
DR. SHAW DC, ND



HARNESS THE POWER OF
NATURE

SHAW FAMILY PRACTICE

Welcome to Shaw Family Practice,

We are so happy to have you here. Thank you for trusting us with your health.

On your first visit you will sit down with Dr. Shaw and discuss your goals, where you are now, how your life has shaped your current level of health. Dr. Shaw uses both naturopathic and chiropractic care to meet your needs. These healing techniques are based in preventive medicine and looking at the entire picture as a complete human being with physical, mental, and emotional health we address all of them here.

After you have shared what brought you in, Dr. Shaw will take you through a physical exam. She will talk with you so that you know what each test means, what she is looking for, and answer any questions you have along the way. With those results she will work with you to set goals, a timeline, and discuss a course of treatment to meet your goals.

This practice is a safe place for families. No need for babysitters, feel free to bring children, spouses, and friends. We invite you to bring your whole family to your visits at our office.

Should you feel the need to reach out, please do so. Dr. Shaw will reply as soon as she can.

We are glad you are here,

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Pediatric Health History: Thank you for coming in, we are glad you are here. Please sit down and take your time with this detailed paperwork. The more information we review in your case the better care we can provide.

Child's Name _____ Birthdate _____ Gender _____
Nickname: _____ School/daycare: _____
Pediatrician: _____
Sibling's Names and Ages: _____
Guardian's Name: _____ Relationship: _____
Address _____ City _____ State _____ Zip _____
Phone: (_____) _____ Email _____@_____.com

EMERGENCY CONTACT

Name:	Address:
Phone:	
Relationship to patient:	

How did you hear about us? Many of our patients are referred by their friends, family, co-workers and doctors. These individuals are concerned for your health and have shown their trust and confidence in Dr. Shaw to provide you with the very best care possible. Please let us know how you heard about us so we can send them a "Thank You".

Circle one: Google Facebook Event Midwife Referral: _____

Authorizing Consent for examination: Please Read Carefully

In order for Dr. Shaw to make a determination on the suitability of my case for care, I acknowledge and understand that a thorough evaluation must be completed. I do hereby request and consent to the performance of such an evaluation by Dr. Shaw, or any party authorized to do so by that person. I understand that there may be risks with examinations and adjustments, as there are with any and all healthcare treatments. I understand that I may ask the doctor to stop the examination or treatment at any time. I understand by signing this form, the doctor continues to be obligated for best practices delivered in my interests.

Signature: _____ Date: _____

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COLORADO SURPRISE/BALANCE BILLING DISCLOSURE

Surprise Billing – Know Your Rights: Beginning January 1, 2020, Colorado state law protects you* from “surprise billing,” also known as “balance billing.” These protections apply when: You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or

You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen? If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan’s provider network, sometimes referred to as “out-of-network,” you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called “surprise” or “balance” billing.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider: Dr. Shaw is out-of-network, you are responsible for the costs of services provided.

Additional Protections: Your insurer will pay out-of-network providers and facilities directly. Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit. Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified. No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in OTHER situations, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed. If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint. If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745. Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions. *This law does NOT apply to ALL Colorado health plans. It only applies if you have a “CO-DOI” on your health insurance ID card.

ACKNOWLEDGEMENT OF RECEIPT OF COLORADO SURPRISE/BALANCE BILLING

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

I, (print name) _____, hereby acknowledge that Shaw Family Practice has provided me with a copy of the Colorado Surprise/Balance Billing Disclosure.

My signature below indicates that I understand that Shaw Family Practice is an out-of-network facility which does not participate with any insurance providers. I further understand that all of the services I receive at Shaw Family Practice will be performed by out-of-network providers.

Signature

Relationship to Patient

Date

970-658-1281

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THIS SECTION IS TO BE COMPLETED BY SHAW FAMILY PRACTICE, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Colorado Surprise/Balance Billing Disclosure from the above-named patient, but was unable to because:

Patient declined to sign this Written Acknowledgement

Other (specify): _____

Naturopathic Care Disclosure

Dr. Shaw DC,ND was trained in naturopathic medicine at National University of Health Sciences. This practitioner received her degree after four years of graduate-level clinical and academic training, as well as the completion of rigorous basic science and clinical science board exams. This naturopathic doctor is registered, but not licensed, in the State of Colorado. The Division of Regulatory Agencies (DORA) is the regulatory board for naturopathic doctors in Colorado. Any complaints regarding our professional services should be submitted in writing to the Office of Naturopathic Doctor Registration. To obtain a complaint form, please contact the Division at (303) 894-7414 or www.dora.state.co.us. As a Naturopathic Doctor, registered by the state to practice naturopathic medicine, under the "Naturopathic Doctor Act," I am not permitted to perform the following acts: • Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs). • Perform surgical procedures, including surgical procedures using a laser device. • Use general or spinal anesthetics, other than topical anesthetics. • Administer ionizing radioactive substances for therapeutic purposes. • Treat a child who is less than two years old without the family also seeing a pediatrician. • Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child's licensed pediatric health care provider, if the child has one. • Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine. Practice obstetrics. Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner. Dr. Shaw is an active member of the Colorado Association of Naturopathic Doctors (www.coand.org). No license or registration has ever been revoked or suspended. The privacy of your medical information is important. This office complies with the United States HIPPA Patient Privacy Guidelines. Detailed information regarding these guidelines is available upon request. As a patient of Shaw Family Practice, you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. You may seek a second opinion from another health care professional or may terminate therapy at any time.

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Dr. Shaw is not a medical doctor or physician licensed under Title 12, Article 36, of the Colorado Revised Statutes. I recommend that the patient named below have a relationship with a licensed physician, or if the patient is a child aged two to seven, with a licensed pediatric health care provider. If the patient is a child aged two to seven, we are required to recommend that the child's parent or guardian follow the immunization schedule that accompanies this form. If the patient has a relationship with a licensed physician or pediatric health care provider, we will attempt to develop and maintain a collaborative relationship with the physician or pediatric health care provider.

Signature: _____

Date: _____

Informed Consent for Chiropractic Spinal Manipulation, Authorization and Release

The nature of chiropractic treatment: The doctor will use her/his hands or a mechanical device to manipulate the area treated. You may feel or hear a "click" or "pop," and you may feel movement. Chiropractic treatment also includes activity advice, exercise, hot or cold packs, or electric stimulation. Your chiropractor will recommend treatment she/he determines is most appropriate for your condition. Possible risks: Chiropractic treatment for pain is safe and the majority of patients experience decreased pain and improved mobility. Approximately 30% of patients experience slight increased pain in the treated area, possibly due to minor strain of muscle, tendon, or ligament. When this occurs within the first few days of treatment, the increased pain is brief and returns to baseline or improves over the next few days. Increased pain may also occur with exercise, heat, cold, and electrical stimulation. Possible skin irritation or burns may occur with thermal or electrical therapy. Serious bodily harm is extremely rare and not an inherent risk of chiropractic treatment. Many variables can adversely affect one's health, including previous injury, medications, osteoporosis, cancer and other illness or disease or condition. When these conditions are present, chiropractic treatment may be associated with serious adverse events, such as fracture, dislocation, or aggravation of previous injury to ligaments, intervertebral discs, nerves, or spinal cord. Symptoms of stroke or cerebrovascular injury alert patients to seek medical and/or chiropractic care. Your chiropractor is aware of this association and when appropriate may assess for symptoms and signs of stroke. Please inform your chiropractor of all medications you are taking, including blood thinners, any surgeries you have had, and any other medical condition you have, including osteoporosis, heart disease, cancer, stroke, fracture, or previous severe injury. Other options for the treatment of pain include: do nothing – live with it, over-the-counter medications, physical therapy, medical care, injections, or surgery. There are hundreds of other treatments for pain. Most treatments that have potential benefit also have potential risk. You are encouraged to ask questions regarding possible risks of chiropractic treatment, and may use the space below for this purpose.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Chiropractor, Dr. Jo Nell Shaw DC, ND.

Signature: _____

Date _____

DR. SHAW DC, ND



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FINANCIAL AGREEMENT

We are glad you have entrusted our office with your health care. To provide you with quality, timely care, we need your cooperation with certain matters to make sure every patient has his/her needs met.

Insurance Shaw Family Practice is not a participating provider with any insurance companies. Our office does not file or submit claims to any health insurance plan. At your request, we can provide you with a receipt of services (Super-Bill) that you can send to your insurance company for your reimbursement under your out-of-network plan. **Medicare:** Dr. Shaw is not a participating provider for Medicare. If you choose to use your Medicare plan we will happy to refer you to a participating provider. **Workers Compensation:** Dr. Shaw does not participate in workers compensation claims at this time. If you become injured on the job we would be happy to refer you for the appropriate care. **Payment:** Shaw Family Practice requires payment at the time of service. We currently accept debit and credit cards (Visa, MasterCard and Discover) cash, and checks. Payment plans are available on an individual basis, and need to be set up prior to service.

Individual Consideration Contract: If there is a financial hardship associated with receiving care in our office, payment arrangements can be negotiated with Dr. Shaw, and **MUST** be done prior to the time of service. Written agreements are required before treatment. **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. We will pass along the fee of \$35 our bank charges us for any returned checks. Balances beyond 30 days will be charged an additional 1.5% of your total balance per month plus any additional costs necessary to collect the balance owed. If we have to refer your account to a collection agency, you agree to pay all of the collection agency fees or commissions that are incurred. We reserve the right to refuse future services until your account is in current status.

Cancellation and Missed Appointment Policy: We require a minimum of 24 hours notice when a patient cancels or reschedules their appointment. When a patient does not show up for an appointment and/or cancels / reschedules with less than 24 hours notice, a \$50 fee will be applied to the patient's account. If short notice cancellations or no-shows are frequent you will be asked for payment at the time of scheduling.

Agreement: This is the entire agreement between Dr. Shaw with Shaw Family Practice and the patient below. I have read this agreement, understand it and agree with its provisions. I do clearly understand that I am ultimately responsible for the payment of fees for services rendered to me, or my family at this clinic. I authorize the doctors to administer such treatment as necessary. I do understand that no guarantees have been made as to the results of treatment. I confirm that I have come to this facility for help with my medical problems and have no intent to mislead or defraud my treating doctor, any insurance carrier, or other party. Although Shaw Family Practice will give you all the information you need to be reimbursed by your insurance if you have chiropractic benefits, the ultimate financial responsibility remains with you, the patient. By signing this you are consenting to receive care.

Signature: _____ Date _____

Thank you for signing all of the spaces above, they are what is required by law, I appreciate your patience. Take a big breath, Now let's focus on your child and why you are coming in today!

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WHY THIS FORM IS IMPORTANT: Our focus is on families to function optimally, to become more self aware, stronger, healthier and for improved adaptation to everyday stresses. Completion of this form provides us with an improved understanding of your child's physical, emotional and chemical stresses that can gradually overwhelm the body and contribute to other health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

People seek care for a number of reasons and have certain expectations and perceptions.

- | | | |
|---|---|--|
| <input type="checkbox"/> Improvement in function | <input type="checkbox"/> Stress reduction | <input type="checkbox"/> Growth and Development |
| <input type="checkbox"/> Pain reduction/relief | <input type="checkbox"/> Learning issues | <input type="checkbox"/> Improved breastfeeding |
| <input type="checkbox"/> Improved quality of life | <input type="checkbox"/> Optimum function | <input type="checkbox"/> Early detection of problems |
| <input type="checkbox"/> Manage my crisis | <input type="checkbox"/> Improved quality of life | <input type="checkbox"/> Headache relief |
| <input type="checkbox"/> Reading/grades | <input type="checkbox"/> Improved performance | <input type="checkbox"/> Mental/emotional balance |
| <input type="checkbox"/> Head shape | <input type="checkbox"/> Overall Wellness | <input type="checkbox"/> Brain health |
| <input type="checkbox"/> Immune support | <input type="checkbox"/> Disease prevention | Other _____ |

What are you seeking help with? _____

What is your primary reason for seeking care at our office: _____

How long has this been a problem? _____

What do you believe the cause is? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No _____

Does this interfere with sleep? Yes No Eating? Yes No Daily routine? Yes No

Is this becoming worse? Yes No

What goal, if you were to complete or accomplish it, would have the greatest impact on your child's life?

Has your child ever received chiropractic care? Yes /No Have they ever seen a Naturopath? Yes/No

If yes, who is your previous Chiropractor or Naturopath? _____

Reason for visit _____ May we contact them? Yes No

In the last year have you had these tests done? Bloodwork Urine X-Rays

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Circle your level of commitment to your child's health? (Bare minimum)-1 2 3 4 5 6 7 8 9 10- (Total)

List below any other health information you feel is important: _____

Child's Birth History

Birth weight ____lbs ____oz Were there any complications? No Yes _____

Was child born: cephalic (head first) breech (feet first) Position: _____

Where was the birth? home birth center hospital other _____

Was labour: spontaneous induced Medications or epidurals? Yes No _____

Assistances used during delivery: Forceps Vacuum extraction Episiotomy C-section

Is there anything else we need to know about the birth Yes No _____

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____ Other _____

Unusual Childhood Diseases: _____

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No _____

At what age did the child:

Respond to sound _____ Sit alone _____ Teethe _____

Hold up head _____ Crawl _____ Walk _____

Follow an object _____ Vocalize _____ Potty train _____

Does your child sleep: front back side Naps (length of time and pattern): _____

How many hours of sleep a night _____

Do you consider the child's sleeping pattern normal? Yes No _____

Medication/Supplement	Reason	Prescribing doctor

Allergies: _____

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Family Health History

Please note any health problems (ie:hereditary conditions) that are present in:

Mother's family _____

Father's family _____

Siblings _____

Is there anyone in your family with any of the following medical conditions?

Condition	Who and type of illness	Condition	Who and type of illness
Cancer		Diabetes	
Arthritis		Stroke	
Autoimmune		Autism	
High blood pressure		Heart disease	
Lung disease/ asthma		Mental illness	
High cholesterol		Other	

Reproductive aged Females

When was your first period? _____ List the first day of your last period: _____

Are your cycles regular? _____ How many days of flow? _____

Date of last PAP smear: _____ Any abnormal results? _____

Birth control methods: _____

Number of pregnancies: _____ How many deliveries? _____

Any complications during labor and delivery? _____

Any history of sexually transmitted infections or diseases? _____

Reproductive aged Males

Have you ever had a prostate exam (digital rectal exam)? No Yes Date: _____

Have you ever had a PSA blood test? _____ Date of last test: _____

Have you had any alteration in urinary frequency, flow of urine stream? _____

Any history of sexually transmitted infections or diseases? _____



SHAW FAMILY PRACTICE

Review of Systems: Please check items your child has or have had in the past 3 months.

Constitutional

- chills
- fatigue
- fever
- night sweats
- weight gain/loss

Eyes

- blurred vision
- glasses/contacts
- sensitivity to light

Ears/Nose/Throat

- ear pain
- hearing problems
- ringing in ears
- nose bleeds
- dental disease
- tooth pain
- hoarseness
- thrush

Cardiovascular

- chest pain
- pain/leg cramp
- palpitations
- leg swelling
- fast heart beat
- varicose veins

Respiratory

- cough/wheezing
- difficulty breathing
- exposure to TB
- coughing up blood

Gastrointestinal

- abdominal pain

- acid reflux
- bloating
- difficulty swallowing
- heartburn
- nausea/vomiting
- vomiting blood
- constipation
- diarrhea
- red blood in stool
- hemorrhoids
- dark tar-like stools

Genitourinary

- painful urination
- blood in urine
- frequent UTI
- waking to urinate
- frequent urination
- urinary incontinence
- discharge
- genital itching/lesions
- sexually transmitted infections
- history of vaginosis
- irregular menstrual cycle
- excessive menstrual flow
- painful periods

Musculoskeletal

- joint pain
- joint stiffness
- pain in arms/legs
- muscle spasm/ache

Skin and Breast

- acne/mole(s)

- eczema/rashes
- breast mass
- tenderness
- nipple discharge

Neurological

- fainting/dizziness
- headaches
- memory loss
- numbness/tingling
- seizure/tremor
- vertigo
- weakness

Hematologic/Lymphatic

- easy bruising
- excessive bleeding
- swollen lymph nodes
- hemophilia

Endocrine

- hair loss/hair growth
- heat/cold intolerance
- excessive thirst/hunger
- excessive sweating

Allergic/Immunologic

- seasonal allergies
- food allergies/sensitivities
- frequent infections
- autoimmune disease

Psychiatric

- anxiety/feeling stressed
- depression
- mood swings
- personality changes
- PMS (premenstrual syndrome)

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Physical Stressors: Dr. Shaw looks for and detects problems related to many activities of daily life, please share any information you have on the following:

Any traumas to the mother during pregnancy? (ie. falls, accidents, etc.) Yes No

If yes, please explain _____

Any evidence of birth trauma to the infant?

- | | | |
|--|---|---|
| <input type="checkbox"/> bruising | <input type="checkbox"/> fast birth | <input type="checkbox"/> respiratory depression |
| <input type="checkbox"/> odd shaped head | <input type="checkbox"/> excessively long birth | <input type="checkbox"/> cord around neck |

Any falls from couches, beds, change tables, etc? Yes No _____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No _____

Any hospitalizations or surgeries? Yes No If yes, please explain _____

Any sports played _____

Is a school backpack used? Yes No Is it heavy or light? _____

Chemical Stressors: Our bodies have chemical stressors from exposure to toxins through our environment, food, air, water, and products we use on our skin, clothes and hair. Please share any information you can.

Was this child breastfed? Yes No If yes, how long: _____

Formula introduced at what age: _____ Which formula? _____

Introduction of cow's milk at what age: _____ Solid foods at what age _____

Food/Juice intolerance? Yes No Type: _____

Nutritional Information

Circle the meals your child eats typically: Breakfast Lunch Dinner #Snacks _____

On a scale of 1-10 (10 being extremely healthful). How do you rate your child's diet? ____/10

If you try to follow a specific diet, please describe it and why you follow this type of diet?

Indicate any specific nutritional goals _____

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

Never On weekends A few times per week Daily On special occasions

Are you aware of the impact of nutrition on children's behavior? Yes No

Would you like information on nutrition for your child? Yes No _____

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Any pets at home? Yes No _____ Any smokers in the home? Yes No
Any antibiotics given? Yes No If yes, reason: _____
Do you use 'green products' in your home for cleaning? Yes No

During the mother's pregnancy:

Did the mother smoke? Yes No What and How much? _____
Drink alcohol? Yes No What and How much? _____
Any illnesses during the pregnancy? Yes No If yes, describe: _____
Any supplements taken during pregnancy? Yes No If yes, describe: _____
Any drugs/medications taken during pregnancy? Yes No _____
Any ultrasounds? Yes No How many: _____ Reasons for being done: _____
Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)? Yes No
If yes, please tell us more: _____

Psychosocial Stressors

Any difficulties with lactation? Yes No Any problems with bonding? Yes No
Any behavioral problems? Yes No Any inattention? Yes No
Any hyperactivity or restlessness? Yes No Any difficulties at daycare/school? Yes No
Any challenges with learning deficiencies? Yes No _____
Any night terrors, sleep walking, difficulty sleeping? Yes No _____
Any prolonged temper tantrums or separation anxiety? Yes No _____

Number hours of television per week? _____ Number of hours of video games per week? _____
Does your child have a cell phone? Yes No How often are they on the phone? _____
Do you feel that your child's social and emotional development is normal for their age? Yes No

Please give any other insight/information that you feel might be helpful in your child's health maintenance:

Thank you for completing this form. If you have anything to add below, please add notes which can then be discussed with the doctor. If there are any other questions or concerns which you have, ask Dr. Shaw.