IRH INSTITUTE for RESTORATIVE HEALTH
A Functional Medicine Specialty Group

1460 Drew Ave, Suite 300, Davis, CA 95618 PH: (530) 758-4IRH (4474) FAX: (530) 758-1880 www.4irh.com

GENERAL PATIENT INFORMATION

NAME_____ DOB: ____/____/_____SSN_____-_____-_____
LAST, FIRST, MIDDLE INTIAL

ADDRESS_____ CITY_____

STATE_____ ZIP_____PRIMARY PH:(_____)_____-_____ ALT. PH:(_____)_____-_____

SEX M / F MARITAL STATUS_____ RACE_____ LANGUAGE _____

ETHNICITY(**circle one**) Hispanic/Latino **or** non Hispanic/Latino

EMAIL_____ □ Check if you do not want to receive notification of events and promotions.

PRIMARY CARE PHYSICIAN_____

EMPLOYER_____ PHONE#_____

EMERGENCY CONTACT _____ PHONE#_____

RELATION TO PATIENT_____

PAYMENT

☐ Insurance-Pay Patient - Please complete below even if we have a copy of your insurance card.
OR

☐ Cash-Pay Patient (No insurance or you do not want to use insurance coverage)

INSURANCE PATIENTS

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____PHONE# _____

REFERRING PHYSICIAN_____PHONE#_____

SUBSCRIBER NAME_____DATE OF BIRTH _____

SUBSCRIBER SSN_____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ID #_____ GROUP #_____

SECONDARY INSURANCE INFORMATION – Please leave blank if no secondary insurance.

INSURANCE COMPANY_____PHONE#_____

SUBSCRIBER NAME_____DATE OF BIRTH_____

SUBSCRIBER SSN_____ RELATIONSHIP TO PATIENT_____

SUBSCRIBER ID_____ GROUP #_____

The above information is true to the best of my knowledge.

_____

Patient/Guardian Signature Date

PATIENT NAME:_____ DATE OF BIRTH_____

LAST, FIRST, MIDDLE INTIAL

ALLERGIES:

MEDICATIONS:_____

_____

FOOD: _____

_____

MEDICATIONS AND SUPPLEMENT LIST: Please Print Clearly

	Name of Medication or Supplement	Dosage	Amount
Ex.	Benadryl	25 mg	1 every 6 hours
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

PATIENT MEDICAL HISTORY:

FAMILY HISTORY: _____

_____

_____

PAST SURGERIES: _____

_____

PATIENT NAME:_____ DATE OF BIRTH_____

LAST, FIRST, MIDDLE INTIAL

LIFE HABITS SCREENING QUESTIONNAIRE.

Answers should be based on your typical habits during an average week.

Nutrition and Oral Intake Behaviors	**1 point**	**0 point**
1) Do you consume at least 3 servings of fruits and vegetables per day?	____Yes	____No
2) Do you drink at least 4 glasses of water per day?	____Yes	____No
3) Do you minimize the intake of junk foods (sweets, crackers, sodas)?	____Yes	____No
4) Do you minimize the intake of simple carbohydrates (pastas, breads...)?	____Yes	____No
5) Do you minimize the intake of fatty foods?	____Yes	____No
6) Do you drink less than two servings of alcoholic beverages per day?	____Yes	____No
7) Do you avoid cigarettes?	____Yes	____No
8) Do you drink less than two servings of caffeinated beverages per day?	____Yes	____No
9) Do you avoid elicit drugs (marijuana, cocaine…)?	____Yes	____No
Section Point Total:		/9

Physical Activity:	**1 point**	**0 point**
1) Do you do at least 20 minutes of aerobic exercise 2 or more times a week?	____Yes	____No
2) Do you do resistive (e.g. weights) exercises at least 2 or more times a week?	____Yes	____No
3) Does your job and daily responsibilities keep you physically active?	____Yes	____No
4) Do you consider yourself reasonably fit for your age?	____Yes	____No
Section Point Total:		/4

Sleep:	**1 point**	**0 point**
1) Do you usually get at least 6 hours of uninterrupted sleep per night?	____Yes	____No
2) Do you sleep without significant kicking or jerking?	____Yes	____No
3) Do you sleep without significant snoring or airway obstruction?	____Yes	____No
4) Do you feel rested in the morning upon awakening?	____Yes	____No
Section Point Total:		/4

Psychoscocial/Emotional:	**1 point**	**0 point**
1) Do you consider your job and home environment pleasing?	____Yes	____No
2) Has your life been free of emotional/psychological trauma?	____Yes	____No
3) Are you comfortable pushing yourself beyond your comfort zone?	____Yes	____No
4) Do you have hobbies or activities to pass the time?	____Yes	____No
5) Do you generally feel happy most of the time?	____Yes	____No
6) Do you generally feel calm most of the time?	____Yes	____No
7) Do you have a strong sense of self confidence?	____Yes	____No
8) Do you enjoy getting out of the house and being active?	____Yes	____No
Section Point Total:		/8

Environmental Exposures:	**1 point**	**0 point**
1) Do you usually avoid drinking unfiltered well or tap water?	____Yes	____No
2) Are you free of mercury amalgam fillings?	____Yes	____No
3) Are your home and work place free of excessive toxin exposure?	____Yes	____No
If no, please explain:_____		
4) Do you avoid microwaving plastic containers?	____Yes	____No
Section Point Total:		/4

PATIENT NAME:_____

LAST, FIRST, MIDDLE INTIAL **TODAY'S DATE**

IRH Modified Medical Symptom Questionaire (MSQ)

Point Scale: **You may use 0-10**

0 **Never have the symptom**
5 **Symptom moderately disables me**
10 **Symptom severely disables me**

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision

_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

_____ TOTAL

MOUTH/ THROAT
_____ Chronic cough
_____ Frequent throat clearing
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gums or lips
_____ Canker sores

_____ TOTAL

SKIN
_____ Acne
_____ Rashes
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ Dry skin

_____ TOTAL

MIND
_____ Poor memory
_____ Confusion/poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in decision making
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

_____ TOTAL

DIGESTIVE TRACT
_____ Nausea/vomiting
_____ Diarrhea
_____ Constipation
_____ Bloating
_____ Belching/passing gas
_____ Heartburn
_____ Intestinal/stomach pain

_____ TOTAL

JOINTS/MUSCLE
_____ Weakness
_____ Pain or aches in joints
_____ Arthritis
_____ Pain/aches in muscles
_____ Stiffness in joints

_____ TOTAL

WEIGHT
_____ Underweight
_____ Craving certain food
_____ Water retention
_____ Compulsive eating
_____ Binge eating/drinking
_____ Excessive weight

_____ TOTAL

ACTIVITY/ ENERGY
_____ Restlessness
_____ Fatigue/sluggishness
_____ Apathy/lethargy
_____ Hyperactivity

_____ TOTAL

HEART
_____ Rapid heartbeat
_____ Chest pain
_____ Irregular heartbeat

_____ TOTAL

LUNGS
_____ Asthma/bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ Chest congestion

_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability
_____ Depression

_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent/urgent urination
_____ Genital itch or discharge

_____TOTAL

_____ /720 GRAND TOTAL

INSTITUTE FOR RESTORATIVE HEALTH TERMS, CONDITIONS AND POLICIES

CONSENT FOR TREATMENT

I hereby authorize the health care providers of the Institute for Restorative Health (IRH) for treatment of services deemed medically necessary. These services will always be described in full and discussed with me prior to their completion.

ASSIGNMENT OF BENEFITS

I authorize my insurance company, or its intermediaries, to make payment directly to IRH for any medical/surgical benefits otherwise payable to me for medical services rendered. I understand that services billed to my insurance company by IRH is a courtesy to me and that I am ultimately financially responsible for services received and not covered or paid for by my insurance carrier.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and read a copy of IRH's Notice of Privacy Practices. This notice is attached to this packet.

FINANCIAL POLICY

As a patient at the Institute for Restorative Health, I agree to provide current and accurate information on all correspondence. If misinformation were to result in non-payment, the medical and visit costs would become my responsibility until sufficient information is received. I realize that if I do not present my insurance information, my insurance company will not be billed and I would be responsible for any account balance. I agree to pay all co-pays and other associated visit costs in full at time of service. In addition, I agree to pay a $25 fee for returned checks due to insufficient funds. I agree to pay $25 for any appointments I do not cancel, reschedule or show up for without giving at least 24 hours notice. If there is a medication that my insurance company requires me to get prior authorization for, I agree to pay $35 for the prior authorization of that medication. I also understand that there is a $50 charge for letters of medical necessity from healthcare providers. These can be done during an appointment to avoid the $50 charge. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for services rendered.

I have read all the information on this form and consent to the terms outline. I agree to adhere to the terms and conditions set forth by IRH.

_____

Patient/Guardian Signature Date

Notice of Privacy Practices
HIPAA Privacy and Security Regulations:
A Synopsis of the Relevant Mandates of
Title II (Administrative Simplification)
Health Insurance Portability and Accountability Act of 1996
Public Law 104-191

In 1996 President Clinton signed the Health Insurance Portability and Accountability Act (HIPAA). This law mandates action that seeks to: 1) ensure continuity of healthcare coverage for individuals changing jobs; 2) impact on the management of health information; 3) simplify the administration of health insurance; and 4) combat waste, fraud, and abuse in health insurance and health care.

Title II: The Security and Privacy Mandates

Title II of the HIPAA law (also known as Administrative Simplification) includes requirements for ensuring the security and privacy of individuals' medical information. The standards aim to maintain the right of individuals to keep private information about themselves. The Department of Health and Human Services is charged with developing and issuing regulations to address these requirements. The final privacy rule was released April 14, 2001; compliance is now required by April 2003. The security rule is being finalized; the released date is expected to be June/July 2001.

Protected Information

HIPAA regulations protect medical records and other "individually identifiable health information" (communicated electronically, on paper, or orally) that are created or received by covered health care entities that transmit information electronically.

"Individually identifiable health information..." includes

- any information, including demographic information collected from an individual; and
- any information that identifies an individual, or could be reasonably believed to identify an individual

HIPAA protects "individually identifiable health information" which…

- relates to the past, present, or future physical or mental health condition of an individual, the provision of health care or the payment for such care
- is maintained or transmitted, and is (or has been) in electronic form
- is used or disclosed by covered entities

What is the Difference between Security and Privacy?

Security—relates to the means (process and technology) by which an entity protects the privacy of health information. The goals of security measures are to keep information secured, and decrease the means of tampering, destruction, or inappropriate access. There are four categories of requirements:

- Administrative Procedures—documented, formal practices to protect data
- Physical Safeguards—protect data from fire, other natural and environmental hazards, and intrusion
- Technical Security Services—protect information and control individual access to information
- Technical Security Mechanisms—guard against unauthorized access to data over communications network

Privacy—refers to the individual's right to keep certain information private, unless that information will be used or disclosed with his or her permission. Privacy topics include:

- Scope of Providers who must Comply
- Rights of Individuals
- Consent/Authorization Issues/Procedures/Processes
- Business Associates Requirements
- Organized Health Care Arrangements

Note: there are civil penalties when entities/individuals violate the privacy rule.
Security and privacy are very intertwined--security assures privacy.

NOTICE OF PRIVACY POLICIES FOR THE
INSTITUTE FOR RESTORATIVE HEALTH

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS DOCUMENT, AND IF YOU HAVE ANY QUESTIONS, PLEASE ASK TO SPEAK TO OUR OFFICE STAFF.

YOUR PRIVACY IS OF THE UTMOST IMPORTANCE TO US. THE FOLLOWING IS OUR PRIVACY PROMISE TO YOU, OUR PATIENT:

At the Institute for Restorative Health, we are committed to preserving, disclosing, and using your protected health information responsibly. Your privacy is a top priority at our practice. This notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit the Institute for Restorative Health, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, 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 heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

We wish to help you better understand what is in your record and how your health information will be used and disclosed. By being open with you, we feel this will ensure accuracy, a better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to other parties.

Your Health Information Rights

Please realize that your health record is the physical property of the Institute for Restorative Health, however, the information belongs to you. You have the following rights regarding your protected health information:

- 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 45 CFR 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, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

The Institute for Restorative Health is required to do the following:

- Maintain the privacy of your health information,
- Provide this privacy practices notice as to our legal duties 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 requested restriction, and
- 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 if we feel it is necessary to protect your information. The new provisions effective for all protected health information we maintain will be mailed to you if necessary. Should our information practices change, we will mail a revised notice to the address you've supplied us. 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. This will not effect discloses made in good faith of the original authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer Trini Perez, ext 205. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. We will not take any retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. *Office for Civil Rights*

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you if you're referred to a specialist or other healthcare provider, or in a situation where you are release from treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. We may also use your mailing and contact information to send you notices from time to time that we feel are important to your healthcare needs. We may use a third party from time to time to get such important notices to you.

For example: Having our patients sign in at the front desk is also part of our operations. The sign in sheet allows us to ensure appropriate treatment, and helps our staff in assessing and improving our quality care.

Calls and Messages: It is our policy to call our patients to confirm appointments. Messages may be left on answering machines to this effect. In the case of a missed appointment, it is our policy to call, make sure everything is all right, and reschedule at a later date.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include chiropractor services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may with your permission use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

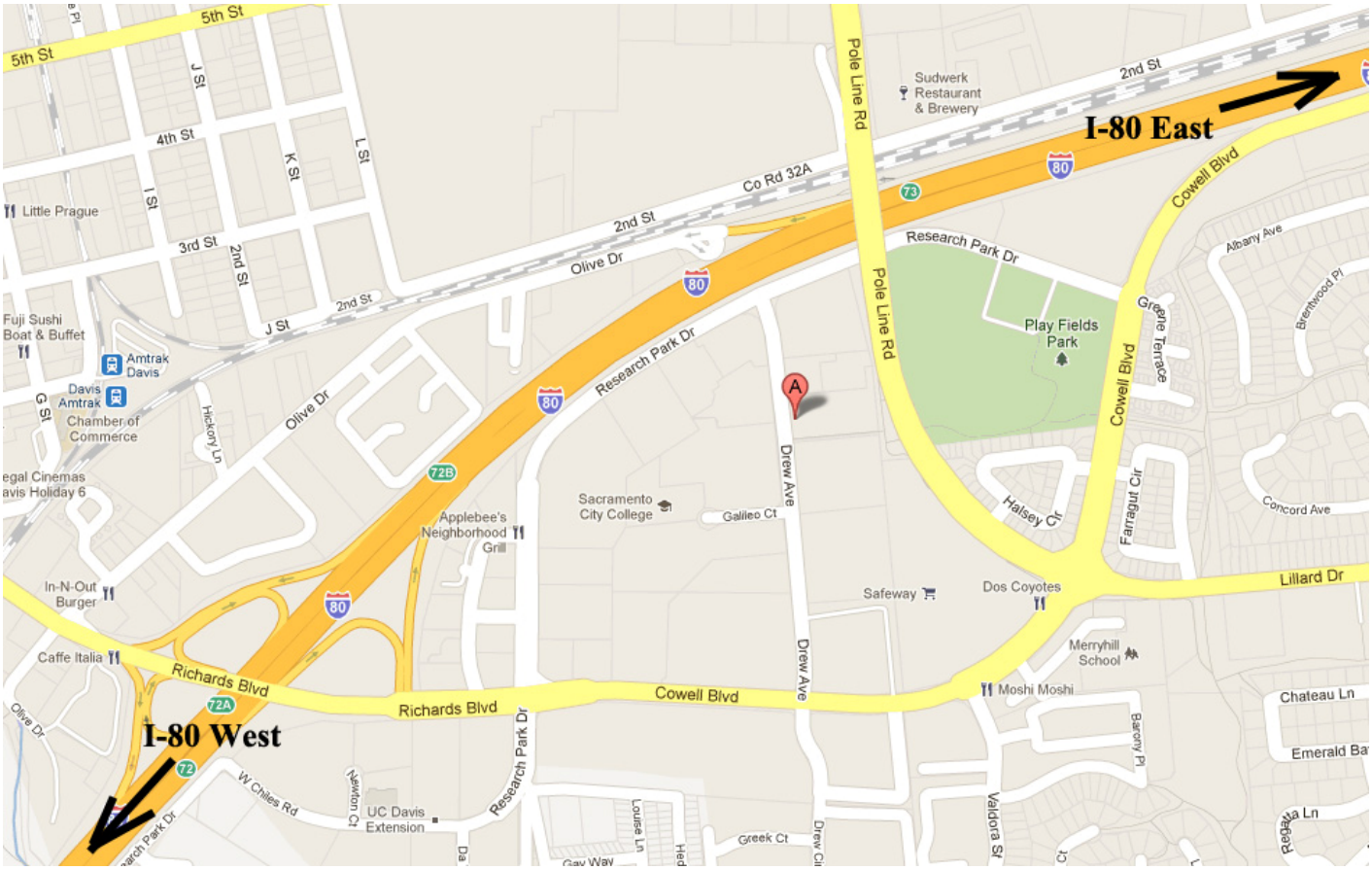
Federal law makes a provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Fund raising: We may contact you as part of a fund-raising effort.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.



1460 Drew Avenue Ste 300
Davis CA 95618

Directions from San Francisco

I-80 East toward Sacramento
Take the **Richards Blvd exit # 72** - toward downtown
Turn **Left** on **Richards Blvd**
Richards Blvd becomes Cowell Blvd
Turn **Left** on **Drew Ave.**
Turn **Right** into 1460 business park.

Directions from Sacramento

I-80 West toward San Francisco
Take the **Richards Blvd South Exit**
Stay straight on Richards which becomes Cowell Blvd
Turn **Left** on **Drew Ave.**
Turn **Right** into 1460 business park.