Silicon Valley Natural Health

Patient Registration Form

Date:

New Patient Information

Name: SEX: DOB:

Age:

Address: City: St: Zip:

Home Phone: Cell Phone: Work Phone:

Email Address:

Would you like to receive our email newsletter?

Additional Patient Information

Primary Care Physician:

Physician's Phone:

Address:

City: St: Zip:

Employer:

Occupation:

Marital Status:

Number of children:

Name of Spouse/Partner:

Emergency Contact:

Relationship to you:

Emergency Contact phone:

Acknowledgement of SVNH Forms: Notice of Privacy Practices, Informed Consent, and Email Consent Silicon Valley Natural Health (SVNH) reserves the right to modify the forms.

Initials: _____ I have read a copy of the Notice of Privacy Practices for Silicon Valley Natural Health

Initials: _____ I have read a copy of the Informed Consent Form

- I acknowledge that no guarantees have been given to me by SVNH doctors regarding cure or improvement of my condition
- I understand that there are risks to procedures and will go to URGENT CARE if needed.
- I understand that SVNH doctors have polices about labs and lab reviews.
- I understand that the SVNH doctors' treatment recommendations are for the patient only. Sharing recommendations can be dangerous to other persons (i.e. sharing with a pregnant woman)
- I understand that SVNH doctors provide supplements and vitamins for convenience and that patients are not obligated to purchase from SVNH. However, I am responsible for the therapeutic quality of the product.
- I understand that purchasing from SVNH supports the clinic.

Initials: _____ I have read a copy of the Email Consent Form

- I understand that email is NEVER for emergency/urgent matters
- I understand that email is like a postcard and is not confidential. Any member of the SVNH team will have access to the emails.
- I understand that email is ONLY for quick questions about product refill, scheduling, keeping SVNH green by emailing invoices and forms.
- I understand that SVNH is emailing invoices and treatment sheets to be eco-friendly.

Initials: _____ I would like to receive interesting health information, and/or newsletters from SVNH

FINANCIAL RESPONSIBILITY AND POLICY STATEMENT
Effective April 2013

Thank you for choosing Silicon Valley Natural Health for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES
Silicon Valley Natural Health is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

In the state of California, no insurance plans directly cover Naturopathic Doctors (ND). This is a complex issue and the California Naturopathic Doctors Association is exploring how this problem can be solved for Californians. Unfortunately, it is not CA law to mandate coverage for patients to see Naturopathic Doctors at this time. All NDs hope this will change one day. For these reasons, Naturopathic Doctors bill fee for service.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover, and American Express. Returned checks are subject to a $50 return fee and no further personal checks will be accepted.

PHONE /EMAIL SUPPORT VISIT

Both phone and email supports are available to all SVNH patients as another option for visit. Phone visits and email support is at the discretion of the SVNH doctor. Please understand that this service is not always appropriate for care and your SVNH doctor will let you know.

SVNH doctors may offer a complimentary 10minute phone call follow up within one week of a visit to clarify anything already discussed. Both phone and email will be billed for the same rate as the visit for which they substitute $200/hour with a minimum of $50. **You must have a CC on file for phone support/email support.**

CANCELLATION POLICY

If you are not able to keep your scheduled appointment, please notify us within 48 hours of the appointment. There is no charge if an appointment is cancelled within 48 hours during Monday-Friday Business hours of 9am-6pm. A cancellation with less than 48 hours notice does not allow enough time for other interested patients to be scheduled, and is a great inconvenience for our center. Late cancellations will be billed at full office visit cost for new patients $250 and $150 for all established patients.

Credit card (Master card or Visa):

Full Name on card:

Expiration:

CVV code:

Billing Address:

Billing Zip Code:

I agree to the above defined financial policies. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I the undersigned, have read, understand and accept the information and conditions specified in this document. Also, my credit card information listed will be charged if needed to pay for services with Silicon Valley Natural Health.

*Patients have the option to decline leaving information on file for personal reasons. It does not however exempt you from paying charges applicable to you. The SVNH team will invoice you. If you Decline please write "DECLINE" in the fields above where CC information would be placed. By declining, you are aware that you are not eligible for phone/email support.

Patient or Parent/Guardian Signature

Date

NATUROPATHIC PATIENT INTAKE FORM

Name:

DOB:

Last time you had a blood work done?

Physician:

List in order of importance your health concerns:

1)
2)
3)
4)

Please indicate the following: Disease **(D), I**mmunized **(I), or N**either **(N):**

Standard childhood immunizations **:**

(Measles, Mumps, Rubella (MMR), Tetanus, Diptheria, Pertussis (DTP), Polio)

Chicken Pox		Tetanus		Whopping Cough	
Hepatitis B		HPV		Flu	

Did/do you have any of the following diseases: Yes (**Y**) No (**N**) Past (**P**)

Scarlet Fever		Diabetes		Kidney Disease	
Hypertension		Seizures		Tuberculosis	

List all known drug allergies and reaction you get when you take medicine:

List all Prescription Medicines & Nutrient Supplements/Herbs that you are taking and include dosage if known:

Medications	Dosage	How long have you been taking it?	Prescribed by Dr's or self?	Side effects

Do you currently see a chiropractic doctor?

Do you have a regular dentist?

What would you rate your energy on a scale from 1-10? (10 being the best)

Do you have fatigue?

If you have fatigue, when in the morning, afternoon, evenings is it the worst?

If you have fatigue, can you do what you need to do during the day?

Family History

	Self	Mother	Father	Siblings	Aunt/Uncle	Grandparent	Children
Allergies/ Asthma							
Auto-Immune Disease							
Cancer/Type							
Diabetes							
High Blood Pressure							
Mental Illness							
Obesity							
Osteoporosis							
Stroke/Heart attack							
TB							
Thyroid Disease							

Exercise

How often do you exercise?

What type of exercise?

For how long?

Hobbies:

Sleep

How long per night?

If you wake up frequently, what is the reason?

Nightmares: **Wake refreshed:** **Must nap during day:**

Sleep walk: **Grind teeth:** **Snore:**

Toxin Exposure

Have you had any job where you were exposed to solvents, heavy metals, fumes or other toxic material?

Social Life

Enjoy job:

Hours worked per week:

Highest level of education:

Active spiritual practice:

Quality of significant relationship:

History of sexual, mental/emotional, physical abuse:

If so, at what age and by whom:

Diet

How often do you eat in restaurants weekly?

Do you strongly crave any particular foods?

Allergies

List all known Allergies (food, environment):

What is your greatest health concern?

How does it limit you the most?

Which statement best describes your attitude towards your health? (Check one)

- I will do whatever it takes to obtain optimal health
- I am willing to change my lifestyle somewhat to feel better
- I may consider change if needed to feel better
- Just give me pills, doc

Timeline

Please mark events in your life that were pivotal. These may be religious events, marriages, childbirth, illnesses, relocations, accidents, occupational changes or educational milestones.

Today

Please indicate **Y** (yes, presently) **N** (no, never) **P** (past concern)

SKIN					
Rash			Color change		
Hives			Lump		
Psoriasis/eczema			Itchy		
Dry			Warts/moles		
Cancer			Unusual perspiration		
HEAD					
Headache			Migraine		
Dandruff			Head injury		
Oil/Dry hair			Hair loss		
NOSE					
Frequent colds			Nosebleeds		
Congestion			Post Nasal Drip		
Polyps			Seasonal Allergies		
Sinus congestion					
EYES					
Dry/Watery			Blurry vision		
Double vision			Cataracts		
Glaucoma			Styes		
Strain			Discharge		
Itchy			Dark under eyelid		
EARS					
Ear infections			Ringing or buzzing		
Vertigo/dizziness			Loss of hearing		
MOUTH/THROAT					
Canker sores			Cold sores		
Sore throat			Gum disease		
Dentures			Cavities		
Loss of taste			Hoarseness		
NECK					
Unusual stiffness			Swollen glands		
Lack of motion			Disc complaints		
RESPIRATORY					
Cough			Bronchitis		
Shortness of breath			Pneumonia		
Wheezing			Asthma		
TB			Painful breathing		

Please indicate **Y** (yes, presently) **N** (no, never) **P** (past concern)

CARDIOVASCULAR			
High blood pressure		Rheumatic fever	
Low blood pressure		Murmurs	
Arrhythmias		Palpitations	
Edema		Chest pain	
GASTROINTESTINAL			
Heartburn/Indigestion		Bowel Movements	per day
Bloating		Recent BM change	
Nausea/Vomiting		Diarrhea	
Ulcer		Constipation	
Change in appetite		Hemorrhoids	
Pancreatitis		Gallbladder disease	
GI surgery		Liver disease	
NERVOUS SYSTEM			
Paralysis		Sciatica/Disc issues	
Tingling/numbness		Carpal tunnel	
Seizures		Fainting	
MUSCULOSKELETAL			
Weakness		Arthritis	
Stiffness		Leg cramps	
Tremors		Pain	
MENTAL/EMOTIONAL			
Depression		Anger/irritability	
Suicidal		High-strung/tense	
Anxiety		Panic attacks	
Eating disorder		Psych hospitalization	
URINARY TRACT			
Incontinence		Pain w/ urination	
Frequent infections		Kidney stones	
Urgency		Discharge/blood	

Please indicate **Y** (yes, presently) **N** (no, never) **P** (past concern)

MALE HEALTH			
Testicular pain/swelling		Sexually active	
Hernia		STD	
Discharge		Prostate complaints	
Impotency		Sexual orientation	

FEMALE HEALTH			
Age period began		How often period occurs	
Last menstrual period		Heavy bleeding	
PMS		Pain/cramping	
Times pregnant		How many births	
Miscarriages		Abortions	
Any abnormal paps		Hormonal birth control*	
STD		Sexual orientation	
Vaginitis/Yeast Infections			
Menopause			
Menopausal since		Use of hormones*	
Dry vagina		Healthy libido	
Pain with intercourse		Hot flashes/Nightsweats	
Dexa bone scan		Mammography	

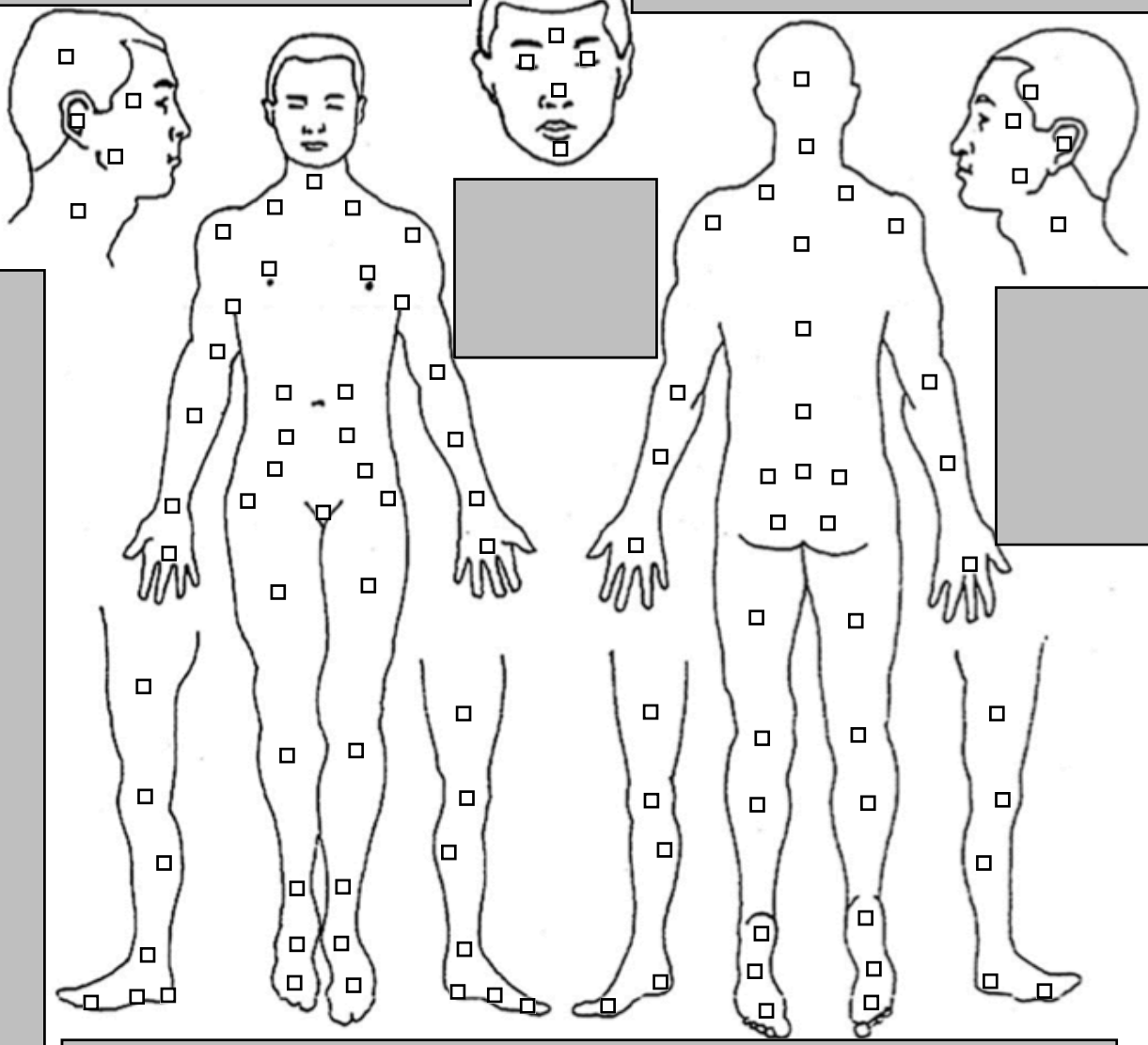
*Please list any birth control or hormone treatments used and ages used:

Diet Diary
Please record *everything* you eat for three days before your appointment. Do your best to estimate quantities.

Meal	Day 1	Day 2	Day 3
Breakfast (please include drinks)			
Lunch (please include drinks)			

Snacks (please include drinks)			
Dinner (please include drinks)			

Please Mark Painful or Distressed Areas on the Charts Below



ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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 treatment.

ACUPUNCTURIST NAME:

PATIENT SIGNATURE X

(Or Patient Representative)

(Date)

(Indicate relationship if signing for patient)

The following pages are for your records.
Please read, but you do not need to print them or bring them into the office.

NOTICE OF PRIVACY PRACTICES Silicon Valley Natural Health – San Jose, CA

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI – Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are used and disclosed by your provider, our office staff and others outside of our office that are involved in our car and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the doctor/physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used as needed, to obtain payment for your health care services. We may use and share PHI for the services we provide to you and to collect payment for the service billed to you, from you, your insurance company, or a third party. We may also share PHI with another provider so that provider can bill and collect for services you received.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your provider is ready to see you.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the

authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders. Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:
• The right to request restrictions on the use and disclosure of your protected health information
• The right to receive confidential communications concerning your medical condition and treatment
• The right to inspect and copy your protected health information
• The right to amend or submit corrections to your protected health information
• The right to receive an accounting of how and to whom your protected health information has been disclosed
• The right to receive a printed copy of this notice

Silicon Valley Natural Health

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Dr. Tran. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

HIPAA Privacy Standards
Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Silicon Valley Natural Health
5595 Winfield Blvd Suite 106
San Jose, CA 95123

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you may contact for further information concerning our privacy practices is:

Silicon Valley Natural Health
5595 Winfield Blvd Suite 106
San Jose, CA 95123
Attn: Medical Director - Dr. Julie Tran, N.D. , LAc

Effective Date: This notice is effective on or after January 1, 2009

Silicon Valley Natural Health (SVNH)
INFORMED CONSENT FOR TREATMENT

I hereby authorize the SVNH Doctors, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: Venipuncture, Pap smears, radiography, laboratory, x-ray.
Minor office procedures: Cleaning and dressing a wound, Stitches, ear lavage, skin scraping, skin cryotherapy.
Medicinal use of nutrition: Therapeutic nutrition, nutritional supplementation, and intravenous and muscular vitamin injections
Botanical medicine: Botanical substances may be prescribed as teas, alcohol or glycerite based tinctures, capsules, tablets, creams, 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, weight management, and balancing of work and social activities.
Physical medicine: Hydrotherapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.
Psychological Counseling
Vaccine Counseling: Per the scope of practice in California, Naturopathic Doctors do not offer vaccinations. The SVNH doctors are happy to discuss vaccinations and immune support recommendations. We refer to MD/DO providers for vaccinations.

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, aggravation of pre-existing symptoms, discomfort, pain, infection, nausea, light headedness, inconvenience of lifestyle changes; injury from injections, venipuncture, or procedures. **Notify the SVNH Doctor if you experience any symptoms, which may be secondary to the above procedures and or go to the urgent care or emergency room.**

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, 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 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.

Laboratory Testing & Specialty testing & records: SVNH doctors utilizes standard laboratory tests & specialty testing to assess the condition of the patient's health and guide treatment plans. I understand that refusal to have laboratory tests &/or specialty tests performed can and or will affect results of treatment. **Also, SVNH doctors do not release lab results to patients prior to an in office consultation about them. They can be faxed to another health care provider per medical release. Also, there is a $25 fee for release of labs to patient. Additionally, full chart copies are subject to $1/page.**

Supplements & Vitamins: SVNH doctors utilizes supplements & vitamins from companies that design products for physicians and health care providers. The Silicon Valley Natural Health does profit from the any products purchased by the patients. I understand that I do not have to buy products from SVNH. Also, I understand that if I buy products elsewhere that I am responsible for the content of those products and the therapeutic value of the products.

With this knowledge, I voluntarily consent to the above procedures, **realizing that no guarantees have been given to me, by SVNH doctors 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 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.

EMAIL POLICIES AND CONSENT

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is not the same as calling our office. We believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us by e-mail.

- **E-mail is never, ever, appropriate for urgent or emergency problems!** Please use the telephone or go to the Emergency Department for emergencies.
- E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include prescription refill requests, appointment-scheduling requests and to send invoices or copies of treatment sheets.
- Emails that requests answers to medical questions that the doctor can answer by email will be billed at $200/hour. Email responses will be billed at a minimum of $50 per email. This option requires a credit card on file or a deposit of $200.
- E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **E-mail is Not Confidential.** It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses. E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
- E-mail is not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment.

Finally, either one of us can revoke permission to use the e-mail system at any time.

- I DO want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.