Dr. Trevor Cates

Pediatric New Patient Registration Form

Dear New Patient,

I look forward to serving you and your family's health care needs and supporting you in achieving a healthy, fulfilling life.

Provided with this new patient registration form is some general information about the holistic health care services I provide. Please fill out the accompanying forms and send them in or bring them with you on the day of your initial visit. In addition, bring with you a complete list of current supplements and medications as well as copies of any medical records in your possession, such as laboratory or diagnostic imaging reports, doctor's chart notes, etc.

I am located at the Silver Mountain Building at Kimball Junction. The address is:

1526 Ute Blvd. #110
Park City, UT 84098

Also, you can learn more about me and the services I offer by reading through my website: www.drtrevorcates.com. My website will give you access to important health information and access not only to my tips and resources but also to me. You may reorder supplements and send me questions directly on this site.

If your schedule conflicts with your appointment time, then please call my office at 435-655-7700 as soon as possible to reschedule. I greatly appreciate you giving us at least 48 hours advanced notice of schedule changes, but require at least 24 hours before a fee of $95 will be assessed.

I look forward to meeting with you.

Healthfully,

Dr. Trevor Holly Cates
Naturopathic Physician

Dr. Trevor Cates

____/____/____
Today's Date

Pediatric New Patient Registration Form

Please fill out the following pages completely so that we can best serve you. Your health and peace of mind are important to us. This information will be kept strictly confidential.

General Information

_____ _____ ___/___/___ _____ M/F
Patient First Name | Patient Last Name | Date of Birth | Age | Sex

_____ _____
Mother, Father, or Guardian First Name | Mother, Father, or Guardian Last Name

_____ _____ _____ _____
Home Address ☐ Dropship Supplements to this Address | City | State | Zip

_____ _____ _____ _____
Secondary Address ☐ Dropship Supplements to this Address | City | State | Zip

(_____)_____ (_____)_____ (_____)_____ Preferred #: ☐ Home ☐ Cell ☐ Work
Home Phone # | Cell Phone # | Work Phone #

_____ Would you like to receive our health newsletter via e-mail? Y / N
E-mail Address

_____ (_____)_____ _____
Emergency Contact | Phone # | Relationship to Emergency Contact

Preferred Pharmacy Name and Location: _____

_____

Other Health Care Providers (M.D., D.O., Dentist, Chiropractor, and Acupuncturist):

_____ _____

_____ _____

_____ _____

Health Concerns and Current Treatments

Please list all current and ongoing health concerns and the treatments you have tried or are currently using. Rank each health concern in the order you would like it addressed.

Rank	Health Concern	Date of Onset	Treatment

Other Health Conditions

1. _____
2. _____
3. _____
4. _____

Has your child had an ailment or disease condition after which he or she was never the same or well; OR has he or she had an ailment or medical condition that resulted in the worsening of other health problems? □ Yes □ No, Explain:

_____
_____
_____
_____

Vaccinations & Immunizations

Mark an X in the box for each vaccination and immunization you have received. Include the approximate date you were last given these shots.

Date	Date	Date
□ Diphtheria	□ Rubella	□ Varicella/Chicken Pox
□ Pertussis	□ Polio	□ Flu
□ Tetanus	□ Hib	□ Rotavirus
□ Measles	□ PCV	□ Typhoid
□ Mumps	□ Hepatitis B	□ Hepatitis A

Has your child ever experienced a bad reaction to a vaccine? □ Yes □ No, If Yes, then Explain:

_____

_____

Current Medications and Allergies

Prescriptions (Rx)	**Dosage**	**Prescriptions (Rx)**	**Dosage**
1		4	
2		5	
3		6	
Over –The-Counter	**Dosage**	**Over-The-Counter**	**Dosage**
1		4	
2		5	
3		6	
Supplements/Vitamins	**Dosage**	**Supplements/Vitamins**	**Dosage**
1		4	
2		5	
3		6	

Allergies to Medications Including Prescriptions, Over-the-Counter Drugs, and Supplements: □ None or Explain:

_____

_____

_____

_____

History of Health Problems Past and Present

Below mark an X in the box next to any of the following that your child has now or has had previously. Write the date of diagnosis next to each applicable item if a diagnosis was established by a healthcare provider.

- □ Acne
- □ Allergies
- □ Anemia
- □ Anxiety/Nervousness
- □ Appetite Lacking
- □ Arthritis/Joint Pain
- □ Asthma
- □ Attention Deficit
- □ Bedwetting
- □ Bleeding Gums
- □ Bleeding Tendency
- □ Body/Breath Odor
- □ Bruising Easily
- □ Bronchitis
- □ Cancer or Tumor
- □ Canker Sores
- □ Constipation
- □ Cries Easily
- □ Chicken Pox
- □ Cough
- □ Croup
- □ Diabetes
- □ Diarrhea
- □ Diphtheria
- □ Dizzy Spells
- □ Ear Infections
- □ Eczema/Psoriasis
- □ Epilepsy/Seizures
- □ Eye Infections
- □ Excessive Fatigue
- □ Fevers (High)
- □ Flat Feet
- □ Frequent Colds
- □ Gastro-Intestinal Complaints/Gas
- □ Hair Loss
- □ Heart Murmur
- □ Headaches
- □ Hearing Loss
- □ Hives/Rashes
- □ Hyperactivity
- □ Measles
- □ Mental Illness
- □ Motion/Car Sick
- □ Mumps
- □ Nightmares
- □ Night Sweats
- □ Sensitive to Light
- □ Sleep Problems
- □ Parasites or Worms
- □ Pneumonia
- □ Polio
- □ Rheumatic Fever
- □ Rubella
- □ Scarlet Fever
- □ Strep/Tonsillitis
- □ Unusual Fears
- □ Urine Bloody
- □ Urination Painful
- □ Urination Frequent
- □ Vomiting Spells
- □ Wheezing
- □ Whooping Cough
- □ Yellow Skin/Jaundice

Other Conditions Not Mentioned:

_____

_____

_____

_____

Medical Tests and Special Studies

List all x-rays, CAT scans, MRI's, electroencephalograms, hearing, speech/language, psychological, etc.

Test or Study	Date(s)	Results

Hospitalizations, Surgeries and Traumas

List all hospitalizations, surgeries, significant traumas (e.g. motor vehicle accidents, severe falls, broken bones, difficult childbirth…) etc.

Event	Date

Typical Food Intake

Breakfast:
Lunch:
Dinner:
Snacks:

Special Diet: _____

Amount of Water per Day: _____ Other Drinks: _____

General Lifestyle

Height: _____ ft. _____ in. (Date: _____) Weight: _____ lbs. (Date: _____)

Weight Loss? □ No □ Yes _____ lbs. When? _____

Date of last pediatric exam: _____

Exposed to Tobacco Smoke? □ Yes □ No □ In the Past When and for How Long? _____

Eat Resturant Food? □ Yes □ No How often? _____

Interests and Hobbies: _____

_____

Do you spend time outside? □ Yes □ No How much? _____

Exercise? □ Yes □ No How much? _____

Watch television? □ Yes □ No How much? _____

Has a religious or spiritual practice? □ Yes □ No

Always wears a seat belt while riding in an automobile? □ Yes □ No

Drinks fresh vegetable juices? □ Yes □ No

Do you own a home air filter unit? □ Yes □ No If Yes, then what kind? _____

Mother's Health During Pregnancy

- □ Bleeding
- □ Smoking Cigarette
- □ Used Alcohol
- □ Recreational Drugs
- □ Physical or Emotional Trauma
- □ High Blood Pressure
- □ Diabetes
- □ Thyroid Problems
- □ Illness
- □ Other: _____

Birth History

Mother's Age at Child's Birth: _____ Weeks Gestation at Birth: _____

Child's Weight at Birth: _____ Length of Labor: _____

Complications:

_____

_____

Problems as an Infant

- □ Allergies
- □ Blue Baby
- □ Birth Defects
- □ Birth Injuries
- □ Cerebral Palsy
- □ Colic
- □ Diarrhea
- □ Fever
- □ Hives/Rashes
- □ Jaundice
- □ Other: _____

Feeding

Breast-fed: □ Yes □ No, How long? _____ Formula-fed: □ Yes □ No, How long? _____

Type of Formula: _____ Age Solid Foods Were Introduced: _____

Milestones

Sitting: _____ Crawling: _____ Walking: _____ 1st Words: _____

Child's 1st Year Sleep Pattern: _____

Child's Current Sleep Pattern: _____

Family Health History

Fill out the following pertaining to your "blood" or natural relatives. Additional space is provided below for adding additional information related to your family history.

	Grandparents						
	Maternal		Paternal		Mother	Father	Siblings
Ages, if living							
Health G= Good F= Fair P= Poor Circle for each.							
Age at **Death**							

Below, provide name, relationship, age condition occurred, complete diagnosis, and treatment. Additional comments can be added, below this table.

Anxiety	
Asthma/Allergies	
Anemia	
Alzheimer's Disease	
Arthritis	
Cancer, Tumor or Polyps	
Depression	
Diabetes	
Eczema	
Glaucoma/Eye Disease	
Gallbladder Disease	
Gout	
Heart Disease	
Hives/Rashes	
High Blood Pressure	
Kidney Disease	
Lung Disease	
Mental Illness	
Osteoparosis	
Seizures/Epilepsy	
Smoking/Drug Abuse	
Stroke	
Thyroid Problems	

Tuberculosis	
Ulcers	

Other:

_____

_____

_____

_____

_____

Attention Deficit Hyperactivity Disorder Rating Scale

Questions	Never or Rarely = 0	Sometimes = 1	Often = 2	Very Often = 3
1. Fails to give close attention to details or makes careless mistakes in schoolwork.				
2. Fidgets with hands or feet or squirming in seat.				
3. Has difficulty sustaining in tasks or play activities.				
4. Leaves seat in classroom or in other situations in which remaining seated is expected.				
5. Does seem to listen when spoken to directly.				
6. Runs about or climbs excessively in situations in which it is inappropriate.				
7. Does not follow through on instructions and fails to finish work.				
8. Has difficulty playing or engaging in leisure activities quietly.				
9. Has difficulty organizing tasks and activities.				
10. Is 'on the go' or acts as if 'driven by a motor'.				
11. Avoids tasks (e.g. schoolwork, homework) that requires mental effort.				
12. Talks excessively.				
13. Loses things necessary for tasks or activities.				
14. Blurts out answers before questions have been completed.				
15. Is easily distracted.				
16. Has difficulty awaiting turn.				
17. Is forgetful in daily activities.				
18. Interrupts or intrudes on others.				

Total Score: _____

Consent for Use and Disclosure of Health Information*

This form is required by the Federally mandated Health Insurance Portability and Accountability Act of 1996

Child's Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain changes. Those changes may apply to any of your protected health information that we maintain. We may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting one from the front desk.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Contact Person: Dr. Trevor Holly Cates

I, _____, have had full opportunity to ready and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ASK OUR STAFF FOR A COPY IF YOU WANT A COPY.

Informed Consent for Treatment and Care

This document provides important information regarding the services being provided and should be carefully reviewed. Please ask any questions you have regarding services before signing this document.

Healthcare Services. Dr. Trevor Holly Cates offers various medical services that are individualized to meet your personal health needs. Dr. Cates is a primary care, family practice naturopathic physician who specializes in integrating diagnostic and treatment methods of both conventional and natural medicine. Dr. Cates completed a 4-year medical school training program, earning her a Doctor of Naturopathic Medicine degree. She has been a licensed naturopathic physician since 2000.

Your first visit will involve an evaluation of your current health needs and you may receive treatments deemed appropriate to your care. At the time of your evaluation, it is necessary you supply the doctor with all applicable personal health information, past and present. Along the course of treatment, whether the duration is days or months, it is necessary to follow the recommended treatment plan, which includes follow up visits to the office for appropriate periodic re-evaluation. If life circumstance makes it difficult to follow the prescribed plan, you understand that you must discuss this with Dr. Cates to ensure that you are provided with the best treatments.

Professional Fees and Payments. The visit lengths vary depending on the complexity of presenting health concerns. Initial visits are usually 60-75 minutes. Initial pediatric visits are typically 45-60 minutes. You may request a shorter initial visit if you have acute health concerns; however, an additional visit may be needed to evaluate you completely if you are presenting with long, chronic issues, multiple diseases or symptoms and/or have a condition that is very severe or life-threatening. Follow-up visits are usually 30, 45 or 60 minutes, and this also is dependent on case complexity and treatments provided at the time. See the "Office Visit Fee Schedule" form for the current fees. You may be charged fees for telephone conversations, email correspondence or for requested additional work. *Kindly give us 24 hours notice if you need to change or cannot make your appointment. Missed or cancelled appointments with less than 24 hours notice will result in a $95 missed appointment charge to your credit card.*

All payments are due at the time of service unless special arrangements are made prior to the appointment. Please talk to the front desk about forms of payments accepted. We ask you to provide us with a credit card number at the time you schedule your initial visit for billing purposes and to reserve your appointment time. In addition, if you do not pay for pharmacy items at the time you pick them up, signing below confirms that you agree to have us charge your credit card for the amount due.

Insurance. The doctor does not bill insurance companies; however, at your request, she will provide you with the necessary forms you can submit to your insurance provider to be reimbursed to you directly. Although many offered services are insurance reimbursable, it is recommended that you contact your insurance provider to determine whether or not your benefits include naturopathic care. It has come to our attention that clients are told by their insurance providers that naturopathic medicine are categorically excluded from their plan or that these services are only covered on an emergency basis. This information is inconsistent with Utah State code. Please refer to the last page of this packet for assistance in how to deal with your insurance provider should you find that they are uncooperative in providing you coverage.

Medicare. Medicare does not cover services provided by naturopathic doctors. No insurance forms can be submitted by Dr. Cates or by you to Medicare or to Medicare supplemental policies. This consent agreement is a private contract between Dr. Cates and you, the patient or guardian, for services provided to Medicare-eligible patients and is excluded from Medicare reimbursement rules.

Contacting the Doctor. Dr. Cates is not always immediately available by telephone. Messages left with the receptionist or on the office voice mail system will be given to the doctor as soon as the doctor is available. The doctor will make every effort to return your call in a timely manner. If you are difficult to reach, please inform us of some times when you will be available. In case the doctor will be unavailable for an extended time, the doctor will refer you to another physician to temporarily manage your health care needs.

I have read, understand and agree to the above information.

Patient Signature (or Representative): _____ Date: _____

Indicate Relationship if Signing for Patient: _____

Informed Consent for Treatment & Care

To the Patient: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment. **If you refuse any specific procedure this will not affect your receiving other care or future treatments.**

I, _____ (Patient's Name or Name of Parent/Guardian) voluntarily request and consent to receive medical care for myself (or for the patient names below, for whom I am legally responsible) provided by Dr. Trevor Holly Cates. I also agree to receive care from the doctors' associates, medical assistants and other health care providers to examine and treat me and my health conditions.

I understand that the course of care may include the use of multiple modalities of naturopathic medicine including nutritional supplements, homeopathic medicines, prescription medicines, bio-identical hormones, chelation therapy and other therapies offered by the doctor(s).

Certain treatments may be inappropriate during pregnancy, and I will notify the doctor(s) if I am or plan to become pregnant. I will immediately inform the doctor(s) in the event I experience any undesired treatment effects or my health worsens during the course of treatment.

I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition, discuss naturopathic and conventional options at any time. I understand there may be complications and risks related to the recommended therapies and procedures and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.

I understand that to receive prescription medications, such as thyroid, bio-identical hormones and certain dietary supplements, I must comply with the required laboratory re-testing schedule in order to receive refills.

I understand that payment in full is due at the time of service. I understand that any expenses incurred, including laboratory or other diagnostic testing, are my responsibility and not that of any other person or insurance group. The doctor(s) will indicate which lab tests require payment at time of service before ordering the lab test. I understand that no claims or guarantees have been made by the doctors or their personnel for future insurance reimbursement of particular medical services.

I understand that, following care, no warranty or guarantee is given promising cure for any medical condition.

All information given now or at any point in the future is confidential. It is Dr. Cates' policy to require a signed medical release form before releasing medical records to anyone other than the patient.

I certify that I have read, or have had it read to me, the above information and I understand its content and meaning and I have sufficient information to give this informed consent to receive health care from Dr. Trevor Holly Cates and/or her medical staff. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

Patient Signature (*or Representative*): _____ Date: _____

Indicate Relationship if Signing for Patient: _____

Office Visit Fee Schedule for

Dr. Trevor Cates

Initial In Person Office Visits

$350 - Initial Consultation 1st Visit (75 Minutes)

$160 - 1st Visit for Acute Conditions (30 Minutes)

Free - Q & A about Dr. Cates' Practice for Potential Patients (15 Minutes)

Follow-Up Office Visits or Phone Consults

$190 - Extended Follow-Up (60 Minutes)

$140 - Intermediate Follow-Up (45 Minutes)

$95 – Limited Follow-Up (30 Minutes)

Standard visits are between 30 – 45 minutes.

CranioSacral Therapy (CST) *(For Return Patients Only)*

$150 – Adult CST (50 Minutes)

$125 – Pediatric CST (30-45 Minutes)

A fee of $95 will be assessed for any appointment not cancelled 24 hours prior to the appointment.

www.drtrevorcates.com

Fee Schedule Effective As Of January 1st, 2014