rate. The form will be filled out and mailed to you for you to submit to your insurance provider for reimbursement. Unfortunately, as it stands we currently cannot submit an insurance claim form for our patients who have Medicare, Medicaid (AHCCS), Tri-care or an HMO plan. Your health related expenses may be tax deductible including any supplements that have been prescribed for you. If you have an HSA of flex spending account you may be able to use those funds to pay for your visit, supplements or any other medically necessary expenses you incur within the office including procedures and IVs, please check with your health care plan administrator.

Medicinary: When you are in need of supplement refills please order through the website, www.wvncaz.com, and fill out the supplement order request form, for the products you need. This is the best method to ensure that we have the product in stock and that you will not be waiting. You will receive a confirmation email for your order and it will be ready for you to pick up or it can be mailed to you for an additional postal fee per your request. Of course you can always stop into the office to pick up your products, but it is recommended that you call ahead to confirm that we have everything that you need in stock. Please understand that there may be an additional wait time. There are no refunds for items purchased from our medicinary.

There are times when a patient may require or desires a specialty product that we do not routinely carry in stock. Please talk to our office manager about the possibility of placing a special order you for the particular item. When specialty orders are placed we will collect payment in advance for the item and you will be called once the item has arrived to the office for pick up.

Banyan Wellness Center carries physician grade supplements, manufactured from facilities with the strictest of standards. This allows us to ensure the potency, safety and efficacy of the products you are using. If you should choose to purchase product outside of the ones that have been recommended for you by your provider here at Banyan Wellness Center, you are taking on the risk and liability of the product including the possibility of heavy metal contaminants such as lead, mercury, PCBs, organocides, fungicides, herbacides and other chemicals. Understanding that these products may not only interfere with your capacity to recapture your life, but also impair your health.

Prescriptions: If you are in need of a prescription refill please contact your pharmacy and have them fax a refill request. Please allow 72 hours for this process to ensure that you will not run out of your medication. Our doctors require a face to face visit at a minimum of every 12 months in order to be able to continue to refill your mediations. Your doctor may require more frequent visits, ranging from monthly to quarterly appointments depending on the medication being prescribed, which occurs frequently when prescribing hormones, thyroid, pain medication and/or controlled substances.

Labs: Most insurance providers provide coverage for laboratory testing, however, the amount of coverage varies greatly. In some circumstances you may have a copay or a deductible that needs to be met prior to your insurance covering the laboratory fee. It is your responsibility to call your insurance provider and to be familiar with your coverage as well as the preferred laboratory for your insurance plan. In the event that labs are ran

through one of the commercial testing facilities (LabCorp or Sonora Quest) and your insurance does not cover your testing they will bill you at the insurance rate which is usually 2-3 times higher then the cash labs that we have available to you. We will provide you with a cash price quote for labs when asked, so that you may better understand your options. Many times the cash price is a significant savings to you.

At Banyan Wellness Center we have a wide array of testing available to better assess your current medical needs include; food allergy testing, neurotransmitter testing, hormone testing, genetic testing and environmental exposure testing. Unfortunately, these labs are traditionally not coved by insurance and are a cash pay.

Lab Copies:
It is the office policy that when your doctor runs labs a follow up appointment is scheduled to go over those labs. This is to ensure that you understand all aspects of your labs as well as an opportunity for your doctor to raise any concerns seen. Your doctor will make recommendations based on your lab work and also give you an opportunity to ask any questions. If you would like to have a copy of your labs without seeing your doctor you will be asked to sign a document stating that you understand the risk in not having a follow up with your doctor to discuss the labs and accept responsibility.

Copies of your labs will be provided to you at the time of your visit. Should you require hard copies of past labs, they will be provided to you at a charge of $.30 per page. If you would like to have your labs faxed or emailed to you, this will be done at no additional charge.

Records: In the event that you should require a copy of your personal health records there will be a $.30 charge per page and a $10 copy fee. You must allow one week for this process. In the event that a transfer of records needs to occur, we will forward your health records to the physician you have chosen at no expense via fax.

Release of Records: Please see the attached separate paperwork acknowledging with whom we may share your protected medical information. If this information is not present we will require a signed document prior to being able to release your records.

Terms: We shall collect payment for services and products at the time of service.
We accept cash, check, Visa, Master Card and Discover as forms of payment. We will charge 20% of the total for any insufficient funds checks that are returned.

Statement: I have read and understand the above policies of Banyan Wellness Center and West Valley Naturopathic Center LLC and agree to them. I consent to treatment from Dr. Brian Archambault NMD and Dr. Carla Briante, as well as any other provider of West Valley Naturopathic Center and Banyan Wellness Center and accept full responsibility for all expenses incurred by or on my patient account. In the event of non-payment, I will bear the cost of collection and/or all court costs and legal fees should it be required.

_____ _____

Signature of Patient or Guardian Date (DD/MM/YY)

BANYAN WELLNESS CENTER
1646 N. Litchfield Road, Suite 200
Goodyear, AZ 85395

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES SUMMARY

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that *Banyan Wellness Center* has provided me with a copy of its Notice of Privacy Practices Summary that summarizes how medical information about me may be used and disclosed. I further acknowledge that a complete copy of Privacy Practices Policies (approx.13 pages) is available upon request and in the waiting area.

I understand that if I have questions or complaints I may contact:

Privacy Officer: Christian Archambault
Tel: 623.643.9598

I also understand that I am entitled to receive updates upon request if *Banyan Wellness Center* amends or changes its Notice of Privacy Practices in a material way. Privacy Practices Policy effective July 1, 2004.

_____ _____

Signature Relationship to Patient, if signed by someone other than patient.

_____

Date

THIS SECTION IS TO BE COMPLETED BY THE BANYAN WELLNESS CENTER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices Summary from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____

Name and title of employee Date