David C. Powell, ND
Chaparral Naturopathic Medicine
At Gold's Gym
3156 Sports Arena Blvd.
San Diego, CA 98125

phone: 619-528-8594
fax: 619-515-6441
www.chaparralnatmed.com

Informed Consent Form

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996**.**

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, IV therapy, certain medications and hormone therapies.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The hormones, medications, herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that I follow the prescribed recommendations when taking hormones, medications, herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I understand that some medications, hormones, herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatments, medications, hormones, herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (printed)_____

PATIENT SIGNATURE _____ **Date:** _____
(or Patient Representative)
Indicate relationship if signing on behalf of patient _____

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Patient Information

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

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

SS#: _____ 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**

Email:_____ **May we leave confidential messages at this address? ❍ No ❍ Yes**

Date of Birth: _____ Sex:_____ Other names that records may be kept under: _____

Are you currently employed? Y N Employer/School: _____

Parents' or Guardians' Names (minors only): _____

Emergency Contact: _____ Relationship to Emergency Contact: _____

Contact's Phone: (_____)_____ ❍ Home ❍ Work ❍ Cell Do you have special needs?: ❍ No ❍ Yes (see front desk)

How did you hear about us? ❍ Newspaper Ad ❍ News Story ❍ Mailer/Flyer ❍ Website ❍ Workshop/Event ❍ Medical Referral ❍ Friend/Family ❍ Yellow Pages ❍ Other: _____

The following information is requested for our grant and federal reporting requirements

Marital Status *(circle one):* Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership

Race/Ethnic Origin: African/African-American Asian Caucasian Native American Pacific Islander/ Native Hawaiian Mixed Race Other

Number of members in your household: _____ Gross annual household income: _____ /year

Guarantor Information

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 Chaparral Naturopathic Medicine does not take insurance at this time. A receipt with appropriate codes will be provided if I wish to file for insurance reimbursement. 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 1.5% 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.

Cancellation Policy: Significant time and effort is required preparing for each visit. As such, appointments cancelled with less than 48 hours notice will result in a fee equal to 50% of the office visit fee. Appointments cancelled with less than 24 hours notice will be charged for the full office visit.

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. Chaparral Naturopathic 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 office at (619) 528-8594.

I hereby acknowledge that I have received a copy of Chaparral Naturopathic Medicine's Notice of Privacy Practices. _____(initial)

I also agree to the terms of admission as listed above.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

_____

Relationship to Patient/Representative Authority

(version 11-16-10)

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Health Information Form

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

Date of Birth: _____ Sex: _____

Are you currently under medical care? ❍ yes ❍ no For? _____

_____

Do you currently have a primary care physician? ❍ yes ❍ no If so, please provide us with your PCP's contact information (name, clinic name, address, and telephone number) _____

_____

_____

Please list any additional health care providers from whom you receive care (name, specialty, and contact information if possible):

_____

_____

_____

_____

Health Concerns

(Please list in order of importance to you)

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6. _____

Do you have any allergies or sensitivities? _____

_____

_____

How would you rate your current health?

Lowest health 1------2-------3------4------5------6------7------8------9------10 Amazing/Perfect health

Are you currently pregnant? ❍ yes ❍ no # of months: _____
Is your condition related to ❍ work-related injury ❍ auto accident

What are your goals for today's visit and for your long-term health? _____

_____

_____

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Serious Illness and Operations

Please describe (indicating the date) any serious illnesses, hospitalizations, or operations:_____

_____

_____

_____

_____

Medications and Supplements

Medications & Dosage – list name, dose and when you take it: If you need more room, please use the Medication and Supplement Form

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

Supplements (vitamins, herbs, etc…) - list name, dose and when you take it:

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

Current/Previous Conditions

Indicate current conditions by circling them:

- ❍ ADD/ADHD
- ❍ Alcoholism
- ❍ Anemia
- ❍ Anorexia
- ❍ Anxiety
- ❍ Appendicitis
- ❍ Arthritis
- ❍ Asthma
- ❍ Back/Neck Pain
- ❍ Bladder infection
- ❍ Bleeding disorders
- ❍ Breast Lump
- ❍ Bronchitis
- ❍ Bulimia
- ❍ Cancer
- ❍ Cataracts
- ❍ Chemical Dependency
- ❍ Chickenpox
- ❍ Crohn's disease
- ❍ Depression
- ❍ Diabetes
- ❍ Eczema
- ❍ Emphysema
- ❍ German Measles
- ❍ Glaucoma
- ❍ Goiter
- ❍ Gonorrhea
- ❍ Gout
- ❍ Heart disease
- ❍ Hepatitis
- ❍ Hernia
- ❍ Herpes
- ❍ High blood pressure
- ❍ High Cholesterol
- ❍ HIV/AIDS
- ❍ Hives
- ❍ IBS
- ❍ Infectious Mono
- ❍ Kidney disease
- ❍ Liver Disease
- ❍ Low blood pressure
- ❍ Lupus
- ❍ Measles
- ❍ Migraines
- ❍ Miscarriage
- ❍ Mitral valve prolapse
- ❍ Multiple Sclerosis
- ❍ Infectious Mono
- ❍ Kidney disease
- ❍ Liver Disease
- ❍ Low blood pressure
- ❍ Mumps
- ❍ Pacemaker
- ❍ Pneumonia
- ❍ Polio
- ❍ Prostate Problem
- ❍ Psychiatric Care
- ❍ Psoriasis
- ❍ Rheumatic Fever
- ❍ Rubella
- ❍ Scarlet Fever
- ❍ Schizophrenia
- ❍ STDs
- ❍ Strep throat
- ❍ Stroke
- ❍ Suicide Attempt
- ❍ Thyroid disease
- ❍ Tonsillitis
- ❍ Tuberculosis
- ❍ Typhoid Fever
- ❍ Ulcer
- ❍ Ulcerative colitis
- ❍ Vaginal Infections
- ❍ Venereal Disease
- ❍ Whooping cough

Others (please list):

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Exams and Immunization History

Please indicate result, date and physician or place of most recent:

Physical Exam _____ Chest X-ray _____

Pap Smear _____ EKG _____

Mammogram _____ Colonoscopy _____

Prostate check _____ Cholesterol screen _____

STD screen _____ HIV test _____

TB test _____ Bone density check _____

Dental exam _____ Eye exam _____

Other:

Immunizations

Tetanus-Diptheria _____ Measles-Mumps-Rubella (MMR) _____

Varicella _____ Flu shot _____

Hepatitis A _____ Hepatitis B _____

Other:

Diet

What do you typically eat?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Sweets (how often): _____

Beverages (how much): _____

Food Cravings: _____

Foods you avoid: _____

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FAMILY HISTORY

Mother: ❍ Living Age:_____ ❍Deceased Cause: _____
Father ❍ Living Age:_____ ❍Deceased Cause: _____
Brother ❍ Living Age:_____ ❍Deceased Cause: _____
Brother ❍ Living Age:_____ ❍Deceased Cause: _____
Brother ❍ Living Age:_____ ❍Deceased Cause: _____
Sister ❍ Living Age:_____ ❍Deceased Cause: _____
Sister ❍ Living Age:_____ ❍Deceased Cause: _____
Sister ❍ Living Age:_____ ❍Deceased Cause: _____
Child ❍ Living Age:_____ ❍Deceased Cause: _____
Child ❍ Living Age:_____ ❍Deceased Cause: _____
Child ❍ Living Age:_____ ❍Deceased Cause: _____

Has any family member had: Use the following abbreviations (M)other, (F)ather, (B)rother, (S)ister, (MGM) maternal grandmother, (MGF) maternal grandfather, (PGM) paternal grandmother, (PGF) paternal grandfather, (U)ncle, (A)unt

❍ Diabetes Relation: _____ Age of onset: _____
❍ Arthritis Relation: _____ Age of onset: _____
❍ Asthma Relation: _____ Age of onset: _____
❍ Severe allergies Relation: _____ Age of onset: _____
❍ Stroke Relation: _____ Age of onset: _____
❍ Heart disease Relation: _____ Age of onset: _____
❍ Heart attack Relation: _____ Age of onset: _____
❍ High blood pressure Relation: _____ Age of onset: _____
❍ High cholesterol Relation: _____ Age of onset: _____
❍ Kidney disease Relation: _____ Age of onset: _____
❍ Osteoporosis Relation: _____ Age of onset: _____
❍ Hepatitis Relation: _____ Age of onset: _____
❍ Thyroid problems Relation: _____ Age of onset: _____
❍ Colitis/Crohn's disease Relation: _____ Age of onset: _____
❍ HIV/AIDS Relation: _____ Age of onset: _____
❍ Tuberculosis Relation: _____ Age of onset: _____
❍ Birth defects Relation: _____ Age of onset: _____
❍❍ Alzheimer's Relation: _____ Age of onset: _____
Drinking/drug problems Relation: _____ Age of onset: _____
❍ Breast cancer Relation: _____ Age of onset: _____
❍ Colon cancer Relation: _____ Age of onset: _____
❍ Ovarian cancer Relation: _____ Age of onset: _____
❍ Uterine cancer Relation: _____ Age of onset: _____
❍ Blood clots in lungs or legs Relation: _____ Age of onset: _____
❍ Other cancer: _____ Relation: _____ Age of onset: _____
❍ Other: _____ Relation: _____ Age of onset: _____
❍ Other: _____ Relation: _____ Age of onset: _____

I certify that the information provided in this form is correct to the best of my knowledge. I will not hold Dr. Powell or Chaparral Naturopathic Medicine responsible for any error or omission I may have made in the completion of this form.

Patient's signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways Chaparral Naturopathic Medicine may collect, store, use and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information
We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

- **Treatment.** We may use and disclose your protected health information to assist your other health care providers in your diagnosis and treatment.

- **Health Care Operations.** We may use and disclose your protected health information in order to perform various operational activities.

- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for you.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.

- **Public Health Activities.** We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose your protected health information to government agencies about abuse, neglect or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

- **Coroners or Funeral Directors.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.

- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures With an Authorization
Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding your Protected Health Information
You may have certain rights regarding protected health information that Chaparral Naturopathic Medicine maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- **Right to Amend Your Protected Health Information.** If you feel that your protected health information is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask us to amend information that was not created by Chaparral Naturopathic Medicine or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. ***We may not agree to your request.*** If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

Health Information Security
Chaparral Naturopathic Medicine requires its employees to follow its security policies and procedures that limit access to health information about patients to those employees who need it to perform their job responsibilities. In addition, Chaparral Naturopathic Medicine maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to This Notice
We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

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