

Classical Homeopathy Patient Information for Children

Please print clearly.

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work-Father _____ Work-Mother _____

Cell Phone: Father _____ Mother _____ Email _____

Age _____ Date of Birth _____ Birthplace _____

Male _____ Female _____ Weight _____ Height : Feet _____ Inch _____

Eye Color _____ Hair Color _____

Social Sec. No. _____

Grade in School: _____ Name of School: _____

Father's: Name _____ Age _____ Occupation _____

Employer Name/ Address _____

E-mail Address: Father _____ Mother _____

Mother's: Name _____ Age _____ Occupation _____

Employer Name/Address _____

Siblings' Names, Genders and Ages _____

Amount & Type of Exercise _____

Describe Child's Diet _____

Living Situation if Other than with Both Parents (any useful information) _____

I agree to the following: I accept full responsibility for all fees incurred. I agree to give two full business day notice if I need to cancel or change my child's appointment (e.g. a 1p.m. Monday appointment must be canceled no later than 1p.m. Thursday). If I fail to do so I agree to pay a cancellation fee of half the appointment cost (minimum \$39.50). If my insurance company does not cover the full fees, then I am responsible for any fees not covered. I understand that fees are paid for the homeopaths time, and results cannot be guaranteed. I allow you to submit insurance forms on my behalf.

Parent Signature

Date

Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by Classical Homeopathy, Inc. for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Classical Homeopathy, Inc. I understand that analysis, diagnosis or treatment of me by Classical Homeopathy, Inc. may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Classical Homeopathy, Inc. is not required to agree to the restrictions that I may request. However, if Classical Homeopathy, Inc. agrees to a restriction that I request, the restriction is binding on Classical Homeopathy, Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that Classical Homeopathy, Inc. has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Classical Homeopathy, Inc. and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Classical Homeopathy, Inc. The Notice of Privacy Practices for Classical Homeopathy, Inc. is also posted in the waiting room at 3326 S Geneva Street Denver, CO 80231 . This Notice of Privacy Practices also describes my rights and duties of the Classical Homeopathy, Inc. with respect to my protected health information.

Classical Homeopathy, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Classical Homeopathy, Inc. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representatives Authority

**Steve Waldstein RSHom(NA) CCH PCH
Classical Homeopathy, Inc.
3326 S Geneva Street
Denver, CO 80231
Tel: 303-338-1776
steve@homeopathy-cures.com**

The practice of Homeopathy in Colorado is regulated under the Colorado Natural Health Consumer Protection Act. Attached are disclosures required under this act. I am not licensed, certified or registered by the State of Colorado as a health care professional, nor am subject to licensure, certification or registration by the State of Colorado. The nature of services to be provided is homeopathic health care.

My educational background for homeopathy is: I am of the generation of homeopaths who started the homeopathic schools in the U.S. When I originally trained there were no schools so like most homeopaths at the time we learned by self study and by seminars. Later I took a 2 years course in homeopathy taught by the Dynamis School and received a Practitioner in Classical Homeopathy Degree (PCH). I am board certified by the Council on Homeopathic Certification (CCH) and the North American Society of Homeopaths (RSHom (NA)). I was President of the North American Society of Homeopaths. I have been in practice since 1978. I am the author of "How to Choose the Diet That's Right for You."

We are required to recommend that you should discuss any recommendations I make with your primary care physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician or other board certified physician.

We are covered by liability insurance applicable to any injury caused by an act or omission in our practice.

I agree that we have received this information as required by the Colorado Natural Health Consumer Act and have received a copy of this notice.

Name of Client

Name of Parent or Guardian

Are You parents, guardian or ?

Signature of Parent or Guardian

Date

**Steve Waldstein RSHom(NA) CCH PCH
Classical Homeopathy, Inc.
3326 S Geneva Street
Denver, CO 80231
Tel: 303-338-1776
steve@homeopathy-cures.com**

For Parents or Guardians of Clients Who are Ages 2-7

Client Name _____

I give consent for us to treat your child.

We hereby state that I am not a physician pursuant to Article 36 of Title 12, C.R.S.

We are required to recommend that your child have a relationship with a licensed pediatric health care provider, and so we do recommend this.

Does your child have a relationship with a licensed pediatric health care provider?

Yes _____ No _____

If yes what is their Name and Address and Phone? _____

If yes, do you give permission for us to attempt to develop and maintain a collaborative relationship with the child's licensed pediatric health care provider? (If you answer yes we will call, write or email your pediatrician. If you answer no we will not.)

Yes _____ No _____

Name of Parent or Guardian

Are You parents, guardian or ?

Signature of Parent or Guardian

Date

Father _____

Father's Mother _____

Father's Father _____

Fathers Other Relatives _____

Brothers/Sisters _____

Children _____

