



Institute for Progressive Medicine

4 Hughes, Suite #175 Irvine, CA 92618 Tel: (949) 600-5100 Fax: (949)600-5101

www.iprogressivemed.com

Naturopathic Doctor New Patient Packet

PLEASE BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT

(Please Print Clearly)

Today's Date: ___/___/___ Driv. Lic. # _____ SS# _____ - _____ - _____

Name: _____

(First, Middle Initial and Last)

Primary Reason for Visit: _____

Birth Date: ___/___/___ Age: _____ Female Male Race: _____ Ethnicity: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Primary Telephone Number: (_____) _____ - _____ home cell

Secondary Telephone Number: (_____) _____ - _____ home cell

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Separated Widowed

Spouse/Partner Name: _____ Spouse/Partner Birth Date: ___/___/___

Payment must be made at the time of service. We cannot accept medical insurance for visits with a naturopathic doctor.

Who is financially responsible for this bill? _____

I will be paying today with: Cash Check Visa/MC

Who may we contact in the case of an emergency?

Name: _____ Tel: (_____) _____ - _____

Relationship: _____

If you are a minor (under 18) or dependent, please provide us with your guardian information:

Name of Guardian: _____ Tel: (_____) _____ - _____

I hereby consent to have my information released to the following individual. This consent will remain in effect until otherwise notified by me in writing.

Medical Information Billing Information Do NOT release any of my information

Name: _____ Relationship: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify the information above is true and correct to the best of my knowledge. I will notify IPM of any changes in the status of the above information.

Signature: _____ Date: ___/___/___

Parent signature (if minor): _____ Date: ___/___/___



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Referral Information

How did you hear about us? Please choose the referral type and fill in the information below.

Healthcare Practitioner (Name): _____

Friend or Family (Name): _____

May we mention your name when sending a thank you to the person who referred you to IPM?

Yes No

Website/Search Engine: _____

Print Media/Mailer (Name): _____

Other (Please specify): _____

Patient Contact Information

Staff at the Institute for Progressive Medicine may contact you by mail, email or telephone to relay important information about your health such as appointment reminders, laboratory results, doctor recommendations and prescription information.

STATEMENT OF PATIENT AWARENESS AND RESPONSIBILITY

- I am aware that any therapy, no matter how well designed and carried out, may fail to alleviate my symptoms and improve my health.
- I agree to make every effort to pursue the program mutually agreed upon with my physician.
- I expect to be informed of those therapies most relevant to my condition, both conventional and alternative, realizing that I have the choice to accept, refuse or terminate them at any point.
- I understand that unforeseen difficulties may arise in the course of treatment.
- I am responsible to seek professional medical attention from a medical or naturopathic doctor employed at the Institute for Progressive Medicine, or another facility for any worsening of my condition, including consideration of hospitalization, invasive procedures or treatment in the emergency room.
- I am aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- I am aware that I will not be told to avoid seeing other physicians. I understand that I may be referred to another physician for treatment and that other options of medical care are available to me.
- I have received a copy of Institute for Progressive Medicine's Notice of Health Information Practices.

Patient Name (Please print)

Patient Signature

Date

Witness

Date



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Office Policy

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of the Institute for Progressive Medicine, you are responsible for the total charges incurred for each visit or any balances not paid by your insurance company to your practitioner. Charges for cash services are to be paid at the time of each visit. Payment is due upon receipt of a statement including charges for deductible, co-pay, or non-covered services. **If your insurance does not remit payment within sixty (60) days, the balance will be due and payable by you.** All patients are required to sign a copy of the standard arbitration form included in this packet before they may see a doctor or receive any services.

We accept Visa, MasterCard, personal checks and cash as forms of payment. There will be a \$35.00 charge for all returned checks. **We are contracted providers for Medicare only. We do not accept Medi-cal, HMO, EPO or other private insurance.** You will be required to sign a waiver if you wish to be seen and are covered under Medi-Cal and/or an HMO. **At this time, we are unable to accept any insurance (including Medicare) for visits with a naturopathic doctor (N.D.).**

If you have a private insurance out office staff can provide you with the necessary paperwork (superbill, procedure and diagnosis codes) you will need to submit for reimbursement to your insurance. Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. **We are unable to submit a bill for you if we are not a contracted provider for your insurance.**

All appointments made with a doctor or IV nurse are confirmed via telephone two days in advance. Doctors' appointments not canceled with **AT LEAST 24 HOURS NOTICE** will be charged a **\$50.00** missed appointment fee. Appointments with the IV nurse that are missed without prior notice given to reception will be charged a **\$25.00** missed appointment fee. This charge is directly payable by you and cannot be submitted to your insurance. **We make every effort to see all scheduled appointments; however, we reserve the right to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time.**

Phone consultations are not billable to Medicare and payment is required at the time of the scheduled appointment.

Payment for all supplements, IVs, and non-covered treatments (e.g. acupuncture, prolotherapy, etc.) is due at the time of service. Most insurance companies do not cover these services. You have the right to refuse any service recommended by our staff.

Mail order supplements are sent via UPS. Payment must be received before any items can be shipped to you.

I have read understand and agree to the above stated policies of The Institute for Progressive Medicine.

Print name: _____

Signature: _____ Date: ___/___/___



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MEDICARE BILLING INFORMATION

Medicare subscriber #: _____ - _____ - _____ Effective Date: ____/____/____

Medicare Insurance Primary Secondary

If secondary, list primary insurance information:

Insurance Name: _____ Name of Insured: _____

Group number: _____ Subscriber number: _____

Birth Date of Insured: ____/____/____ Relationship to Patient: _____

Is your Medicare connected with an HMO? Yes No

In order to bill Medicare, we must have a copy of your driver's license, Medicare and secondary (if any) insurance cards. Please be prepared to give your card(s) to the receptionist. If you do not have your Medicare card with you, please ask receptionist to assist you in calling Medicare at 1-800-MEDICARE (1-800-633-4227) to verify your Medicare coverage.

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made on my behalf to the Institute for Progressive Medicine for nay services furnished to me by a physician as part of that group. I authorize the holder of any medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient Signature

Date

MEDI-CAL/MEDICARE POLICY

The Institute for Progressive Medicine is a Medicare provider. We are happy to bill Medicare for any eligible charges you have after receiving services. However, the Institute for Progressive Medicine is NOT a Medi-Cal/Medicaid provider. Therefore, if you have Medi-Cal or Medicaid as a secondary insurance, you will be responsible for all remaining co-insurance and/or deductible expenses after Medicare remits payment.

Do you have Medi-Cal/Medicaid as your secondary insurance? Yes No

I, _____, have read the Medi-Cal/Medicaid policy above for the Institute for Progressive Medicine and I understand that as a Medical/Medicaid patient I will be responsible for all secondary costs after Medicare pays for the services I receive in this office.

Patient Name (Please print)

Patient Signature

Date

Witness

Date



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Laboratory Billing Information

Our doctors may order laboratory or other diagnostic testing for you. Some laboratory testing is performed in our private laboratory and other tests must be sent to an outside laboratory for processing. It is your choice whether or not to receive laboratory testing recommended by your doctor.

Although we do not bill insurance other than Medicare PPO for office visits, as a courtesy to our patients we will bill most PPO insurances (some exclusions apply) for in-house laboratory testing ordered by your doctor at the Institute for Progressive Medicine. We can not accept HMO, EPO, Medi-Cal or Medicaid insurance plans for laboratory testing or any other service, visit or procedure at the Institute for Progressive Medicine.

Some specialized outside laboratory testing is payable by the patient directly to the company performing the testing, unless specific provisions are made by the laboratory to accept insurance. A minimal sample processing fee may apply for outside laboratory tests.

If you would like us to bill insurance for in-house laboratory testing, please fill in the following information:

Name of Insurance

Name of Insured if different from patient

Group Number

subscriber Member ID Number

Date of Birth of Insured

Relation to Patient

More on Insurance Billing

There are many great insurance companies, each with a variety of different plans serving the patients in our practice. It would be an impossible task for our staff to know which labs and services are covered or deemed by the insurance company to be medically necessary for each patient at the time of services.

We feel confident that we provide services during your visit that are appropriate and important for our age and/or condition. Your insurance company might not always agree. They may deny coverage of certain labs or services as medically unnecessary or because your specific policy may not provide coverage for certain services.

It is the patient's responsibility to understand their individual insurance policy and coverage. If you are unsure about coverage for a particular test or procedure, please contact your insurance company directly.



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Medical Questionnaire

Height: _____

Weight: _____

Current Medications:

<u>Name of prescription:</u>	<u>Strength and Dosage:</u>	<u>How often per day</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Nutritional Supplements and Over the Counter Medications:

<u>Name of prescription:</u>	<u>Strength and Dosage:</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Drug Allergies: please check or list all drugs and the type of reaction:

- I am not allergic to any medications
- Penicillin Reaction _____ Codeine Reaction _____
- Sulfa Reaction _____ Other Reaction _____
-
-

Medical problems: Have you had (or do you have now) any of the following medical problems:

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Abnormal PAP | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Anemia | <input type="checkbox"/> Received Blood Transfusion |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver/Pancreas Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexually Transmitted Disease |
- Positive HIV or AIDS Other (Describe): _____

Would you like to be tested for HIV? Yes No

Smoking and Alcohol History:

- Do you smoke now? Yes No Have you smoked in the past? Yes No
- For how many years did you smoke? _____ When did you quit: _____
- Do you use other tobacco products: Yes No
- How much alcohol do you drink: None 1-7 Drinks/week 8-14 Drinks/week
- More than 14/week Specify: _____



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Past surgery: have you had any of the following operations, and the year:

- | | | |
|---|---|--|
| <input type="checkbox"/> Appendix ____ year | <input type="checkbox"/> Gall Bladder ____ year | <input type="checkbox"/> Thyroid ____ year |
| <input type="checkbox"/> Hernia ____ year | <input type="checkbox"/> Heart ____ year | <input type="checkbox"/> Lung ____ year |
| <input type="checkbox"/> Hysterectomy ____ year | <input type="checkbox"/> Gall Bladder ____ year | <input type="checkbox"/> Tonsils ____ year |
| <input type="checkbox"/> Spine/joint ____ year | <input type="checkbox"/> other: _____ | |

Hospitalizations, Illnesses, surgeries:

- | | |
|----------|---------|
| Year: | Reason: |
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |

Family Health

Please give the following information about your immediate family:

Relationship	Age if living	Age at death	State of health or cause of death
Father			
Mother			
Brothers/Sisters			
Spouse			
Children			

Other diseases in your family:

- Stroke
 Kidney Disease
 Asthma
 Tuberculosis
 Goiter
 Anemia
 Sickle cell
 Bleeding problems
 Leukemia or Lymphoma
 Other cancer _____



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Nutrition and Diet

Please answer the following questions in the space provided:

1. How many meals do you eat each day? _____

2. Do you diet frequently? Yes No

3. Do you exercise? Yes No

If so, what type of exercise do you do? _____

4. How many hours per night do you sleep? _____

5. What types of foods do you eat? List a typical day below:

Immunizations:

Tetanus: _____ year

Pneumonia: Yes No

Chicken Pox: Yes No

Influenza: _____ year

Hepatitis A: Yes No

Hepatitis B: Yes No

TB skin test: _____ Year

TB test positive? Yes No

Other

If you were born after 1957, have you received a second measles vaccination? Yes No

Do you have any additional information not mentioned above? _____



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Current (or recent past) Symptoms

General

Weight loss:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight gain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night sweats:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weakness and fatigue:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensitivity to heat or cold:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Skin

Rashes/itching:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nail fungus:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Moles that have changed color or size:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise easily:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Changes in hair or nails:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Changes in color or pigmentation:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Eyes

Wear glasses or contact:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred vision:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual disturbances or double vision:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts or Glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye pain/Inflammation or discharge:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Ears

Ringling in your ear:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble hearing:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Nose

Nosebleeds:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nasal congestion/drainage:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of smell:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent colds:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Allergies

Hay fever or allergies (Year round)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taken allergy shot now or in the past:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug reaction:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mouth & Throat

Dental problems/Dentures/Tooth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth sores:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat or Hoarseness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty swallowing:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in taste:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Respiratory

Persistent cough:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough productive of sputum:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing up blood:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma or wheezing:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exposure to tuberculosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Shortness of Breath

At rest:	<input type="checkbox"/> Yes <input type="checkbox"/> No
With exercise, climbing hill or stairs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wake up at night short of breath:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep on more than one pillow to prevent shortness of breath at night:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Heart

Feel your heart racing even at rest:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart palpitations:	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling on your feet or ankles:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain in leg or buttock when walking:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain or discomfort: At rest:	<input type="checkbox"/> Yes <input type="checkbox"/> No
At exertion:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing blood:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sputum production:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blueness of skin:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Endocrine

Goiter:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid problem/Medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prednisone treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sugar in urine/ Diabetes:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heat or cold intolerance:	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Gastrointestinal

Indigestion or heartburn:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent use of antacids or acid:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal bloating:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach ulcer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea or vomiting:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting blood:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gallstones:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids or rectal pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea frequently or persistently:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood with bowel movement:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Black or tar-like stools:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in bowel habits:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent use of laxatives:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous jaundice:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty swallowing:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in appetite:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Genitourinary

Discomfort/burning/straining with urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nocturia (urination at night) How many times at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty starting or stopping urine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney stones:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dark color or cloudy urine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leaking bladder:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of libido:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with intercourse:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Testicular pain or swelling:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gonorrhea:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Syphilis:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Neurologic

Common headache:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent or severe headache:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures or epilepsy:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Numbness or weakness in arm or leg:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory loss:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Muscles/Joints

Do you have arthritis or joint pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swollen or red joints:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neck or back pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle cramps/weakness:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deformity of joints:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Blood/Lymphatic

Anemia:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transfusions:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding tendency:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lymph node enlargements or pain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mental Health

Marital problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty sleeping:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeling sad or depressed:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeling nervous or anxious:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suicidal thoughts:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you seeing a therapist:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take illicit/illegal drugs:	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Women only

Age menses started: _____
Date of last period: _____
Number of pregnancies: _____
 Births: _____
 Miscarriages: _____
 Abortions: _____
Complications of pregnancy Yes No
 Diabetes Yes No
 High blood pressure Yes No
 C-section Yes No
 Toxemia: Yes No
 Other: _____

Do you examine your breasts regularly:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever taken birth control pills:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you noticed any breast lumps:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vaginal discharge at present time:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vaginal discomfort at present time:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular period:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding when not your period:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain with intercourse:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hot flashes:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Men only

History of prostate trouble:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with erection/sexual difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penile discharge:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you examine your testicles frequently	<input type="checkbox"/> Yes <input type="checkbox"/> No

MY SIGNATURE BELOW CONSTITUTES CONSENT TO MEDICAL SERVICES:

I consent to medical evaluation and treatment by The Institute for Progressive Medicine. I understand that the Institute for Progressive Medicine may recommend various methods to help me regain my health and those methods will be discussed.

Patient Name (Please print)

Patient Signature

Date



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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Duly (Date)
Authorized Representative Signature

By: _____
Patient's Signature (Date)

Print Patient's Name

By: _____
Print or Stamp Name of Physician,
Medical Group or Association Name

By: _____
Patient's Representative's Signature (if applicable) (Date)

By: _____
Signature of Translator (if applicable) (Date)

Print Name and Relationship to Patient

Print Name of Translator



Institute for Progressive Medicine

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Notice of Health Information Practices

Notice of privacy – Introduction

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

At Institute for Progressive medicine (hereafter known as IPM), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit IPM, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of information for public health officials for improving the health of this state and the nation
- A source of data for our planning
- A tool with which we can assess and continually work to improve the care we render

Understanding what is in your health record and how your health information is used, helps you to ensure its accuracy. It will help you understand who, what, when, where and why others may access your health information. It will also help you make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your record is the physical property of IPM, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Information Practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

IPM is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.