



# Institute for Progressive Medicine

4 Hughes, Suite #175 Irvine, CA 92618 Tel: (949) 600-5100 Fax: (949)600-5101  
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## Medical Doctor New Patient Packet

\*\* IMPORTANT - PLEASE BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT \*\*

Full Legal Name \_\_\_\_\_

Nickname \_\_\_\_\_

Primary Reason for Visit \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_  Female  Male Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Primary phone (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_  home  cell  work

Secondary phone (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_  home  cell  work

Employer phone (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status  Single  Married  Divorced  Separated  Widowed

Spouse/Partner Name \_\_\_\_\_ Spouse/Partner Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Who may we contact in the case of an emergency?

Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_ Relationship \_\_\_\_\_

(Minors under 18) Name of Guardian \_\_\_\_\_ Tel (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

### Check below if you agree to share personal information with a named individual:

I consent to have my personal medical and billing information shared with the person listed below.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_ - \_\_\_\_

### Patient Contact Information

Staff at IPM may contact you by mail, email, text or telephone to relay important information about your health such as appointment reminders, lab results, physician recommendations and prescription information.

**IPM does not accept any medical insurance plans for services. We currently accept cash, check, most major credit cards, and CareCredit as valid forms of payment. Payment is due at the time of service.**

I certify the information above is true and correct to the best of my knowledge and 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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## Patient Medical History

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 supplement</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 \_\_\_\_\_

\*\*IMPORTANT: Have you ever had an adverse reaction to anesthetics during or after a surgical procedure?  Yes  No

Please explain: \_\_\_\_\_

### Medical problems (past and present)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Hepatitis or Jaundice
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Urinary Tract Infection	<input type="checkbox"/> Liver/Pancreas Disease
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Other Kidney Disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Received Blood Transfusion	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Abnormal PAP	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Positive for HIV or AIDS	<input type="checkbox"/> Other
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Sexually Transmitted Disease	

Would you like to be tested for HIV?  Yes  No

### Tobacco, Alcohol and drug History

Do you smoke now?  Yes  No Smoked in the past?  Yes  No Use other tobacco products?  Yes  No

For how many years did you smoke? \_\_\_\_\_ When did you quit \_\_\_\_\_

How much alcohol do you drink?  None  1-7 Drinks/wk  8-14 Drinks/wk  More than 14/wk Other \_\_\_\_\_

Do you or have you ever used drug(s) recreationally?  Yes (Current)  Yes (Past)  No

If yes, please list drug(s) and frequency \_\_\_\_\_



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## Past surgery

<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 familial relationships

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

Other diseases in your family

<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Leukemia or Lymphoma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> 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

Breakfast \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks \_\_\_\_\_  
\_\_\_\_\_

Do you Drink Coffee? If so how often? \_\_\_\_\_

Do you consume soft drinks? If so how often? \_\_\_\_\_

## Immunizations (Please complete to the best of your ability)

Tetanus \_\_\_\_\_ Year

Pneumonia \_\_\_\_\_ Year

Chicken Pox \_\_\_\_\_ Year

Influenza \_\_\_\_\_ Year

Hepatitis A \_\_\_\_\_ Year

Hepatitis B \_\_\_\_\_ Year

TB \_\_\_\_\_ Year

TB test positive?  Yes  No

Measles \_\_\_\_\_ Year

Other \_\_\_\_\_

## What are your top three health goals?

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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 and 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
Ringing in the ear	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Allergies

Hay fever or allergies	<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
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Shortness of Breath

Shortness of breath at rest	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath 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	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Heart

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
Chest pain or discomfort 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
Diabetes Type I or II (Circle which)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prediabetes	<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

## Muscle 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
Work Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Financial Stress	<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

## Genitourinary

Discomfort/burning/straining with urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nocturia (urination at night)	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many times at night?	
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
Leaky 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



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## Women Only

Age menses started	
Date of last period	
Number of pregnancies	
Births	
Miscarriages	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abortions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complications of pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes during pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure during pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
C-section	<input type="checkbox"/> Yes <input type="checkbox"/> No
Toxemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
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
Other	

## 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
Other	

**Do you have any additional information you would like the doctor to know? (Please write below)**

## 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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## 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, diagnosis, 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.



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## 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 my 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 understand that IPM is not contracted with any health insurance provider and does not have an active billing department or billing staff members. I understand that IPM staff are not authorized to answer specific questions about coverage for services or therapies received at IPM and cannot guarantee a specific medical insurance provider will cover the codes provided on superbills when requested.

I have read, understand and agree to **IPM's Notice of Health Information Practices and Statement of Awareness and Responsibility** above.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



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## IPM 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. Charges for cash services are to be paid at the time of each visit. All patients are required to complete the following forms: **1) IPM New Patient Packet, 2) IPM Physician-Patient Arbitration Agreement 3) IPM Patient Private Contract. These documents must be completed and signed before a patient may see a doctor or receive any service at IPM.**

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Payment for all services is due at the time of service. You have the right to refuse any service recommended by our staff for any reason. We accept cash, check, most major credit cards, and Care Credit as valid forms of payment. There will be a \$35.00 charge for any returned checks.

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**IPM does not accept medical insurance plans for services rendered at our facility. If you have any questions about our payment policy, please contact reception.** If you have private insurance our office staff may provide you with the necessary paperwork (super-bill, procedure and diagnosis codes) that you will need to submit for reimbursement to your insurance company. Most insurance companies do not cover integrative or alternative medical services. You have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. Unfortunately, due to Medicare regulations, IPM is unable to provide superbills or billing assistance for reimbursement for patients who have Medicare or Medicare Advantage plans.

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We are committed to providing timely and exceptional care to our patients. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call reception at least 24 hours in advance of your appointment for any changes or cancellations. To change or cancel a Monday appointment, please call us before 12:00pm on Friday.** If prior notification is not given, there will be a **\$50.00** charge missed appointments or appointments cancelled without enough notice.

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, or in case of emergency.

I have read, understand, and agree to the **IPM Office Policy** above.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



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## IPM Prescription Medication Policy

Prescription medication may be recommended and prescribed by a physician at the Institute for Progressive Medicine. All prescription medications present a potential risk of side effects which may or may not be noticeable to the patient. Side effects may be compounded or worsened when using multiple medications. For this reason, their use must be monitored by a physician. Our policy on prescription refills exists to comply with federal drug regulations and to protect the health of our patients.

- No patient will receive a prescription refill unless he or she has been seen in person by a physician at the Institute for Progressive Medicine within the last 12 months. If you have not been seen by a physician at IPM within this time, you will be required to be seen in-person by an IPM physician before a refill can be granted by our staff.
- Under certain circumstances our physicians may require a patient to be seen in-person before a refill can be given, even if it has been 6 months or less since the last office visit.
- When requesting a refill, please do not call our office. Instead, request that your pharmacy fax a prescription refill request to us at 949-600-5101. Allow up to 72 hours for our medical staff to respond to refill requests from your pharmacy.

## Laboratory Billing Information

Our doctors may order laboratory or other diagnostic testing for you. Most testing will be sent to an outside laboratory for processing and billing. It is your choice to receive laboratory testing recommended by your doctor. The fee for collection of samples at IPM to be sent to an outside laboratory is \$30.

Outside laboratories are usually contracted with most major insurance plans, so they may bill your insurance for you. Please make sure you provide your current insurance information to our staff so that it can be forwarded to the lab for billing purposes.

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.

I have read, understand and agree to the **IPM Prescription Medication and Laboratory Billing Policy** above.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



# Institute for Progressive Medicine

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## IPM 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 \_\_\_\_\_



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## IPM Patient Private Contract Updated for Jan 1, 2025

**This contract is made between physicians at Institute for Progressive Medicine, A Professional Medical Corporation (referred to as "IPM Physicians") and any patient seeking treatment at IPM (referred to as "Patient"). If as a patient you have any questions about this contract, please contact IPM reception.**

- Patient has been informed that IPM Physicians have voluntarily opted out of the Medicare program effective January 1, 2019 for a period of at least two years and are not excluded from participating in Medicare Part B under Sections 1128, 1156 or 1892 or any other section of the Social Security Act. This contract is valid from the date signed and is effective for the entire duration of the opt-out period.
- Patient or his or her legal representative, accepts full responsibility for payment of charges for all services furnished by IPM Physicians. He or she further understands that Medicare limits do not apply to what IPM Physicians may charge for items or services furnished at IPM.
- Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask IPM Physicians to submit a claim to Medicare.
- Patient or his or her legal representative understands that Medicare will not pay for any items or services furnished by IPM Physicians.
- Patient agrees to this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from a physician and or practitioner who has not opted out of Medicare. This contract does not prevent Patient from seeking Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.
- Patient or his or her legal representative understands that Medigap plans, Medicare Advantage programs and other supplemental insurance plans may not pay for items and services not paid for by Medicare.
- Patient or his or her legal representative acknowledges that he or she is not entering into this contract during a time when Patient is requiring emergency or urgent care services.
- Patient agrees to reimburse IPM Physicians for any costs and reasonable attorney's fees that may result from violation of this contract by Patient and his or her legal representatives.

(Continued on next page)



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- Patient or Patient's legal representative has had the opportunity to read, understand and ask questions regarding this contract before signing.
- Patient or his or her legal representative acknowledges that a copy of this contract has been made available to him or her before items or services are furnished under the terms of this contract. This contract supersedes (replaces) any previous agreements between Patient and IPM Physicians regarding Medicare.
- IPM Physicians will retain this original contract for the duration of the opt-out period and will supply a copy of this contract to Centers for Medicare Services (CMS) upon request.

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Provider Signature

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Date

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Provider Signature

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Date

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Provider Signature

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Date

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Patient Full Name (please print)

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Date of Birth

---

Telephone

---

E-mail Address

---

Patient or Legal Representative Signature

---

Date

---

Witness

---

Date