NOURISH
HOUSE CALLS

Pediatric Intake Form

Patient's Name: _____ DOB: _____ Male__ Female__

Home Address: _____City: _____State:_____ Zip:_____

Home Telephone #: _____Mobile #:_____ Work #: _____

E-mail: _____Employer: _____Occupation: _____

Insurance Company: _____ Insured Name: _____

Relation to Patient: _____Insurance ID #: _____Group #: _____

Parent #1 Name: _____DOB: _____Male __Female__

(Complete the following if different from patient's information)

Home Address: _____City: _____State: _____Zip: _____

Home Telephone #: _____Mobile #: _____Work #: _____

E-mail: _____Employer: _____Occupation: _____

Parent #2 Name: _____DOB: _____Male __Female__

(Complete the following if different from patient's information)

Home Address: _____City: _____State: ___ Zip: _____

Home Telephone #: _____Mobile #: _____Work #: _____

E-mail: _____ Employer: _____Occupation: _____

Do both parents have legal medical decision-making authority? o Yes o No

Are both parents supportive of alternative/integrative medical treatments? o Yes o No

Who has legal custody? _____ With whom does the patient live? _____

Siblings seen in this practice: _____, _____, _____

Who may we thank for your referral? _____

Authorization for Integrative Medical Treatment

I authorize the Nourish House Calls, Inc. to administer such medical and health care services, treatments and procedures for my child as deemed appropriate and necessary. I understand that my practitioner will prescribe an integrative treatment program for my child, which may include conventional medical care, nutritional therapies, homeopathy, herbal medicine, functional medicine, biomedical approaches to autism, and other aspects of integrative medical treatment. As a patient or parent seeking integrative medical treatment, I understand that I must decide, in conjunction with my child's practitioner, what course of treatment will best benefit my child. I understand that any or all of the above referenced treatment modalities may be considered unproven or experimental by other doctors, medical agencies, or third-party payers and may not be reimbursable. I understand that the benefits and/or risks and dangers of any treatment program prescribed by my practitioner will be explained to me to my full satisfaction. I understand that if any explanations as to the benefits and/or the risks and dangers of any of the prescribed treatment programs are unclear, it is my responsibility to ask for clarification before giving my consent to treatment. While I understand that there have been no warranties or assurances of successful outcome for my child, I nevertheless desire to pursue integrative medical treatment for my child after having considered all factors, including the information contained herein. I understand that it is my responsibility to contact Nourish House Calls, Inc. to report any issues that my child is having with the treatment program, and to schedule consult time to make program adjustments and to conduct appropriate testing. I am responsible for seeking professional medical attention from my practitioner at Nourish House Calls, or another facility if my child experiences any unanticipated or unpleasant effects associated with treatment or a worsening my child's condition. If an emergency medical condition arises, I will seek treatment for my child immediately from the nearest emergency department or by calling 9-1-1.

By signing this, you indicate you have read and accept the terms of this section.

If patient is a minor, both parents and/or all legal guardians must initial and sign.

Parent #1_____Date: _____

Parent #2_____Date: _____

General Informed Consent to Diagnosis and Treatment

The intention of this consent form is to help patients, clients, and authorized representatives become better informed so that they may give or withhold consent to undergo diagnosis and treatment after having an opportunity to discuss health concerns - including potential benefits and risks, and treatment alternatives.

I,_____ PATIENT, CLIENT, or AUTHORIZED GUARDIAN or REPRESENTATIVE, (hereafter referred to as "patient or representative") acknowledge the opportunity to read and inquire about this consent and all the items addressed herein and hereby authorize Joya Van Der Laan, MSN, FNP-BC, (hereafter referred to as "clinician"), in accordance and within the scope and limits of her clinical license(s), to perform or recommend any of the following procedures for diagnosis and/or treatment:

__ Common Diagnostic Procedures: venipuncture, radiography, laboratory, x-ray, ultrasound, etc.

__ Alternative Diagnostic Procedures: including diagnostic methods, functional laboratory testing, and devices that may fall outside of the "conventional standard of care."
__ Lifestyle Counseling: therapeutic dietary advice and guidelines and the promotion of wellness including, but not limited to, recommendations for sleep, exercise, stress management and reduction, balancing of work and self-care activities, and developing and nurturing healthy relationships and community relationships.
__ Medical Nutrition: therapeutic nutrition; nutritional supplementation; intramuscular vitamin, mineral, amino acid, lipid, phytonutrient, and metabolite precursor and other nutrient injections; detoxification; and chelation.
__ Botanical Medicine: medicinal herbs and plant derivatives prescribed as loose teas, alcohol or glycerin tinctures, capsules, tablets, creams, suppositories, etc.
__ Intravenous Therapies: including high dose vitamin, mineral, amino acid, lipid, botanical and other nutrients, and chelation therapy.
__ Minor Office Procedures: wound dressing, ear cleansing, sutures, biopsies, immunizations, joint injections, bursa injections, trigger point injections, etc.
__ Physical Medicine: massage, stretching, exercises, contrast heat/cold applications and manual or instrument-assisted joint mobilizations, as permitted by licensure.
__ Prescription Medications: As allowed by the clinician's licensure and for both FDA-approved and non-FDA approved (i.e. "off label") applications.
__ Hormonal Replacement: oral, transdermal, injected or device-implanted hormonal applications intended to restore symptomatic patients to levels at or above age-appropriate hormone levels through bioidentical, synthetic, and animal derived preparations.
__ Group Counseling (in person and online): to facilitate efficient and effective community creation and education regarding the diagnosis, treatment and management of health concerns.

Informed Consent:
____ (Patient's or Representative's Initials) acknowledges the right, opportunity and responsibility to ask questions and to become informed regarding the clinician's diagnostic and treatment recommendations to his or her satisfaction. Patient acknowledges that all questions asked have been fully answered by the clinician.
Potential Risks:
____ (Patient's or Representative's Initials) acknowledges and accepts that there are risks to the diagnosis and treatment measures that fall within and outside the conventional standard of care, and that these risks may include: unintended exacerbation of symptoms, new symptoms, allergic and other unintended injury and side effects from exercise, lifestyle modifications, dietary modifications, herbal and nutritional supplements, injected or intravenous therapies, hormonal therapies, adverse interactions with drugs, herbs and/or nutrients. The specific risks associated with the proposed procedures have been explained to the patient and/or the patient's representative.
No Guarantee of Potential Benefits:
____ (Patient's or Representative's Initials) acknowledges that treatment may result in the restoration of health and optimal functional capacity, relief of pain and symptoms, injury and disease recovery, and prevention or reversal of disease or disease progression, but ALSO acknowledges that no expressed or implied guarantees or representations can or have been made by the clinician or any affiliated staff regarding the cure or improvement of the patient's condition.
Limitations of Full Disclosure:

___ (Patient's or Representative's Initials) acknowledges that the clinician cannot know or anticipate and explain every possible risk or complication, and that the patient or representative willingly chooses to rely on the clinician to exercise their best judgment within the bounds of their licensure for any of the above.

Responsibility to Report Possible Pregnancy:

___ (Patient's or Representative's Initials) agrees to alert the clinician should she suspect that she is or may be pregnant in acknowledgement that some of the diagnostic or therapeutic techniques could present risks to a pregnancy.

Disclosure Coverage:

___ (Patient's or Representative's Initials) acknowledges and agrees that consent form will cover the entire course of treatment for the present condition and for any future condition(s) for which treatment is sought.

Willing Participation:

___ (Patient's or Representative's Initials) understands that the patient is free to discontinue participation in any and all aspects of the medical care provided by the clinician at any time, and that the patient or representative is responsible for informing the clinician of the adherence to or discontinuation of any and all aspects of care and that the choice to discontinue treatments may create the risk of adverse effects for which the patient or representative bears full and sole responsibility.

Clinician Collaboration:

___ (Patient's or Representative's Initials) understand that the clinician may consult with preceptors, clinical student residents and colleagues related to the care provided, and that the patient or the patient's authorized representative have the right to decline their presence or involvement during any aspect of the patient's care.

Agreement to be Contacted:

___ (Patient's or Representative's Initials) understand and accept that the clinician or affiliated staff may contact the patient or representative (e.g. by phone, email, voicemail, SMS text message) to consult or exchange information related to the patient's care.

Remote Consultations:

___ (Patient's or Representative's Initials) At times, consultation may be provided remotely and without direct contact with clinician. In such cases, the patient or their representative agree to maintain direct contact with a licensed health care provider that is appropriate for the patient's age, gender and known or suspected health conditions. The clinician does not take responsibility for providing the full spectrum of primary care services such as managing preventative care procedures or providing screenings on the recommended timeline.

Patient's Responsibility to Disclose Information:

___ (Patient's or Representative's Initials) understands that the patient bears full responsibility for any adverse effects experienced during or after the course of treatment that were reasonably deemed to be caused or related to a deficit in the full, accurate and timely disclosure of symptoms and other medical information to the clinician to the best of the patient's or representative's ability.

Responsibility for Payment:

___ (Patient's or Representative's Initials) understands that some or all of the recommended diagnostic and treatment measures may fall outside the conventional standard of care and may not be approved or covered by the patient's insurance because the services rendered fall outside the "standard of care," and in such event, that the patient accepts full responsibility for all associated costs and fees.

Dispute Resolution:

___ (Patient's or Representative's Initials) agrees that short of overt negligence or malpractice, that any complaint or dispute that arises related to the diagnosis or treatment from clinician will be settled through binding mediation in the state which the clinician is licensed.

Patient's Signature: _____

Patient's Name: _____Date: _____

Representative's Signature: _____

Representative's Name: _____ Date: _____

Relationship to Patient: _____