Crossroads Healing Arts
Medicine Naturally

1004 Parkway Avenue, Suite C
Elkhart, IN 46516
Phone: 574-294-1883
Fax: 574-295-1749
www.crossroadshealingarts.com

Hello and Welcome to Crossroads Healing Arts!

Enclosed you will find all of your paperwork for your first visit. Please complete the forms in full, sign and bring with you to your appointment. Please also bring your insurance cards.

It is very important that we have correct information on the medications that you are currently taking. Please bring with you all of your current medications and supplements to your appointment.

If you have had any recent lab work done (past 12 months), it would be helpful for you to bring these copies with you so that we do not duplicate any testing.

If you are female and your visit is regarding possible hormone related issues, we ask for a copy of your recent pap and mammogram prior to prescribing hormone therapy.

Please contact the ordering physician to obtain copies of your previous lab and test results prior to your visit, this would most certainly expedite your treatment. Please bring these with you or ask that they are faxed to us at 574-295-1749 prior to your appointment.

Please note; we do not file any insurance. However, we will give you all the necessary information for you to submit an insurance claim on your behalf.

Finally, if you could arrive here 10-15 minutes early prior to your appointment, that will give our staff a little extra time to get all of your paper work processed.

We look forward to meeting you very soon!

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Patient Registration

Patient: _____ _____ _____
Legal First Name Middle Initial Last Name

Nick Name: _____ Birthdate: _____ Sex: Male Female

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

Phone: _____ Cell: _____

Preferred # to contact you (please circle one): Home Cell Other: _____

Preferred way for appointment reminders (please circle one): Voicemail Text Email

Marital Status: S M D W Email Address: _____

Employer: _____ Address: _____ Phone: _____

Spouse/Parent: _____ Living in Household? Yes No

Employer: _____ Address: _____ Phone: _____

Responsible Party: _____ Address: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Office Policy

Crossroads Healing Arts does not file any insurance claims. A copy of your itemized bill will be given at the time of service so that you can file with your insurance company if you so desire. We are not a member of any PPO or HMO network, insurance program, Medicare or Medicaid. If you have any questions about coverage, please contact your insurance company for specific details. Payment is expected at the time of service regardless of your insurance coverage. We do accept Discover, MasterCard and VISA, check or cash.

I understand and agree to the above office policies and the above information I have provided is correct and true to the best of my knowledge. I authorize the release of medical information to my insurance carrier should I decide to file charges incurred.

Patient Signature: _____ Date: _____

Parent Signature (If Patient is a Minor): _____ Date: _____

How did you hear about our clinic? TV Radio Referral Friend Other: _____

Patient Name: _____ **DATE OF BIRTH:** _____

Allergies (to medications, latex, testing dyes, state "none" if none are known):

_____

Health Concerns (Please rank by priority) Example: Headaches	**Onset**	**Frequency**	**Severity**
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Medications: Please list prescription medications as well as over the counter medications currently taking, with dosages

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

Past Medical History:

Childhood Illnesses: (Circle and indicate age of illness or mark C for current as it applies to your child)

Acne:	No	Yes/Age _____	Ear Infections:	No	Yes/How Often _____
ADD:	No	Yes/Age _____	Eating Disorder:	No	Yes/Age/What Type _____
ADHD:	No	Yes/Age _____	Constipation:	No	Yes/How Often _____
Allergies:	No	Yes/Age _____	Colds:	No	Yes/How Often _____
Mononucleosis:	No	Yes/Age _____	Sinus Infections:	No	Yes/How Often _____
Obesity/Overweight:	No	Yes/Age _____	Cough:	No	Yes/How Often _____
Bronchitis:	No	Yes/Age _____	Diarrhea:	No	Yes/How Often _____
Colic:	No	Yes/Age _____	Eczema:	No	Yes/Age _____
Asthma:	No	Yes/Age _____	Bedwetting:	No	Yes/Age _____
Behavioral Problems:	No	Yes/Age _____	Pneumonia:	No	Yes/Age _____
Croup:	No	Yes/Age _____	Vomiting:	No	Yes/Age _____
Depression:	No	Yes/Age _____	Whooping Cough:	No	Yes/Age _____
Other:		Age _____ Illness _____			
Other:		Age _____ Illness _____			

Immunizations: (Please place an X in either yes or no box next to each vaccination. If yes, please indicate whether there were any reactions and describe in detail)

Vaccination	No	Yes	Reaction Description
Hepatitis B			
Diphtheria, Tetanus, Pertussis			
Haemophilus Influenza Type B			
Inactivated Polio			
Measles, Mumps, Rubella			
Varicella (Chicken Pox)			
Pneumococcal			
Influenza			
Rotavirus			
Human Papilloma Virus (HPV)			

Past Surgical History:

Type of surgery:	Example: Jan. 2000 Date of surgery:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Major Injuries:

Example: Car accident-head injury 2000 Type of injury:	Date of injury:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Labs and Examination History: (Please indicate date and results)

Date of last well child check: _____ Results: Normal Other: _____

Date of last blood work: _____ Results: Normal Other: _____

Date of last urine test: _____ Results: Normal Other: _____

Nutritional History:

What is a typical breakfast? _____

What is a typical lunch? _____

What is a typical dinner? _____

What are typical snacks? _____

How many glasses of water does your child drink each day on average? _____

Does your child have special dietary restrictions? _____

Crossroads Healing Arts

Patient Supplement List

Patient Name: ______________________________ Date of Birth: ____________________

Date	Supplement	Directions	Reason for Use

Prescription Medications

Patient Name: ______________________________ Date of Birth: ____________________

Medication Allergies: ____

Pharmacy Date/Provider	Medication	Dose/Instructions	Date	# Refills	Initial	Faxed, Phoned or Written	Date Discontinued or Changed

Date	Preferred Pharmacy	Fax #	Phone Number	City

Allergies Alert: ____

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CANCELLATION/MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Crossroads Healing Arts promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Any appointment that is not cancelled at least 24 hours before the appointment time will result in a fee of **$50** billed to the patient's account.

No-Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". Any "no-show" will result in a fee of **$50** billed to the patient's account.

I have read the above policy, and will comply accordingly.

_____ _____

Patient Name (Printed) Patient's Signature

Date: _____

Crossroads Healing Arts, LLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have read and been offered a copy of
(Patient's Name)
Crossroads Healing Arts' Notice of Privacy Practices.

I, _____, give Crossroads Healing Arts, LLC, permission to discuss my medical status, laboratory results, appointment time(s), and all other medical care with the following person(s) effective immediately. This authorization will remain in effect until I notify Crossroads Healing Arts' office manager of any change in writing.

_____ _____ _____
Patient's Signature DOB Date

_____
Witness Signature

NAME	RELATIONSHIP