Dear New Patient,

Welcome to Root of Healing Naturopathic Medicine. I look forward to helping you achieve your health and wellness goals. Let me take this opportunity to tell you a little more about my practice. I am a licensed naturopathic doctor who specializes in classical homeopathy and NAET (Nambudripad's Allergy Elimination Technique). I received my Naturopathic Doctor (ND) degree from Bastyr University in Seattle, WA, which is one of four federally-accredited Naturopathic Medical Schools in the United States. In addition to my naturopathic medical training, I have studied homeopathy with many internationally renowned teachers, including Rajan Sankaran, Massimo Mangialavori, Louis Klein, Paul Herscu, Amy Rothenberg and Roger Morrison. I am also a graduate of New England School of Homeopathy, which is based in Amherst, Massachusetts. In addition to homeopathy and NAET (Nambudripad's Allergy Elimination Technique), I also use flower essence therapy, craniosacral therapy, somato-emotional release, botanical medicine, nutritional and emotional counseling to help my patients create wellness from within.

What is Homeopathy?

Homeopathy is a 200-year-old system of medicine whose principles date back as far as 400 BC. Millions of people all over the world use homeopathy as a safe, natural, and effective way to treat acute and chronic disease. More and more people in the United States are experiencing increased health, vitality, and energy from the use of homeopathy.

The human body possesses the ability to heal itself. Homeopathy is a scientific method of triggering your body's self-healing potential. It is a holistic medicine that works on the body and mind together so you that will experience increased physical, mental, and emotional health. Patients report feeling more joy, freedom, relaxation, and peacefulness after homeopathic treatment.

What is NAET (Nambudripad's Allergy Elimination Technique)?

Our immune systems are constantly identifying substances as either healthy or toxic. But in today's world—as industries produce so many new products, new foods, and new chemicals—our bodies are exposed to an ever-increasing variety of substances. Our immune systems often become so overwhelmed that they begin to make errors, identifying healthy foods or harmless pollens as toxic. This misidentification leads to allergic reactions.

NAET (Nambudripad's Allergy Elimination Technique) is a systematic way of training the body to recognize which substances are not toxic. Once the body understands that something is not toxic, it will no longer create an allergic reaction to it. NAET is a safe, natural, and remarkably effective method of permanently removing allergies and other reactions against healthy substances.

I have been trained in the practice of NAET by Dr. Devi Nambudripad, MD, DC, LAc, PhD—who developed NAET by combining techniques from her expertise as a medical doctor, a chiropractor, and an acupuncturist.

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What will the first homeopathy visit be like?

Your initial constitutional homeopathic evaluation will last approximately 2 to 3 hours. Although this is much longer than a typical visit to the doctor, the methods that I use require that I completely understand you as a whole person—how you function in the world, how you respond to stress, and who you are both psychologically and physiologically. Many patients report that they have never had someone listen to them so carefully and understand them so fully. I believe that the deepest healing occurs once the root of the problem—the underlying imbalance that creates your symptoms—has been found.

After the visit, I will carefully study your case and everything that we discussed in the visit. Then, I will choose a constitutional homeopathic remedy specifically for you from the thousands of remedies available. Depending on your situation, I may also recommend other treatments, such as NAET, herbs, nutrients, dietary/lifestyle changes, craniosacral therapy, or counseling.

What are the fees?

The fee for the initial constitutional homeopathic evaluation is $335. This includes an initial office visit (2 to 3 hours) and my time for analyzing your case and selecting a remedy. Typical homeopathic follow-ups last about 45 minutes ($105), and are scheduled approximately every 6 weeks until your condition stabilizes.

If you are coming in for services other than homeopathy (including NAET), the first appointment is $210, and typically lasts about 1 ½ to 2 hours. NAET follow-ups are about 40 minutes and are scheduled 1-2 times per week. NAET follow-ups are $93 per session.

Phone appointments are billed at the same rate as office visits. All missed appointments and appointments cancelled with less than 24 hours notice will be billed the full appointment fee. Payment is due at the time of service. We accept Master Card, Visa and Discover cards, but prefer payment by check or cash if possible. We also offer a 3% discount for payment in cash or check at the time of service.

What about health insurance?

After each visit, we will provide a detailed receipt that includes the medical codes for diagnosis and treatment. You may submit this receipt to your health insurance company for possible reimbursement. Many insurance providers do cover naturopathic treatments.

Where is Root of Healing located?

Root of Healing Naturopathic Medicine, PLLC is located at 5400 California Avenue SW, Suite C, at the corner of SW Brandon Street, a few blocks south of the Alaska Junction in West Seattle, Washington. Free parking is easily available on the street around the building. You may also park in the spot labeled Full Life Nutrition if it is available. You may enter the building either from the door by the parking lot or the door on Brandon Street. Suite C is located on the second floor.

How do we get started?

Please fill out the enclosed forms and mail them to me at least one week before your first appointment. You can also e-mail the forms to office@rootofhealing.com or fax them to (206) 801-0810. We typically schedule new patients after we receive the forms.

I look forward to meeting you.

In health,

Rebecca Maya Parker, ND

Pediatric Intake Questionnaire

Name:	**Age:**	**Birthdate:**	**Gender:**
School Grade:	**School Name:**	**Height:**	**Weight:**
Allergies to Medications or Other Substances:			
Primary Care Physician:	**Last physical exam:**	**Last blood test:**	
Other Health Care Providers:			
Mother/Parent/Guardian:	**Father/Parent/Guardian:**		
If parents are not living together, describe child's living situation:			

Major Health Concerns, In Order of Importance for You: (Use Additional Pages If Necessary.)

Complaint	Since	Causes (known or suspected)

Currently Taking Any Medications Or Herbs/Supplements? (Use Additional Pages If Necessary.)

Medication/Supplement/Herb	Dose	Since	Results/Adverse Effects

Other Treatments, Diets, or Regimes? (Use Additional Pages If Necessary.)

Treatment or Regime (& practitioner, if any)	Since	Results

Members of Household (Including Pets)

Name	Age	Relationship

Birth History

Lbs_____ Weeks_____

☐ Full term ☐ Preterm

☐ Vaginal ☐ C-section Reason for C-section:

APGARS (If known):

Medications During Pregnancy

☐ None

☐ Prenatal Vitamins

☐ Other - Please list:

Mom's Pregnancy

☐ Uncomplicated
☐ Early Labor
☐ Hyperemesis (excessive vomiting)
☐ Bleeding
☐ Diabetes
☐ Thyroid problems
☐ Pre-eclampsia

Post Natal Complications

☐ None
☐ Jaundice
☐ Respiratory
☐ Cardiac
☐ Infections
☐ Gastrointestinal
☐ Hospitalized. How long?

Developmental History

Rolled over at _____ Walked at_____ Sat at_____ Talked at_____

Regression of speech? ☐ No ☐ Yes Difficulty comforting? ☐ No ☐ Yes Difficulty nursing? ☐ No ☐ Yes

Medical History

☐ Allergies
☐ Anemia
☐ Asthma
☐ Breath-holding spells
☐ Chicken pox
☐ Colic or esophageal reflux
☐ Dehydration
☐ Ear infections ☐ many ☐ rarely ☐ none
☐ Eczema
☐ Encephalitis
☐ Head injuries
☐ Headaches
☐ Meningitis
☐ Passing out (syncope)
☐ Strep infections
☐ Seizures
☐ With fever
☐ Without fever
☐ Whopping Cough

Other Medical Conditions:

Immunizations

Check (✓) immunizations given and circle how far in the series.

☐ HIB 2mo 4mo 6mo 12-15mo

☐ Pneumococcal 2mo 4mo 6mo 12-15mo

☐ Diptheria ☐ Pertussis ☐ Tetanus
2mo 4mo 6mo 6-18mo 4-6yrs 11yrs (tetanus only)

☐ Measles ☐ Mumps ☐ Rubella 12-14mo 4-6yrs

☐ Hep B birth to 2mo 1-4mo 6-18mo

☐ Varicella (12mo)

☐ Polio OPV or IPV 2mo 4mo 6-18mo 4-6yrs

Other? Any reactions to immunizations? Please describe:

Previous surgeries, injuries or hospitalizations: (Please include dates)

List substances child is allergic to and describe allergic reaction:

Please Check Any of The Following Conditions That Have Affected Your Blood Relatives:

☐ Alcoholism	☐ Bleeding Disorders	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Schizophrenia
☐ Allergies	☐ Brain Tumors	☐ Gonorrhea	☐ Learning Disabilities	☐ STDs (_____)
☐ Anemia	☐ Cancer (_____)	☐ Gout	☐ Mental Illness	☐ Skin Diseases
☐ Aneurysms	☐ Cerebral Palsy	☐ Hay Fever	☐ Mental Retardation	☐ Stroke
☐ Anxiety	☐ Chemical Dependency	☐ Headaches	☐ Migraines	☐ Syphilis
☐ Arthritis	☐ Depression	☐ Heart Disease	☐ Muscular Disease	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Obsessive Compulsive DO	☐ Tics
☐ Bipolar Disorder	☐ Eczema	☐ High Blood Pressure	☐ Paralysis	☐ Tuberculosis

Relative	Age If Alive	Age at Death	Major Ailments/Cause of Death
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Significant family deaths and their age at death, if any particular losses had a great impact on you or your family:

Academic Performance ☐ Excellent ☐ Average ☐ Poor **Which areas are difficult?**

Behavior ☐ Excellent ☐ Variable ☐ Disruptive **How is his/her play?** ☐ Appropriate ☐ Inappropriate

Is There a History of...

☐ Biting	☐ Bed Wetting	**Sensitivity to**
☐ Hitting	☐ Stuttering	☐ sound
☐ Head banging	☐ Teeth grinding at night	☐ touch
☐ Aggressiveness	☐ Teeth grinding in the day	☐ smells
☐ Odd fascinations	☐ Pulling own hair	☐ lights

Are There Excessive Fears of:

☐ Water	☐ Strangers	☐ Other fears:
☐ Being Alone	☐ Animals (which ones?)	_____
☐ Dark	_____	_____
☐ Night Terrors	_____	_____
☐ Thunder	_____	_____

How does (s)he interact with other children? ☐ Very well ☐ Average ☐ Poorly

Abnormal Movements ☐ None ☐ Excessive turning ☐ Hand flapping ☐ Tics

Sleep Pattern ☐ Normal ☐ Difficulty falling asleep ☐ Frequent waking ☐ Nightmares ☐ Night terrors
☐ Other:

Vision: Vision tested? ☐ No ☐ Yes If yes, what were the findings?_____

Hearing: Hearing tested? ☐ No ☐ Yes If yes, what were the findings?_____ Excessive wax? _____

Diet: Please describe a typical day's diet. Include all meals and snacks.

What beverages does your child consume? How much per day?
Does s/he prefer warm, cold or room temperature?

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

May we leave confidential voice-mail messages for you by phone or e-mail? ❍ **No** ❍ **Yes** (specify): ❍ **Home** ❍ **Work** ❍ **Cell** ❍ **E-mail**

E-mail Address:_____ Special Needs: _____

Date of Birth: _____ Sex:_____ Previous names that your records have been kept under: _____

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #1: (_____)_____ ❍ Home ❍ Work ❍ Cell

Contact's Phone #2: (_____)_____ ❍ Home ❍ Work ❍ Cell

How did you hear about us? _____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial:_____

Address: _____ City: _____ State: ____ Zip: _____ Phone: (_____)_____

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

X _____ _____

Guarantor's Signature **Date**

Terms of Admission

Privacy Terms: We keep a record of the healthcare services we provide to 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 others unless you direct us to do so or applicable laws authorize or compel us to do so. Root of Healing Naturopathic Medicine is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgment that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, 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 Root of Healing, wish to inquire about your rights, or wish to schedule an appointment to view your medical record, please call our office at (206) 801-0810. Medical record copy fee is $19.00 + $0.83/p for first 30 pages, and $0.63 for additional pages.

Financial Terms: I understand that full account payment is due at the time of each visit, and that if I am billing insurance, I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 30 days past due for payment at a rate of 1.5% per month. I understand that a cancellation fee of the full appointment fee will be charged for all missed appointments and all cancellations within 24 hours of my scheduled appointment. 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 that guarantor is someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

I hereby acknowledge that I have received a copy of Root of Healing Naturopathic Medicine's Notice of Privacy Practices and that I agree to the Financial and Privacy terms explained above. Should I refuse or fail to sign this form, I acknowledge that Root of Healing has made a good faith effort to obtain my acknowledgement.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

CONSENT FOR TREATMENT & AGREEMENT TO ARBITRATE

I hereby voluntarily consent to receive patient care at Root of Healing Naturopathic Medicine, PLLC, including but not limited to routine diagnostic procedures, physical examinations, and naturopathic medical treatment (homeopathy, botanical medicine, nutritional and psychological counseling, hypnotherapy, NAET, and craniosacral). Potential Risks include, pain, discomfort, nausea, giddiness, heat; allergic reactions to prescribed herbs or supplements; and aggravation of pre-existing symptoms. Potential Benefits include drugless relief of presenting symptoms and an improved balance of bodily energies, the restoration of the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

I recognize that some treatment modalities may be considered experimental such as NAET and in the event that I choose to undergo such therapies I understand that I have been informed of the benefits and risks of these treatments, and that results are dependent on the unique response of my body and thus cannot be guaranteed. I understand that such patient care is provided at my request and will be performed by Dr. Rebecca Parker, and her assistant or designee. I further declare that I have been informed of the nature of the aforementioned patient care, and that I have the freedom to refuse any specific treatment.

Notice to Pregnant Women: All female patients must alert Dr. Parker or her designee or assistant if they know or suspect that they are pregnant. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from your pregnancy care provider authorizing or recommending such a treatment.

Notice to patients receiving NAET: I recognize that NAET is a method applied for helping me clear my allergies. By no means is the NAET method a guarantee of cure or clearance of said ailments, but the techniques used by Dr. Parker and the method invented by Dr. Nambudripad are to help me calm my immune system's over-reactivity to stimuli in my food, water and environment. To this end, I attest I have made myself familiar, or will do so before I am treated, with the methods engaged in for NAET sessions, as well as the self-massage of the 8-10 gates at the particular meridian sites on my body to enhance and engage my body's own healing mechanisms for the re-alignment of my immune system. I recognize that if I don't regularly engage and follow up treatments within the guidelines of the treatment plan and techniques set forth that my results may be less than satisfactory I agree to hold Dr. Rebecca Parker, and Root of Healing Naturopathic Medicine, PLLC harmless and free of blame for any side effects due to my own neglect of adhering to the instructions.

I understand that I may ask questions regarding my treatment before signing this form and with this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Rebecca Parker regarding cure or improvement of my condition. Additionally, it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, Dr. Rebecca Parker and myself, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Furthermore, I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law. I understand that I may look at my medical record by scheduling a time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment.

I hereby acknowledge that I have read and understood Root of Healing's Consent for Treatment and Agreement to Arbitrate form and that I agree to the terms explained above.

_____ Guardian name (PRINT)

_____ Patient's Name (PRINT)

X _____ Guardian Signature

X _____ Patient's Signature

_____ Relationship/Representative's Authority

_____ Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Root of Healing Naturopathic Medicine respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes. Your signature on our registration form has given us this authorization.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:
- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you and/or leave a message for you (at a number you provide) to remind you about appointments and reasons for them. We may also contact you to provide information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plan;
    - Accounting, legal, risk management, and insurance services; and,
    - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have the right to:
- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. There may be a charge to copy your protected information.
- Have us review a denial of access to your health information – except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information, to any other than third-party payers. There may be a clerical charge for the protected information.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released, or action already taken. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact: Rebecca Maya Parker, ND at (206) 801-0810.

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Our Responsibilities

We are required to:
- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact: Dr. Rebecca Maya Parker at (206) 801-0810 during normal business hours.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Dr. Rebecca Maya Parker at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others:
- Unless you object, we may release health information about you to family member or friend who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:
- With Medical Researchers – if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- To Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- To Organ Procurement Organizations (tissue donation and transplant) or persons who obtain, store, or transport organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- To comply with Worker's Compensation Laws – if you make a worker's compensation claim.
- For public health and safety purposes as allowed or required by law:
    - to prevent or reduce a serious, immediate threat to the health or safety of a person,
    - or the public,
    - to public health or legal authorities,
    - to protect public health and safety,
    - to prevent or control disease, injury, or disability,
    - to report vital statistics such as births or deaths.
- To report suspected abuse or neglect to public authorities.
- For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For health and safety oversight activities. For example, we may share health information with the Department of Health.
- For disaster relief purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For work-related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.
- To the Military authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- For specialized government functions. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

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