WELCOME!

Thank you for trusting Integrative Medical Specialists with your health care needs. We take our commitment to you and your family very seriously. We look forward to establishing a partnership that will enhance your health and well being; now, and well into the future.

We value your time, and realize that office visits may be an interruption in an otherwise very busy schedule. For this reason, we've taken steps to assure that your time in our clinic is as focused and efficient as it can be.

Enclosed you will find new patient information forms. Before your scheduled appointment, please read and complete the attached forms. These forms are our first introduction to you, as a patient. Your detailed and thoughtful responses will help us to utilize our time in the clinic more effectively. **Please bring these completed and signed forms to your first office visit.**

Your first visit will be a thorough assessment of your health and may last up to 1 hour or more. Our fees vary based on the time and complexity of your case. This office is a cash office and payment is expected at the time of your visit. For your convenience we accept cash, debit cards, Visa, MasterCard, and Discover. We do not accept checks.

Integrative Medical Specialists requires a $100.00 deposit for initial visits. We have a large number of new patients who would like to be seen by our office and we make every effort to schedule each one as soon as possible. When someone fails to keep a new patient appointment without prior notice, we are unable to schedule someone else in that time slot.

We have found that financial commitment keeps no shows and last minute cancellations to a minimum. It is our policy to require a deposit of $100.00 in order to hold your appointment. A credit or debit card number will be required when scheduling your appointment. The deposit amount will be applied to your charges at the time of the initial visit. The minimum charge for an initial visit is $130.00.

We require 48 hours notice to cancel or reschedule an initial visit. If the visit is cancelled prior to 48 hours your deposit will be refunded. If your appointment is not canceled or rescheduled prior to the 48 hours, your deposit will not be refunded or applied to your initial visit. If you have previously scheduled and lost your deposit, a new deposit will be required upon rescheduling your initial appointment.

Please remember to bring in copies of any recent lab work, imaging reports, and recent medical records, as well as, the bottles of supplements or medications you are currently taking.

We look forward to seeing you in our clinic. Our goal is to become a trusted partner to you and your family in your health care needs.

Sincerely,

Integrative Medical Specialists

25055 W. Valley Parkway • Suite 204 • Olathe, KS 66061 • Phone (913) 825-6111 • Fax (913) 825-6115 • www.drdiehn.com

Integrative Medical Specialists, LLC®
Trusted Partners in Alternative Care

PATIENT DEMOGRAPHICS

Name ____ _____ ____/____/____
(Last) *(First)* *(Middle)* *(Sex)* *(Date of birth)*
Perm. Address_________________________ City ____________ State _____ Zip ________
Temp. Address_________________________ City ____________ State _____ Zip ________
Phone Perm (______)__________ Cell Phone (______)__________ Work Phone(______)__________
E-Mail Address ____
(We give notice of any important changes and sales through e-mail. We will not send any notification by post mail.)

As these are not considered "secure" communication devices:
Is it acceptable for us to contact you via e-mail? YES / NO
Is it acceptable for us to leave a message on a voicemail / answering machine for you? YES / NO
Is there anyone else that you would like us to contact regarding your patient information? YES / NO
If yes: Name ______________________________ Number (______)__________

How did you hear of us?
Yellow pages ________ Newspaper ________ Radio/TV ________ Internet ________ Sign ________
Were you referred by another physician? YES / NO Other: ____________________
If "YES", could you provide us with as much information as possible for the Referring Physician?
Referring Physician's Name ____
Address, City, State, Zip ____
Telephone Number ____

ADDITIONAL PATIENT INFORMATION

Today's Date ____/____/____ MD Physician ______________________________________
Employer ______________________________ Occupation ____________________
Work Address_________________________ City ____________ State _____ Zip ________
Name of nearest relative not living with you ______________ Relation ________ Phone (____)________
Marital Status (circle) Single Married Separated Divorced With Partner Widow(er)
Name of Spouse (or parent for minor child) ______________________________________
Whom may we contact in case of an emergency ______________________________________
Relationship to you ______________________________ Emergency Contact # (______)__________

Name of Patient/Guardian ______________________________ Date ____________________
Sign
Name of Patient/Guardian ______________________________ Relationship ____________________
Print

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FINANCIAL POLICY

Thank you for trusting Integrative Medical Specialists where we are committed to providing the best health care possible. The following statement explains our financial policy. Please read the policy, sign and return to us prior to your treatment. Payment is due at the time services are provided. All supplements, health products, services and labs sales are final. We gladly accept cash, debit cards, Visa, MasterCard, and Discover. We do not accept checks.

Naturopathic Medicine may be covered by some PPO plans as an out of network provider. Please check with your insurance company to determine if this is a covered benefit. Integrative Medical Specialists does not submit billing claims. A superbill will be provided for you to send attached to a claim form (provided by your insurance company) to your insurance company for reimbursement. Most HMOs do not reimburse for services provided by Doctors of Naturopathic Medicine.

Missed Appointments
Integrative Medical Specialists has a 24-hour cancellation/reschedule policy for established patients. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a $75.00 fee for the appointment.

CONSENT TO TREAT

I consent to the use and/or disclosure of my protected health information by Integrative Medical Specialists for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my health care provider is a Doctor of Naturopathic Medicine. I understand and agree that diagnosis or treatment of me by Integrative Medical Specialists and my doctor may be conditioned upon my consent as evidence by my signature on this document.

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Integrative Medical Specialists. I have read and agree to the financial policy. As the child's parent or guardian I understand that I am consenting for the child to be treated.

Please request a copy of our Privacy Practices if you have any questions or concerns.

I UNDERSTAND AND AGREE THAT INTEGRATIVE MEDICAL SPECIALISTS IS A CASH OFFICE. I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE TIME OF EACH OFFICE VISIT. THIS INCLUDES ALL NATUROPATHIC THERAPIES, SUPPLEMENTS, OFFICE VISITS, AND LABORATORY CHARGES.

Name of Patient/Guardian ______________________________ Date ________________________
Sign
Name of Patient/Guardian ______________________________ Relationship ____________________
Print

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Cancellation Policy

New Patient Deposit

Integrative Medical Specialists requires a $100.00 deposit for initial visits. We have a large number of new patients who would like to be seen by our office and we make every effort to schedule each one as soon as possible. When someone fails to keep a new patient appointment without prior notice, we are unable to schedule someone else in that time slot.

We have found that financial commitment keeps no shows and last minute cancellations to a minimum. It is our policy to require a deposit of $100.00 in order to hold your appointment. A credit or debit card number will be required when scheduling your appointment. The deposit amount will be applied to your charges at the time of the initial visit. The minimum charge for an initial visit is $130.00.

We require 48 hours notice to cancel or reschedule an initial visit. If the visit is cancelled prior to 48 hours your deposit will be refunded. If your appointment is not canceled or rescheduled prior to the 48 hours, your deposit will not be refunded or applied to your initial visit. If you have previously scheduled and lost your deposit, a new deposit will be required upon rescheduling your initial appointment.

Cancelling and Rescheduling Return Visits

Integrative Medical Specialists has a 24-hour cancellation/reschedule policy. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a $75.00 fee for the appointment.

I HAVE READ AND UNDERSTOOD THIS POLICY.

Name of Patient/Guardian ______________________________ Date ________________________
Sign

Name of Patient/Guardian ______________________________ Relationship ____________________
Print

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INFORMED CONSENT FOR TREATMENT

I, ____, hereby authorize the doctors of Integrative Medical Specialists to perform the following procedures to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: e.g. Laboratory bloodwork, radiology, diagnostic imaging, thermographic imaging, allergy testing, environmental testing, hormone testing, and other specialty labs.

Physical Examination: Screening Physical Exams may include any of the following: Skin & Dermatology; Head, Ear, Eyes, Nose & Sinuses & Throat; Face & Neck; Lungs & Pulmonary; Chest & Cardiovascular; Abdominal; Hands, Arms & Lower Limbs; Reflexes; Motor Skills; Back and Spine; Cranial Nerves; Male Genitalia, Prostate & Rectal Exams; Female Genitalia, Gynecological & Breast Exams; Mini-Mental Status Exams; Nutritional Exams.

Minor Office Procedures: e.g. Wound dressing, ear cleansing, and wart treatment.

Medicinal use of Nutrition: e.g. Therapeutic nutrition, and nutritional supplements.

Physical Medicine: e.g. Therapeutic ultrasound and electrical muscle stimulation, manipulative therapy, muscle stretching/massage, constitutional hydrotherapy.

Botanical Medicine: Botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.

Homeopathic Medicine: The use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing responses.

Immunization: e.g. Homeopathic immunizations.

Detoxification: e.g. Heavy metal and environmental detoxification.

Chinese Medicine: e.g. Acupuncture, cupping, electrical stimulation, TDP lamp, Chinese herbal medicine.

Lifestyle Counseling and Hygiene: e.g. Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risk: Allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

Potential Benefits: Restoration of health and body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease of its progression.

Notice to Women: All female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present a risk to the pregnancy and fetus.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Integrative Medical Specialists or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand Integrative Medical Specialists will keep a record of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or my representative in writing, or unless it is required by law. I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will not be kept more than ten years after the last day of my last treatment. I understand that any questions concerning this form can be asked of the doctor.

Name of Patient/Guardian ____ Date ____________________
Sign

Name of Patient/Guardian ____ Relationship ________________
Print

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS FOR PATIENTS OF INTEGRATIVE MEDICAL SPECIALISTS

I consent to the use or disclosure of my protected health information by Integrative Medical Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for Integrative Medical Specialists. I understand that diagnosis or treatment of me by my doctor(s) at Integrative Medical Specialists may be conditioned upon my consent as evidence by my signature on this document.

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. Integrative Medical Specialists is not required to agree to the restrictions that I may request. However, if Integrative Medical Specialists agrees to the restrictions that I request, the restriction is binding on Integrative Medical Specialists and my doctor(s) at Integrative Medical Specialists.

I have the right to revoke this consent, in writing, at any time, except to the extent that my doctor(s) at Integrative Medical Specialists 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 doctor, 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 understand I have a right to review Integrative Medical Specialists Notice of Privacy Practices prior to signing this document. Integrative Medical Specialists Notice of Privacy Practices has been provided to me. 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 Integrative Medical Specialists. This Notice of Privacy Practices also describes my rights and Integrative Medical Specialists duties with respect of my protected health information.

Integrative Medical Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy to be sent in the mail or asking for one at the time of my next appointment.

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NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGEMENT OF RECEIPT FORM

Patient's Acknowledgement of Receipt

Integrative Medical Specialists ***Notice of Privacy Practices*** provides a thorough explanation of how we may use and disclose your protected health information, as well as your rights as a patient.

I, ________________________________ (*print your name*), have received a copy of Integrative Medical Specialists Notice of Privacy Practices.

I choose to designate the individuals listed below as my primary contacts. Integrative Medical Specialists personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Patient's Name ___________________________________ Patient DOB ___________________________

Contact Name ____________________________________ Contact Name __________________________

Relationship _____________________________________ Relationship ___________________________

Phone ____ Phone ________________________________

Signature ____ Date ___________________
(Patient, Parent, Authorized Representative)

****

Inability to Obtain Acknowledgement

To be completed by Integrative Medical Specialists Representative:

It was not possible to obtain the individual's acknowledgement, due to:

___ Emergency Situation

___ Patient physically unable to sign

___ Patient Refused

___ Patient left office prior to obtaining signature

___ Other (explain) ____

Name of Patient ____
Comments ____

Signature of Integrative Medical Specialists Representative ____________________________ Date _________

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NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: December 8, 2004 Privacy Contact: 913-825-6111

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.

We at Integrative Medical Specialists understand that your medical/health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of the care and services you receive in our office(s). We respect the privacy and confidentiality of medical/health information about you and that can be identified with you. This is called "protected health information". Your protected health information is contained in the medical and billing records maintained by our practice. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

This Notice of Privacy Practices ("Notice") describes the ways in which we may use and disclose your protected health information. It also describes your rights and our legal obligations with respect to your protected health information. This Notice applies to uses and disclosures we may make of all your protected health information, whether created by us in our practice or received by us from another health care provider.

Federal and State Laws require us to: ensure the privacy of your protected health information, which we have either created in our practice or received from another health care provider, whether it is about your past, present, or future health care condition; maintain the privacy of your protected health information regarding payment for your health care; explain the manner in which we may use and disclose your protected health information; abide by the terms of this Notice, as currently in effect; and obtain your written authorization to use or disclose your protected health information for reasons other than those listed below and permitted by law.

You may request a copy of this Notice at any time by contacting our office in writing or by phone. We reserve the right to amend this Notice at any time in the future, and make the new provisions effective for all protected health information we maintain, regardless of when it was created or received. If the Notice is amended, we will post the revised Notice, with the new effective date, in our office(s) and make copies of the revised Notice available to you upon request.

INCIDENTAL DISCLOSURES

In the process of using or disclosing your protected health information for an authorized use, we may make incidental disclosures. We will take reasonable steps to limit incidental disclosures.

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE YOU WITH TREATMENT, TO OBTAIN PAYMENT FOR SERVICES RENDERED TO YOU, AND FOR HEALTH CARE OPERATIONS.

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For treatment: We may use and disclose your protected health information to provide you with medical treatment and services, and to coordinate or manage your health care and related services. We may disclose your protected health information either within our practice or an outside health care provider. We may also disclose your protected health information to providers or facilities who may be involved in your care after you leave our facility or our care.

For Payment: We may use and disclose your protected health information to an insurance company or managed care company or any other third party payer to bill and receive payment for treatment and services. We may also provide protected health information to collection departments, consumer reporting agencies or any other health care provider who requests information necessary for them to collect payment.

For Health Care Operations: We may use and disclose your protected health information for internal operations as necessary for us to operate our medical practice such as:

- General administrative activities and quality assurance programs.
- To train and educate doctors, nurses, students, volunteers or other medical staff;
- To plan for services, such as when we assess certain services that we may want to offer in the future;
- To our lawyers, consultants, accountants, and other business associates;
- In order to compare your information with that of several other patients to determine if we should offer new services or if new treatments were effective;
- To identify groups of patients who have similar health problems to give them information about treatment alternatives, programs, or new procedures;
- To organizations that assess the quality of care we provide to our patients (such as government agencies or accrediting bodies)
- To organizations that evaluate, certify or license health care providers, staff or facilities in a particular specialty;
- For procedures involving health care fraud and abuse detection and compliance

The following are situations in which we may use or disclose your protected health information without your written authorization or an opportunity for you to agree or object.

We may use or disclose your protected health information:

- When required to do so by federal, state or local law or other judicial or administrative proceedings.
- As necessary in emergency treatment situations.
- For public health activities such as reports about communicable disease, injuries or disability, births and deaths, child abuse and/or neglect, victims of abuse or neglect, and regarding the recall of products.
- *Unless you object*, we will also call your name to notify you that the practitioner is ready to see you or that we need to discuss something with you.
- *Unless you object*, we may disclose protected health information about you to a family member, relative, close personal friend or any other person you identify, including clergy, who is involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in payment for your care.
- For a health oversight agency for activities, such as audits, investigations, inspections, licensure actions or other legal proceedings.
- In response to a court or an administrative order.
- For certain law enforcement purposes, including, but not limited to reporting certain types of wounds and/or other physical injuries (i.e. gunshot wounds); reports required by law; identifying or locating a suspect or missing person, material witness or fugitive; answering requests for information concerning crimes, about the victim of crimes; reporting criminal conduct that took place on our premises; and in emergency situations to report a crime, the location of the crime or victim or the identity, description and/or location of a person involved in the crime.
- To a coroner, medical examiner for the purposes of identifying you or funeral director if necessary to allow them to carry out their duties.
- If you are an organ donor, to an organization involved in the donation of organs and tissue to enable them to carry out their lawful duties.

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- For research purposes, provided that the privacy and safety aspects of the research have been reviewed and approved by an institutional review board or a privacy board.
- If we believe it is necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- If you are a member of the armed forces, we may use and disclose your protected health information as required by military command authorities.
- We may disclose protected health information to authorized federal officials conducting national security, counterintelligence, and intelligence activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official to enable the correctional institution or law enforcement official to provide you with necessary health care services; to protect your own health and safety; to protect the health and safety of others; and/or for the safety and security of the correctional institution.
- To comply with laws and regulations relating to workers' compensation or similar programs established by law that provides benefits for work-related injuries and/or illnesses.
- We may use limited protected health information such as your name, address and phone number and the dates you received treatment or services, to contact you in an effort to raise money for a program developed by our practice. We may also disclose contact information for fundraising purposes to a foundation related to our organization. If you do not want to be contacted this way, you should notify us in writing by contacting Integrative Medical Specialists LLC at the telephone number listed on the first page of this Notice.
- To remind you about appointments in our organization; and appointments that we have scheduled for you with other health care organizations.
- To inform you about treatment alternatives and health-related benefits and services that may be of interest to you. This may include telling you about treatments; services; products; other health care providers; special programs; nutritional services.

Your authorization is required for all other uses and disclosures of your protected health information.

Except for those circumstances listed above, we will use and disclose your protected health information only with your written authorization. You may revoke your authorization, in writing, at any time. If you revoke an authorization, we will no longer use or disclose your protected health information for the purposes covered by that authorization, except where we have already relied on the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

You have the following rights regarding your protected health information that we maintain:

1. **The Right to Access Your Protected Health Information:** Except under limited circumstances, and **upon written request**, you have the right to inspect and obtain a copy of your protected health information. Your protected health information is contained in our medical and billing records or any other record used by us to make decisions about your care. We may charge you for the record copy. We may deny your request to inspect or receive copies of your Protected Health Information (PHI) in the following limited circumstances:

   - The information was compiled exclusively in connection with a criminal, civil or administrative proceeding;
   - The disclosure to the patient is prohibited by the Clinical Laboratory Improvement Act (42 U.S.C. §263a);
   - You are a correctional institution inmate and the correctional administrators have provided reasons for denying access;
   - The information is for a research study not yet complete;
   - The Privacy Act (5 U.S.C. §552a) prohibits access;
   - The information was obtained by a person other than a health care provider upon our promise to keep the information confidential, and access would reveal the informant's identity;

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- We determine access is likely to endanger the life or safety of the patient or others;
- The information contains information about another person and we determine that access is likely to cause substantial harm to that person;
- The request for access is made by the patient's personal representative and we believe access is likely to cause substantial harm to the patient or others

2. **The Right to Request Restrictions:** You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on the protected health information that we disclose about you to a family member, friend or other person involved in your care or the payment of your care. **<u>If you wish to request such a restriction, you must submit your written request to us.</u>** You must tell us what information you want restricted, to whom you want the information restricted, and whether you want to limit our use, disclosure or both. *We are not required to agree to such a restriction*. If we do agree to the restriction, we will honor that restriction except as needed to provide you with emergency treatment.

3. **The Right to Request Confidential Communications:** You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. **<u>You should submit your written request for confidential communications to us.</u>** You must tell us how and where you want to be contacted. We will accommodate your reasonable requests, *but may deny the request if you are unable to provide us with appropriate methods of contacting you*.

4. **The Right to Request an Amendment:**
   You have the right to request that we amend medical or billing records, or other protected health information maintained by us, for as long as the information is kept by us. **<u>Your request must be made in writing and must explain the reasons for the requested amendment.</u>**

   We may deny your request for amendment if the information:
   - was not created by us (unless you prove the creator of the information is no longer available to amend the record);
   - is not part of the records maintained by us;
   - in our opinion, is not accurate and complete;
   - is information to which you do not have a right of access.

   We must respond to your request within 60 days of receiving the request. If we agree to the amendment, we will notify you and amend the relevant portions of your medical record. We will also make a reasonable effort to inform business associates and other individuals known to us, or identified by you, as having the protected health information being amended.

   If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial and explain to you that you have the right to submit a written statement disagreeing with the denial. Your statement of disagreement will be attached to your medical record. If you should submit a statement of disagreement, we have the right to insert a rebuttal statement into the medical record. We will provide you with a copy of the rebuttal statement. If you do not wish to submit a statement of disagreement, you may request that a copy of the amendment request and a copy of our denial be included with all future disclosures.

   Should we deny your request for an amendment, you have the right to pursue a complaint process by contacting Integrative Medical Specialists LLC, or you may contact the Secretary of Health and Human Services to lodge your complaint.

   If you wish to request an amendment, you should submit the request to us in writing.

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5. **The Right to an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures of your protected health information made after December 8, 2004. You may request an accounting of disclosures made up to six (6) years before the date of your request, beginning with records created on or after December 8, 2004. An accounting is a listing of disclosures made by us or by others on our behalf, but does **not** include:

   - disclosures made for treatment, payment and health care operations;
   - disclosures made directly to you, that you authorized, or those which are made to individuals involved in your care;
   - disclosure made to correctional institutions or law enforcement official about an inmate in custody;
   - disclosure made for national security or intelligence purposes;
   - disclosure of a limited data set; or
   - an incidental disclosure.

   You must submit your request for an accounting of disclosures to us in writing. You must state the time period for which you would like the accounting. We must respond to you 60 days after receipt of your request. The accounting will include the disclosure date, the name, address (if known) of the person or entity that received the information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure. If you request a listing of disclosures more than once within a 12-month period, we will charge you a reasonable fee for the accounting. The first accounting, within a 12-month period, is provided to you at no charge.

SPECIAL RULES REGARDING THE DISCLOSURE OF MENTAL HEALTH CONDITIONS, SUBSTANCE ABUSE, AND HIV-RELATED INFORMATION.

1. **Mental Health Information:** If needed for your diagnosis or treatment in a mental health program, mental health information may be disclosed as needed between your treatment team members, and very limited information may be disclosed for payment purposes. Otherwise mental health information may **not** be disclosed without your authorization, except as specifically permitted by state or federal law. A special authorization is required for the disclosure of psychotherapy notes, and special rules may apply which limit the information which is disclosed.

2. **HIV-related Information:** HIV-related information will not be disclosed, except under limited circumstances set forth under state or federal law, without your specific written authorization.

3. **Substance Abuse Treatment:** If you are treated in a substance abuse program, information which could identify you as alcohol or drug-dependant will not be disclosed without your specific authorization except for purposes of treatment or payment or when specifically required or allowed under state or federal law.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the federal government. You will not be retaliated against for filing a complaint.

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Medication Form

Name:______________________________ Date Completed:______________________
Address:____
Phone Number:__________________________ Birth Date:______________________
Emergency Contact/ Phone:____
E-Mail ____
(We give notice of any important changes and sales through e-mail. We will not send any notification by post mail.)
Allergies and Drugs to Avoid/Adverse Reactions:
____
____

Please list any other special dietary information, or foods you can or will not eat. (ex: vegan, vegetarian, etc.)
____
____
____

Current Medications:

List all medications you are taking, include over-the-counter (e.g., supplements, prescriptions, aspirin, antacids).

Medication:___________________________________ Dosage:__________________
Reason for Taking:_________________________ Directions:____________________
Date Started:_________________________ Date Discontinued:____________________

Medication:___________________________________ Dosage:__________________
Reason for Taking:_________________________ Directions:____________________
Date Started:_________________________ Date Discontinued:____________________

Medication:___________________________________ Dosage:__________________
Reason for Taking:_________________________ Directions:____________________
Date Started:_________________________ Date Discontinued:____________________

Medication:___________________________________ Dosage:__________________
Reason for Taking:_________________________ Directions:____________________
Date Started:_________________________ Date Discontinued:____________________

Medication:___________________________________ Dosage:__________________
Reason for Taking:_________________________ Directions:____________________
Date Started:_________________________ Date Discontinued:____________________

Medication:___________________________________ Dosage:__________________
Reason for Taking:_________________________ Directions:____________________
Date Started:_________________________ Date Discontinued:____________________

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Name:____

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Medication:______________________________________ Dosage:______________
Reason for Taking:__________________________ Directions:______________________
Date Started:_________________________ Date Discontinued:_________________________

Immunization Record:
(Include dates administered)
☐ Tetanus____________ ☐ Pneumonia Vaccine____________ ☐ Flu Vaccine__________________
☐ Hepatitis Vaccine________________ ☐ Other____

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ADULT INTAKE FORM

Patient Name: ______________________ DOB: ____________ Age:________

List in Order of importance what your problems are:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

Last time you had blood work done and with what physician: ______________________

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	____	____	____	____	____	____
Age when died	____	____	____	____	____	____
Reason for death	____	____	____	____	____	____
Cancer type	____	____	____	____	____	____
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: ______________ MRI/Cat Scans: ______________

Ultrasounds: ______________ Accidents: ______________

TB Test: ______________ HCV: ______________

HIV: ______________ Last Dental Visit: ______________

Last Eye Exam: ______________

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles:	D I N	**Chicken Pox**:	D I N	**Mumps**:	D I N	**Rubella**:	D I N
Tetanus:	D I N	**Whooping Cough**:	D I N	**Hemophilus (Hib)**:	D I N	**Hepatits B**:	D I N

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German Measles: D I N Any vaccination reactions: ____________________
Patient Name: ____________________ DOB: __________

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day & number of years: __________

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes/Past: __________

Soda Pop: Y N P Ounces per day if Yes/Past: ______

Alcohol: Y N P How often & how much if Yes/Past: ______

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P

Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

____

____

____

Review of Systems:

Present Weight: __________ Weight one year ago: __________ Height: __________

Ideal Weight: __________

REGARDING THE NEXT LONG SECTION: Please circle (**Y**) if you have the problem **NOW**, (**N**) if you've **NEVER** had the problem, (**P**) if you had the problem in the **PAST**.

Good Energy: Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? __________

If you have fatigue, can you do what you need to during the day? Y N

SKIN				
Rash:	Y N P		Color Change:	Y N P
Hives:	Y N P		Lump:	Y N P
Psoriasis/eczema:	Y N P		Itchy:	Y N P
Dry:	Y N P		Warts/moles:	Y N P
Cancer:	Y N P		Perspiration:	Y N P
HEAD				
Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oil/dry hair:	Y N P		Hair loss:	Y N P
NOSE				
Frequent Colds:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Post Nasal Drip:	Y N P
Polyps:	Y N P		Seasonal Allergies:	Y N P

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EYES			
Dry/Watery:	Y N P	Blurry Vision:	Y N P
Double Vision	Y N P	Cataracts/Glaucoma:	Y N P
Glasses:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under Eyelid:	Y N P
MOUTH/THROAT			
Canker sores:	Y N P	Cold sores:	Y N P
Sore Throat:	Y N P	Gum disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of taste:	Y N P	Hoarseness:	Y N P
NECK			
Stiffness:	Y N P	Swollen Glands:	Y N P
Full movement:	Y N P	Tension:	Y N P
RESPIRATORY			
Cough:	Y N P	TB:	Y N P
Shortness of breath w/ exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying down:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P
CARDIOVASCULAR			
High Blood Pressure:	Y N P	Rheumatic Fever:	Y N P
Low Blood Pressure	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P
Edema:	Y N P	Chest Pain:	Y N P
URINARY TRACT			
Incontinence:	Y N P	Pain w/ Urination	Y N P
Frequent Infections:	Y N P	Kidney Stones	Y N P
Urgency:	Y N P	Discharge/Blood:	Y N P
GASTROINTESTINAL			
Heartburn:	Y N P	Bowel Movement Freq:	
Indigestion:	Y N P	Recent BM Change:	Y N P
Bloating:	Y N P	Diarrhea/Constipation:	Y N P
Nausea:	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall Bladder Disease	Y N P
Change in Appetite:	Y N P	Liver Disease:	Y N P
Pancreatitis:	Y N P	Ulcer	Y N P

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MALE GENITALIA

Testicular pain/swelling:	Y N P	Sexually Active:	Y N P
Hernia:	Y N P	S.T.D.:	Y N P
Discharge:	Y N P	Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P	Sexual Orientation:	Hetero Homo Bi

FEMALE GENITALIA

Age Period Began:		How Often Period Occurs:	
How long period lasts:		Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P	Menstrual Pain:	Y N P
PMS:	Y N P	Start date of last period:	
Times Pregnant:		How many births:	
Miscarriages:		Abortions:	
Last Pap Smear:		Diagnosis:	
Any abnormal paps:	Y N P	When was abnormal:	
Menopausal since what age:		Use of hormones:	Y N P
Type of hormones used:		Healthy libido:	Y N P
Dry vagina:	Y N P	Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P	Vaginitis:	Y N P
S.T.D.:	Y N P	Mammography:	Y N P
Dexa Scan:	Y N P	If Yes, what were results:	
Sexual Orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: ____________________

MUSCULOSKELETAL

Weakness:	Y N P	Arthritis:	Y N P
Stiffness:	Y N P	Leg Cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P

NERVOUS

Paralysis:	Y N P	Sciatica:	Y N P
Tingling/numbness:	Y N P	Carpal tunnel syndrome:	Y N P
Seizures:	Y N P	Fainting:	Y N P

Mental/Emotional

Depression:	Y N P	Anger/irritability:	Y N P
Suicidal:	Y N P	High-strung/tense:	Y N P
Anxiety:	Y N P	Fear/Panic	Y N P
Eating disorder:	Y N P	Psych Hospitalization:	Y N P

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Exercise

How often do you exercise? ______ What type of exercise? ______

For how long? ______ Hobbies: ______

Sleep

How long per night? ______ If you wake up frequently, what is the reason? ______

Nightmares: Y N P   Wake Refreshed: Y N P   Must nap during the day: Y N P

Sleep walk: Y N P   Grind teeth: Y N P   Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ______

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? ______

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? ______

Are you particularly sensitive to perfumes, gasoline or other vapors? ______

Do you use pesticides, herbicides or other chemicals around your home? ______

Social Life

Enjoy job: Y N P   Hours worked per week: ______   Excessive exposure to environmental toxins: Y N P

Quality of significant relationship: ______

History of sexual, mental/emotional, physical abuse: Y N P If so, at what age and by whom: ______

What is your greatest health concern: ______

How does it limit you the most: ______

How committed are you towards making valuable changes: Little Moderately Very

Ethnic Background: ______

Typical Day's Diet

Breakfast: ______

Lunch: ______

Dinner: ______

Snacks: ______

Allergies

List all known Allergies (food, drugs, environment): ______

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