Alt Med Ctr L.L.C.
Alternative Medicine Center

1951 W. Camelback, Suite 300
Phoenix, AZ 85015
Phone (602) 332-8079
Fax (480) 747-9682

New Patient Information Package

Thank you for making your first appointment at Alt Med Ctr. We welcome you and look forward to helping you achieve a higher level of health through alternative medicine.

Important: These are your patient information forms, print them out, and complete them before your first appointment.

Prior to your first appointment: In order to expedite your first appointment please complete the attached registration and medical history **prior to your arrival.** It may take up to one hour to complete these forms, and we want you to get the maximum benefit from your appointment time. You may Fax your completed forms to us at **(480) 747-9682**.

Your First Appointment: bring copies of recent any recent diagnoses, laboratory tests, medical reports, and a complete list of all prescriptions, medications, herbs, homeopathic medications, nutritional supplements, vitamins, etc. that you are presently taking.

We encourage you to prepare any written questions ahead of time and bring them to your initial appointment.

Forms Included:

- **HEALTH HISTORY AND PERSONAL INFORMATION**
- **PRACTITIONER-PATIENT SERVICES AGREEMENT**
- **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPPA)**
- **ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)**
- **DISCLOSURE AND CONSENT FORM**

Thank you, we look forward to your appointment. If you have provided a valid email address an email confirming your appointment will be sent to you. We will contact you with a reminder 24 hours prior to your appointment including directions to our office.

Respectfully,

Mario Fontes LAc, CCH
Mario.Fontes@altmedctr.com
Phone: (602) 332-8079
Fax: (480) 747-9682

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This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you.
Please fill it out as completely as possible.

Personal Information

Name_____Age_____ Date _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____E-mail_____

Birth Date _____ If under 18, person responsible for your account _____

Emergency Contact: Name_____ Contact Phone:_____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No With Whom? _____

Have you had homeopathic treatment before? □ Yes □ No With Whom? _____

Please indicate if any of the following pertain to you (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

Give the following information for the last times you have been hospitalized starting with the most recent (except normal deliveries); include type of illness, month and year hospitalized, name of hospital, city and state.

#1:_____#2:_____

#3:_____#4:_____

Please indicate the use and frequency of the following:

Coffee _____ Soft Drinks _____Water _____

Alcohol_____ Recreational drugs _____ Tobacco_____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:_____

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Health History

What are the health problems for which you are seeking treatment?_____

How long have you had this condition? _____

What other forms of treatment have you sought_____

What helps your condition? _____

What aggravates your condition? _____

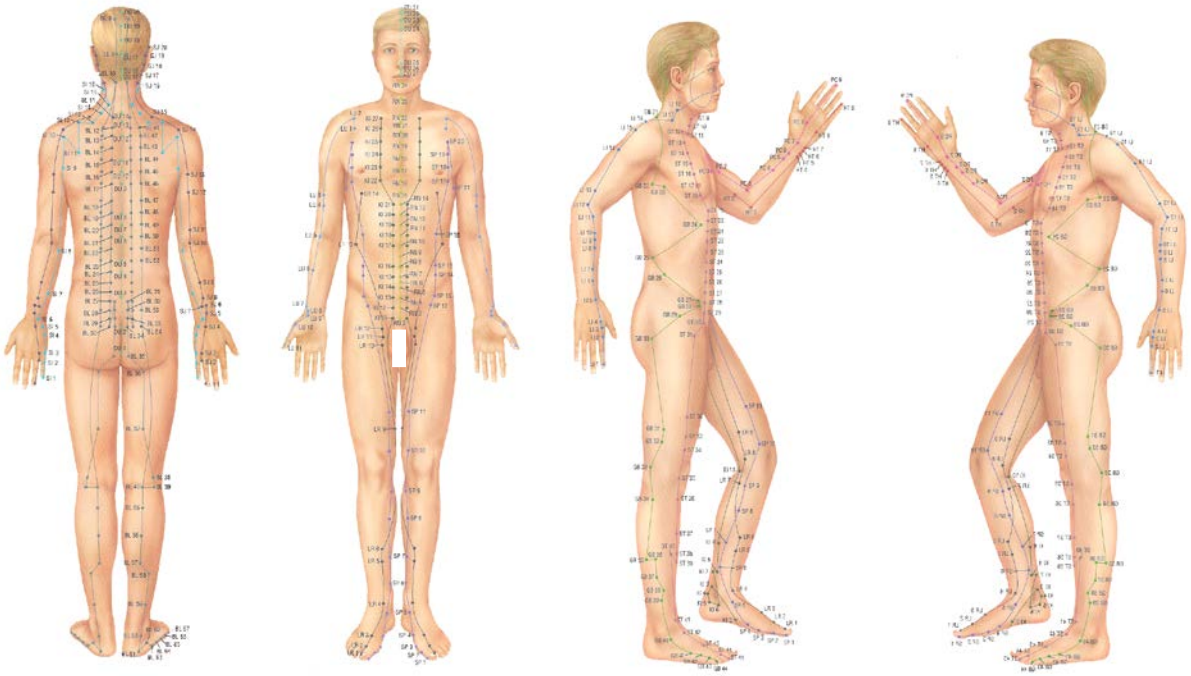
Please list any surgeries or major health incidents (accidents, etc.) in your life: _____

_____

Additional Information:_____

_____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



Characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

What would you like to achieve with treatment?

_____

_____

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Symptom Survey

Please "check" the symptoms or conditions you experience frequently:

□ I am always hot □ I am always cold

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
□ excessive appetite	□ insomnia	□ cough	□ low back pain	□ eye problems
□ loose stool/diarrhea	□ palpitations	□ short of breath	□ knee problems	□ jaundice
□ digestive problems, indigestion	□ cold hands and feet	□ decreased sense of smell	□ hearing impairment	□ difficulty digesting oily food
□ vomiting	□ nightmares	□ nasal problems	□ ear ringing	□ gall stones
□ belching, burping	□ mentally restless	□ skin problems	□ kidney stones	□ light colored
□ heartburn/reflux	□ laughing for no reason	□ claustrophobia	□ decreased sex drive	□ soft or brittle nails
□ stomach bloating	□ chest pains	□ colitis/diverticulitis	□ hair loss	□ easily angered
□ obsession in work, relationships	□ poor memory	□ constipation	□ urinary problems	□ difficulty making decisions
□ fatigue	□ sadness	□ blood in stool	□ easily bruised	□ high cholesterol
□ lack of appetite	□ edema	□ hemorrhoids	□ dental problems	□ dizziness
□ get sick easily		□ asthma		□ headaches
□ recent use of antibiotics		□ allergies		□ bitter taste

♀ For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow_____

Color of flow:	Amount of flow:	# of pads/tampons you use per day:	Pain & cramping:
□ pale/light red	□ spotting	1st day ___	□ Yes □ No
□ red	□ light	2ND day ___	□ mild □ moderate □ severe
□ bright red	□ even throughout	3RD day ___	□ before flow
□ dark red	□ heavy	4th day ___	□ during flow
□ dark red/brown	□ clots	+days ___	□ after flow

Other symptoms related to menses:

□ Discharge □ PMS □ Headache □ Nausea □ Constipation □ Diarrhea

□ Swollen Breasts □ Mood Swings □ Increased Appetite □ Decreased Appetite □ Insomnia

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Symptom Survey/Family History

What are you most sensitive to (e.g. noise, odors, light, pain): _____
Describe an ideal day in terms of weather and temperature: _____
What are your fears?_____
_____
Do you have any hobbies?_____
Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams:_____
_____
_____
How is your energy? _____Is there any particular time of day when it is lower or higher?_____
What environment do you feel most comfortable in? (e.g. desert, mountains, ocean, city) _____
How is your sexual interest/drive?_____
What food do you crave or most like to eat _____
What foods do you most dislike?_____
Are there any foods that you are sensitive to or allergic to? _____
How is your thirst? _____ What temperature do you like fluids? _____

Family History: Place an (X) in the appropriate columns for any illnesses you or your relatives have had

Illness	self	father	mother	brothers	sisters	child #1	child #2	child #3	grandparent
Allergies									
Anemia									
Arthritis									
Asthma									
Bleeding problems									
Cancer									
Epilepsy									
Diabetes									
Alcohol/Drugs									
Eczema									
Emphysema									
Heart trouble									
Hepatitis									
High Blood Pressure									
Frequent Infection									
Kidney problems									
Mental illness									
Migraines									
Abnormal Periods									
Psoriasis									
Pneumonia									
Polio									
Prostate Problems									
Gout									
Rheumatic fever									
Stomach problems									
Stroke									
Thyroid Problems									
Tuberculosis									
Ulcers									
Venereal Disease									

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PRACTITIONER-PATIENT SERVICES AGREEMENT

Welcome to Alt Med Ctr LLC. This document (the Agreement) contains important information about Alt Med Ctr LLC alternative medicine services, business procedures and policies.

Initial Appointment:

A valid Visa or MasterCard is required to confirm your appointment, your signature will serve as a pre-authorization for payment.

Payment :

Credit or debit card (Visa or MasterCard) is required for your first appointment and will be kept on file. Payment is due at time of service. We accept cash, check, money order, Visa, or MasterCard. There is a returned check fee of $35.00.

Missed Appointments:

In the event of a late cancellation or missed appointment your credit card will be charged for the full amount. You will receive an electronic e-mail receipt from Alt Med Ctr. To avoid charges a minimum of 24 hours notice is required for cancellations.

Insurance Coverage:

Qualified policy holders receive a 25% discount through American Specialty Health Incorporated (ASH**).** Alt Med Ctr LLC will provide you with a receipt for you appointment . You may file for reimbursement from your insurer, amounts recovered vary with insurance plan.

Service Hours and Emergencies:

Hours by appointment only. Phone calls are usually returned on business days within 24 hrs. Please leave a telephone number where you may be reached. For any emergencies, urgent, severe or life-threatening conditions that require immediate treatment seek care from your local urgent care or hospital emergency department.

Professional Records:

The laws require that Protected Health Information about you kept in your clinical record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others. You may receive a copy of your clinical record by requesting it in writing. There is a fee of $25 for a copy of your records**.**

Phone Consultation:

Brief telephone calls (less than 10 minutes) to clarify issues from consultation or brief progress reports incur no charge. Longer calls are billed at $25.00 per 15 minutes under the following circumstances: When you receive a new prescription or new problems arise or when your call exceeds 10 minutes.

Fee Schedule:

Appointments: (45 minute visits): $75

Extended Visits: (billed at $25 for each additional 15 minutes) $100/hour

Additional Fees: (out of office, after hour visits): $25

This document represents an agreement between us, please read this agreement thoroughly and sign below to acknowledge acceptance of terms of service.

Patient Name:_____ Signature: _____Date:_____

Email address: _____ Phone: _____

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPPA)
Limits On Confidentiality

The law protects the privacy of all communications between a patient and a health care practitioner. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

We may occasionally find it helpful to consult other health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of our patients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that we practice with other health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

If you are involved in a court proceeding and a request is made for information concerning the professional services we provided you, such information is protected by the physician-patient privilege law. We cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

If a patient files a complaint or lawsuit against me, we may disclose relevant information regarding that patient in order to defend myself.

If a patient files a worker's compensation claim, and we are providing services related to that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

If we have reason to believe that a child under 18 who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that we file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.

If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that we file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.

If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)

Original to be maintained in Patient's permanent medical record. I acknowledge that I have received a copy of the office's Notice of Privacy Practices for Protected Health Information (HIPPA).

Name: _____ Signature: _____ Date_____
(or Legally Authorized Individual Signature)

Relationship to Patient:_____ (example: self ,parent, legal guardian, personal representative, other)

Disclosure and Consent Form

This consent is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered alternative by physicians trained in the United States.

I understand that some of, or all of, the following alternative treatments are planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize the following: I understand that no warranty or guarantee has been made regarding results or treatment. I realize that there may also be healing reactions related to this treatment, including worsening of present symptoms or development of new symptoms (aggravations).

I authorize Mario Fontes L.Ac, Dipl OM, CCH to treat my medical conditions. I recognize that the treatments I receive may include: Administration of homeopathic remedies, herbal and nutritional supplements and flower essences, acupuncture, alternative, moxibustion, cupping, low level laser treatment, electrical stimulation, acupressure, Tui-Na (Chinese Massage), preventive and/or conventional (allopathic) therapies.

I have been informed that the herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of chinese medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).

I understand that heat thearapy/moxibustion as part of therapy, there may be burning or scarring the skin from its use. In fact, burning and scarring may even be a part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse this therapy.

I understand that Acupressure/Cupping/Tui-Na (Chinese Massage), as part of therapy, side effects could include, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. Bruising is a common side effect of cupping and is part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

I understand that Low level laser therapy/ electro-acupuncture may be administered as an alternative to acupuncture, side effects may result including, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that Mario Fontes L.Ac, Dipl OM, CCH practices Alternative Medicine by providing treatment of the spiritual vital force in accordance with Hahnemannian (the founder of classical homeopathy) principles through the use of homeopathic remedies that are highly diluted and prepared in accordance with the Homeopathic Pharmacopeia of the United States.

I have been given the opportunity to ask questions about this treatment. I have had the opportunity to discuss the possible risks and hazards of treatment and I believe that I have sufficient information to give this informed consent. I certify that this form has been fully explained to me, that I have read it (or have had it read to me), and that I understand its contents. I also certify that Mario Fontes L.Ac, Dipl OM, CCH has provided this consent form to me and has made no guarantees to me as to the success of this treatment. I acknowledge that Mario Fontes L.Ac, Dipl OM, CCH has informed me that he/she is not a primary care health provider and that this treatment does not replace the need for conventional medical treatment. I also understand that all of my conventional medications need to be supervised by a licensed health care practitioner.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Name: ccc_____ Signature: ccc_____ Date_____

Parent or Guardian Signature:_____ Date_____