SOUTHWEST INTEGRATIVE MEDICINE naturopathic physician + acupuncturist

DATE _____

PATIENT PROFILE

Last Name: _____ First Name: _____

Preferred name: _____ Birthdate: _____Gender: _____

A note to our patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid your physician in your diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?	Physician who diagnosed your condition?
1		
2		
3		
4		

What goals do you have for your visit at the clinic today? _____

_____

Have you ever consulted a Naturopathic physician, an Acupuncturist, a Nutritionist or a Counselor before? (please circle)

Do you have any questions about our clinic or the care that you've chosen today? _____

_____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

List vitamins, minerals, herbs, homeopathic remedies, etc. that you are currently taking, and include dosages:

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6._____

Please list any severe or **life-threatening allergies**: _____

Explain: _____

Personal Habits:

Please circle any of the following substances that you use regularly: Tobacco Coffee/black tea/cola Alcohol Recreational drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? ☐ Yes ◉ No What type? _____

How long? _____ How often? _____

Past History:

Hospitalizations: _____

_____

Serious Illnesses and Injuries: _____

_____

Date of last visit to your physician _____ Date of last blood tests: _____

Personal and Family History:

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	DATES RESOLVED Past(P)/Current(C)		YES	RELATION	DATES RESOLVED Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History:

Please circle those that apply: ◯ Single ◉ Married ◯ Significant other

Do you have any children? ◉ Yes ◯ No Please list their age(s) _____

Southwest Integrative Medicine
4045 East Bell Road, Suite 107
Phoenix, AZ 85032
1 877 655 7869 Tel
602 493 2399 Fax

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name:_____ Other name(s) that records may be kept under: _____

Date of Birth: _____ Gender:_____ SS#: _____

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

Email Address:_____

Home Ph:(_____)_____ Work Ph:(_____)_____ Cell Ph:(_____)_____

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify): ❍ **Home** ❍ **Work** ❍ **Cell**

Employer/School: _____

Mother's Name (minors only): _____ Father's Name (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone #1: (_____)_____ ❍ Home ❍ Work ❍ Cell

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 2.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Notice of 24 Hour Cancellation Policy: Should you require canceling a scheduled appointment we require 24 hours notice of this cancellation. In the event we don't receive 24 hours, you may be charged 50% of the scheduled appointment fee.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Southwest Integrative Medicine is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our medical records office at (480) 285-9794.

I hereby acknowledge that I have received a copy of Southwest Integrative Medicine's Notice of Privacy Practices. Should I refuse or fail to sign this form, I acknowledge that Southwest Integrative Medicine has made a good faith effort to obtain my acknowledgement.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

SOUTHWEST INTEGRATIVE MEDICINE naturopathic physician + acupuncturist

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the private practitioners of Southwest Integrative Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:
Common diagnostic procedures: e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological Counseling
Contraception
Immunization
Acupuncture: insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.
Cupping: a technique to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.
Gua Sha: a rubbing on an area of the body with a blunt, round instrument.
Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.
Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.
Tuina: an ancient massage used to treat a wide variety of common disharmonies.
Dietary Advice: based on traditional Chinese Medical Theory.

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

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. **For acupuncture:** discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression. **For acupuncture:** drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the constitution.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Southwest Integrative Medicine 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 that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____ Date

_____ Signature of Patient

Original to: Chart
Copy to: Patient (if requested)

_____ Signature of Patient Representative or Guardian

PATIENT NAME:

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 state and federal law, and not by a lawsuit or resort to court process, except as state and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE