# Institute For Ayurvedic And Naturopathic Therapies
## New/Return Patient Form

Please fill in all that apply. All information is confidential and will be used only for the purposes of diagnosis and treatment.

**New Patient**: Please complete **ALL** forms bring to appointment or send to health@ayurct.com
**Returning Patient**: Please complete **STARRED**

*Today's Date: _____

*Patients Name: _____
*Age: _____ *Date of Birth: _____
Sex: Pick One Preferred Pronouns: Pick One
*Address: _____
City: _____State:_____ Zip: _____ _____
Home Phone: _____ Work Phone: _____
Email Address: _____
Status: Pick one
Children: (Number and Ages) _____
Employer: _____
Employer Address: _____
_____
Occupation: _____ Hours worked per week: _____
*Social Security Number: _____ Referred by: _____
In case of emergency, notify (include phone): _____
_____

**Insurance Information:** (Please supply the receptionist with your insurance card)

Company: _____
Address: _____
_____
Policy Number: _____
Person under whose policy you are covered under: _____
Relationship to that person: _____

***Current Physician(s):**

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Who should we thank for referring you (Please specify which if website, print media, and prior patient):
_____
*Reason for your visit today: (First visit, revisit, therapies, etc.) _____
*Any symptoms you are suffering of today: _____
***Patient Signature** (parent if patient is a minor) **:**

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## New Patient History Form

## HEALTH HISTORY

Have you had any of the following? If so, mark "P" for past, "N" for now.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| No | Heart disease | No | Stroke | No | High cholesterol | No | High blood pressure |
| No | Allergies | No | Asthma | No | Varicose vein | No | Difficulty breathing |
| No | Alcoholism | No | Liver disease | No | Gallbladder disease | No | Digestive complaint |
| No | Cancer | No | Fatigue | No | Anemia | No | Thyroid disease |
| No | Diabetes | No | Seizures | No | Arthritis | No | Autoimmune disease |
| No | Kidney disease | No | Breast lumps | No | Sexual complaints | No | Gynecological problems |
| No | Headache | No | Mental disease | No | Memory loss | No | Hearing problems |

HOSPITALIZATIONS AND SURGERIES (when and for what reason):_____

_____

_____

SERIOUS TRAUMA, SUCH AS FALLS OR AUTO ACCIDENTS: _____

_____

_____

CURRENT PRESCRIPTION MEDICATIONS (including dosage, doctor who prescribed it and for what reason) _____

_____

Do you currently take any over-the-counter medication, such as pain relievers (aspirin, ibuprofen etc.), antacids, or laxatives? Pick One

If yes, what do you take, how often and for what reason? _____

_____

CURRENT SUPPLEMENTS/VITAMINS/HERBS (multivitamin such as Centrum, herbs like ginko or St. John's Wort, or supplements like vitamin C, Calcium etc.)

_____

_____

_____

Have you ever had an adverse reaction to any prescription or over-the-counter medication, recreational drug, supplement, or herb? ? Describe: _____

_____

Do you have any allergies? ? Describe: _____

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_____

Do you exercise regularly? (If so, what type and how frequently?) _____

_____

How much do you sleep per night? _____

Normal bedtime _____ Normal wake time _____

Fall asleep easily: ☐ No ☐ Yes Wake Rested: ☐ No ☐ Yes Wake at night: ☐ No ☐ Yes

Do you follow any specific dietary guidelines or diets (such as vegetarian diet, blood-type diet, Atkins diet, etc)? Please describe:_____

_____

## Please describe your typical diet for a day (or what you have had in the last 24 hours):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Caffeine drinks (coffee, tea, soda) per day? _____ Alcoholic drinks per week? _____

Do you smoke cigarettes/ cigars/ pipes? Which one and how often?_____

Are you or have you been exposed to noxious to noxious fumes or solvents at home or on the job? Select One

## Childhood Illnesses and Vaccinations: Mark all those which you have Had, either as a child or as an adult.

| | Yes | No | Vaccination |
|---|---|---|---|
| Measles/Rubella……. | ☐ | ☐ | _____ |
| Mumps……..……. | ☐ | ☐ | _____ |
| Spinal Meningitis……..……. | ☐ | ☐ | _____ |
| Chicken Pox……..……. | ☐ | ☐ | _____ |
| Small Pox……..……. | ☐ | ☐ | _____ |
| Polio……..……. | ☐ | ☐ | _____ |
| Rabies……...…. | ☐ | ☐ | _____ |
| Hepatitis B……...……. | ☐ | ☐ | _____ |
| Diphtheria……..……. | ☐ | ☐ | _____ |
| Pertussis (whooping cough) ……. | ☐ | ☐ | _____ |
| Tetanus: most recent and date……..……. | ☐ | ☐ | date: _____ |

## FAMILY HISTORY

Any Cancer (CA), Heart Disease (HD), Diabetes (Di), or other major diseases in your Family.
Do not include people related to you by marriage or adoption. Please explain your answer.

Mother CA HD Di Other_____

Father CA HD Di Other_____

Siblings CA HD Di Other_____

Grandparents CA HD Di Other _____

Aunts/Uncles CA HD Di Other_____

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## HEALTH CONCERNS THAT YOU WOULD LIKE ADDRESSED:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Any other factors that you would like us to know about which may affect your treatment (include such things as Hanford downwinder, recovering substance abuser, inner-city resident, divorced, previous occupation, etc.): _____
_____
_____

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## For women only, please answer the following:

Age at first menses _____
First day of Last Period: _____ # of days of bleeding _____
Date of Last GYN Exam _____ Date of Last Pap _____
Any abnormal Paps? ☐ No ☐ Yes
Do you examine your breasts monthly? ☐ Yes ☐ Sometimes ☐ No ☐ Don't know how
Are you currently sexually active? ☐ Yes ☐ No Birth Control Type: _____

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How would you like to be contacted: ☐ Phone ☐ E-mail ☐ Voicemail
Would you like to be add you to our e-mail list for our newsletter? Select One

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I, the undersigned, acknowledge and agree that few insurance or health plans cover naturopathic care, and I understand that ultimately I am financially responsible for payment of professional services rendered. The balance of my account will be paid in full within thirty (30) days unless prior arrangements are made in writing with the doctor. I have read and completed all the information supplied on this form and certify that this information is true and correct to the best of my knowledge.

I hereby authorize any physician, hospital, insurance company, or medical facility to provide all information regarding medical history and treatment(s) to Institute for Ayurvedic and Naturopathic Therapies/ Dr. Kaushik.

Patient Signature: _____ Date:_____
Parent Signature (if patient is a minor): _____

# Institute For Ayurvedic And Naturopathic Therapies

## PAYMENT POLICY

It is the policy of the Institute for Ayurvedic And Naturopathic Therapies (IANT) to have a financial policy to avoid any misunderstanding or disagreement concerning payment for the provided services.

IANT participates with many insurance companies and managed health care programs. For the members of these plans, our office will submit claim for the services rendered. Patient must provide the necessary insurance information.

If you have insurance that we do not participate in, our office will provide you the claim form to be submitted to your insurance company.

It is the patient's responsibility to pay any deductible, co-payment, co-insurance, or any portion of the charges as specified by your plan at the time of your visit. Any medical services or therapies not covered by individuals insurance plan are the patient's responsibility and payment in full is due at the time of visit.

It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.

A $25.00 fee will be charged to your account for all returned checks plus any bank fee charges.

It is the patient's responsibility to ensure that any required referrals for treatment are provided to the office before the visit. If not provided, the patient may be financially responsible due to lack of the referral.

The adult accompanying a minor, and the parents are responsible for payment at the time of service.

Payment for professional services can be made with cash, check, Master card or Visa.
You must notify the office 48 hours prior to canceling your appointment. We reserve the right to charge a $35.00 fee for cancellations made less than 2 business days before your appointment.

I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 33% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, and all other expenses so stated elsewhere. The authorized fee of 33% and the additional costs and charges listed above represent the actual costs incurred by IANT to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signers failure to pay as specified in this agreement.

Institute For Ayurvedic And Naturopathic Therapies/Dr. Kaushik firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. We are here to help you.
PLEASE SIGN THIAT YOU HAVE READ AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of Patient/Responsible Party Date

# Institute For Ayurvedic And Naturopathic Therapies

## Notice of Privacy Practices

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 BEFORE SIGNING***

Federal Law requires us to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept confidential. HIPPA gives you, the patient, new rights to understand and control how your health information is used. That law also requires us to give you this explanation of how we maintain the privacy of your health information. We reserve the right to change our privacy practices provided the changes conform to applicable laws. Before we make a significant change in our privacy practices, we will change this notice available on request.

We may disclose your medical records only for the following purposes: treatment, payment, health care operations, health care reminders, and for public benefit. Any other discloser will require your written authorization.

- Treatment: means providing or managing health care and related services by one or more health providers. .
- Payment: means such activities as obtaining reimbursement for services, billing or collection activities and utilization review.
- Health care operations: include the business aspects of running the clinic quality assessment, evaluating practitioner, provider, accreditation certification or credentialing activities.
- Reminder: means providing you with appointment reminders or to inform you or changes in the clinic services or hour by such means as postcards, voicemail messages or litters.
- Public benefit : means the disclosure of information for the following types of reasons; for public health activates including disease and vital statistic reporting; to abuse, neglect or domestic violence; to health oversight agencies; to law enforcement officers pursuant to subpoenas and other lawful processing; to medical examiners and coroners; to avert a serious threat to health or safety; in connection with certain research activities; and as authorized by state and federal laws.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with YOUR WRITTEN AUTHORIZATION. You must give such authorization in writing to disclose it for any purpose, including but not limited to having a copy sent to another physician or receiving a copy for your own personal use. You may revoke such authorization in writing and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization.

**You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Institute.**

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The right to request restrictions or certain uses and disclosures of protected health information, including those related disclosures to family members, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications or protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee.
The right to amend your protected health information. Your request must be in writing and must include an explanation why we should amend records. We may deny your request under certain circumstances.
The right to receive an accounting of disclosures or your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel your privacy protections have been violated. If you want more information about our privacy practices or has any questions or concern, please contact us using the information listed at the end of this notice. You may also submit a written complaint to US Department pf Health and Human Services. Office of Civil Right about violations of provisions of this notice or the policies and procedures of our clinic. We will not retaliate against you for filing a complaint.

I have read and understand the above-stated information.

_____ _____
Patient's Name Legal Guardian (under 16 yo)

_____ _____
Patient's Signature Relationship to Patient

_____
Date

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## INFORMED CONSENT FOR TREATMENT

- **Common diagnostic procedures:** e.g. pap smears, radiography, laboratory, x-ray and Naturopathic diagnostic techniques e.g. Bolan blood analysis, Caroll Food Intolerance test, Hair Toxic Element test and Iridology and; Ayurvedic assessment techniques e.g. Tongue and Pulse analysis. Charges include cost of the test and interpretation.
- **Minor office procedures**
- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins, minerals, amino acids and other nutritional or therapeutic substances.
- **Botanical Medicine and Ayurvedic medicine:** botanical substances (herbal medicines) may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, 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, fasting, elimination diets, promotion of wellness including recommendation for exercise, sleep, stress reductions and balancing of work and social activities.
- **Psychological counseling, Physical Medicine, acupuncture and bodywork.**

**POTENTIAL RISKS:** allergic reactions to prescribed herbs and supplements; side effects of natural medications; inconvenience of lifestyle changes; possible prescription drug interaction with prescribed natural supplements or products. Acupuncture may produce temporary numbness, tingling, bruising, bleeding or redness. Colonic irrigation may be uncomfortable for some individuals. Physical Medicine may result in temporary pain or discomfort.

**POTENTAL BENEFITS:** restoration of health and the body's maximal function capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**NOTICE TO PREGNANT WOMEN -** All female patients must inform the treating doctor if they know or suspect that they are pregnant as some of the procedures and therapies described above may present a risk to the pregnancy.

**ALTERNATIVES –** It has been recommended to me that I consult with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

**CONSENT –** With this knowledge, I voluntarily consent to the above procedure(s), realizing that no guarantees have been given to me. I understand that I am free to withdraw my consent and to discontinue participation on these procedures at any time.

**CONFIDENTIALITY –** 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 directed by my lawful representative, or me or unless law permits or requires it. I understand that my request to view or receive a copy of my medical record can only been done with a signed form of records release.

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I understand that my medical record will be kept for a minimum of seven 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 my practitioner will answer any questions I heave, to the best of his/her ability.

I certify that I have read and fully understand this consent and the matters that have been explained to me. I further certify that I have full authority and accept full responsibility to execute this consent for and on behalf of the above-named patient and that I am signing freely and voluntarily.

_____ _____

Patient Name (Please Print) Signature of Patient

_____ _____

Date Signature of Patient Guardian

Notes_____

_____

_____