Austin's Favorite Pharmacy

Wellness Consultation Policies

Cancellation Policy: There is a $50 charge for cancellations of less than 24 hours or failure to show up for a scheduled appointment.

Email Policy: Email may be used for answering brief clarifying questions at your practitioner's discretion. If you are emailing about a new or more detailed concern, you will be asked to schedule a phone or office consultation to ensure effective communication and comprehensive care.

Costs of any laboratory tests are paid directly to the lab and do not include the fee for follow-up consultation to discuss the results.

Consultation Fees:

Practitioner	90 minutes	60 minutes	30 minutes	15 minutes
PharmD, DC, or ND	$195	$145	$85	$30
Classical Homeopath, CCN, L.Ac., MS, RD, or RN	N/A	$110	$75	N/A
ACN, Ayurvedic, Certified Herbalist, NA, or LMT	N/A	$85	$55	N/A
Chiropractic Adjustment	$40 per visit			

Austin's Favorite Pharmacy

HIPAA Notice of Privacy Practices

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

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 relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information

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

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of 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 to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health care plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician'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 protected health information 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 indicated your physician. We may also call you by name in the waiting room when

your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

PEOPLES Rx
Austin's Favorite Pharmacy

Privacy Notice Acknowledgement Form

The Federal Health Insurance and Portability and Accountability Act (HIPAA) regulates how health care providers may use and disclose health information, and also requires that patients be notified of the provider's privacy practices.

I, _____ (*Printed Name of Patient or Patient's Representative*), acknowledge receipt of the "Privacy Notice Acknowledgement Form" and "Wellness Consultation Policies".

_____ _____

Signature (*Patient or Patient's Representative*) Date

Wellness Consultation Consent Form

I hereby understand, agree, and attest to the following:

1. I fully understand that the Wellness Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

2. Since the Wellness Consultant is not a medical doctor or primary care physician, it is recommended that I continue services with my primary care physician.

3. The services offered by the Wellness Consultant are at all times restricted to helping me gain a better understanding of 'health' (not disease), so that I will have greater self-awareness and be able to use a self-care plan for daily living.

4. The wellness plan offered (which may include discussion and or sale of nutritional supplements, nutrition and lifestyle modifications, homeopathic remedies, vitamins, minerals, food grade herbs, and other dietary supplements) pertains to the whole body concept of nutrition rather than addressing a specific ailment or condition.

5. The Wellness Consultant does not provide emergency or after-hours care. In the event of an emergency, I will dial 911 or proceed to the nearest emergency room.

6. Laboratory testing may be conducted for screening purposes only and does not constitute a diagnosis of any medical condition. It is my responsibility to follow up with a medical doctor if any of the lab results are abnormal.

7. Women who are pregnant or planning pregnancy must inform their Wellness Consultant, as this will likely alter the recommendations that are made.

8. Since they are not prescribing physicians, the Wellness Consultants will not be able to advise me to discontinue or change doses of my medications. I am advised to consult with my prescribing physician concerning any modifications of my pharmaceutical medications.

9. Potential benefits of following a wellness plan include health optimization, symptomatic relief, and disease prevention. Potential risks include rare allergic reactions, paradoxical reactions to supplements (example: valerian is a relaxing herb for most people, but it is stimulating in some people), and drug-supplement interactions. Although there is a growing body of information regarding such interactions, I understand that not all drug-supplement interactions are known at this time.

10. There are wide individual differences in response to a wellness plan, and no guarantees are made that I will gain any benefit nor suffer any adverse consequences.

11. While I may experience immediate benefits from the wellness plan, I understand that the most effective results will occur when I make a long-term commitment to rebuild my health, which will likely involve some lifestyle modifications.

_____ _____

Signature of Client or Client's Representative: Printed Name of Client or Client's Representative:

Phone Number:(_____)_____-_____ Date: _____

Referred By: _____

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www.dramyneuzil.com www.peoplesrx.com

Dr. Amy Neuzil, N.D.

CONFIDENTIAL HEALTH INFORMATION

Name:_____ **Today's Date**:_____

How did you hear about us? ☐ Newspaper ☐ Yellow Pages ☐ Radio/TV ☐ Location
☐ Internet ☐ Referred by_____
☐ Other _____

Age:_____**Date of Birth**:_____**Marital Status**:_____

Permanent Address:_____

Mailing Address:_____

Email Address:_____

Phone (home):_____ (cell):_____ (work):_____

Name of spouse (or parent for minor child):_____

Whom may we contact in case of emergencies? **Name**: _____

Relationship to client:_____**Phone**:_____

POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES.
We accept cash, check, Visa, Mastercard, AMEX, and Discover. We do not bill to insurance.

At the time of payment you can request a bill from our office. This will show the diagnosis, services, and charges for that day. You can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office in dealing with any possible follow up inquiries from your insurance company regarding your claims.

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and myself. I hereby authorize Dr. Amy Neuzil, N.D. to furnish medical information to my insurance carriers should it be necessary. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Client's Signature:_____**Date**:_____

Signature of Parent or Guardian (for minors): _____

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CONFIDENTIAL CLIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Name :_____D.O.B. _____Today's Date:_____

Please list the main reason(s) for your visit: _____

_____

Symptoms: Please check all that apply

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Sleep Disturbance
- ☐ Sweats

EMOTIONAL
- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorder
- ☐ Fear/Panic
- ☐ High Strung
- ☐ Irritability
- ☐ Psychiatric Disorder
- ☐ Suicidal

NEUROLOGICAL
- ☐ Carpal Tunnel
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Sciatica
- ☐ Seizures

SKIN
- ☐ Bruise Easily
- ☐ Change in Moles
- ☐ Dry Skin
- ☐ Itching
- ☐ Rash
- ☐ Sores that Won't Heal
- ☐ Warts

HEENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Difficult Swallowing
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hair Loss
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Glaucoma
- ☐ Gum Disease
- ☐ Migraine
- ☐ Mouth Sores
- ☐ Nasal Congestion
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Post Nasal Drip
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Swollen Lymph Nodes
- ☐ Visual Disturbance

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Lack of Coordination
- ☐ Stiffness
- ☐ Tremors
- ☐ Weakness

GI
- ☐ Bad Breath
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting

HEART/LUNGS
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Pulse
- ☐ Low Blood Pressure
- ☐ Murmur
- ☐ Pain Breathing
- ☐ Palpitations
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Short of Breath
- ☐ Suffocating Feeling
- ☐ Swelling Ankles
- ☐ Varicose Veins
- ☐ Wheezing

MALE ONLY
- ☐ Breast Lump
- ☐ Discharge from Penis
- ☐ Erection Difficulties
- ☐ Lump in Testicle
- ☐ Sore on Penis
- ☐ Testicular Pain
- ☐ Testicular Swelling
- ☐ Other:_____

FEMALE ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Heavy Bleeding
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ PMS
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Other

Last Menstrual Period:_____
Last Pap:_____
Have you had a Mammogram?_____

URINARY
- ☐ Blood in Urine
- ☐ Difficult Urination
- ☐ Frequent Infections
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

MEDICATIONS:
Please List all medications and dosages

- ☐_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____

ALLERGIES:
Please List

- ☐_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____
- ☐_____

HEALTH HABITS:
Please check any you use and indicate how much

- ☐ Coffee: _____
- ☐ Alcohol: _____
- ☐ Tobacco:_____
- ☐ Marijuana:_____
- ☐ Drugs:_____
- ☐ Other:_____

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CONDITIONS

Please check (✓) any conditions you have had.

☐ AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problems
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psoriasis/Eczema
☐ Allergies	☐ Diabetes	☐ Kidney Disease	☐ Psychiatric Care
☐ Anemia	☐ Emphysema	☐ Leg Cramps	☐ Rheumatic Fever
☐ Anorexia	☐ Epilepsy	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Gall Bladder Disease	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bulemia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease

FAMILY HISTORY

Relation:	Father	Mother	Sibling 1	Sibling 2	Child 1	Child 2
Age if living:						
Age at Death:						
Cause of Death:						
	Please check if any of the following conditions applied to the above relatives:					
Auto-Immune Disease:	☐	☐	☐	☐	☐	☐
Cancer:	☐	☐	☐	☐	☐	☐
Diabetes:	☐	☐	☐	☐	☐	☐
Heart Attack/Stroke:	☐	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Mental Illness:	☐	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐	☐
TB:	☐	☐	☐	☐	☐	☐

PREGNANCY HISTORY

Number of Pregnancies:_____

Number of Live Births:_____

Check if you've had any of the following:

☐ Abortion ☐ Miscarriage ☐ Premie

SLEEP HISTORY

How many hours per night?_____

Please check if you have any of the following:

☐ Frequent Waking ☐ Nightmares ☐ Snoring

☐ Nap during day ☐ Sleep walk ☐ Grind Teeth

OCCUPATION

Check if you are exposed to: ☐ Stress

☐ Heavy Lifting ☐ Hazardous Substances

EXERCISE

How often do you exercise?_____

What type?_____

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Amy Neuzil, ND or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____Date: _____

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CLIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives clients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The individual is also given the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's residence. We would like to respect those rights in every way possible and request that you fill in the following:

Please fill out the top portion. The bottom will be a record of any disclosures of your records from our office.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with name and call-back number only

☐ Work Telephone_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with name and call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address
- ☐ O.K. to fax to this number: _____

☐ Other: _____

_____
Client Signature

_____
Date

_____
Print Name

_____
Date of Birth

Date	Disclosed to Whom Address/Fax	(1)	Description of Disclosure Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if Disclosure is authorized
(2) Type Key: T= Treatment Records P= Payment Information O= Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P= Phone ; E= Email; M= Mail; O= Other

Privacy regulations generally require healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary. These provisions do not apply to uses or disclosures requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided above constitutes an adequate record.

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.

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Complementary and Alternative Health Client Bill of Rights

As a valued client of Excelon Health, it is important that you are fully aware of the laws surrounding Naturopathic Medicine. If you have any questions or concerns please talk with myself, Dr. Amy Neuzil, N.D. I will be more than happy to discuss them with you.

The state of Texas does not regulate Naturopathic Doctors, or the use of the title "N.D." For this reason it is especially important to verify your Naturopathic Doctor's training and certification. I attended a fully accredited four-year post graduate program at Southwest College of Naturopathic Medicine in Phoenix Arizona. I passed board exams in the State of Arizona and I hold a current and valid Arizona license (AZ# 03-781). Texas does not license Naturopathic Doctors at this time.

Due to lack of State licensing in Texas, I am not legally able to prescribe pharmaceutical drugs, perform minor surgeries, administer injections, diagnose or treat disease. I AM able to use natural methods like supplements, homeopathy, herbs and lifestyle changes to improve your health as a whole person. **The goal is to increase your overall health and vitality as a whole person thereby decreasing the symptoms you suffer and encouraging vibrant health.** If you are interested in learning more about naturopathic medicine and current licensing efforts please see our national association, the AANP at www.naturopathic.org or our state association, TXAND at www.txand.org.

I stand firmly behind the quality of care you will receive. Please do not hesitate to ask questions or give feedback. I look forward to being your partner in health.

The fee schedule is as follows:

New Clients:
- Standard New Client Visits (up to 1.5 hours): $195.00
- New Client Visits for Infants or Children 10 and Under (up to 1 hour): $145.00

Established Clients (in person or over the phone):
- Standard Follow-up Visit (up to 30 min): $85.00
- Extended Follow-up Visit (up to 45 min): $110.00
- Complicated Follow-up Visit (up to 1 hour):$145.00

Phone or Email Questions or Check-Ins:
- General questions (less that 5 minutes): Free within reasonable use. I consider this to be part of our relationship and will only bill if the calls or emails are frequent or extremely complicated.
- Complicated calls or emails (up to 15 minutes): $55.00
- Questions requiring more time: Billed as regular visits.

Because Naturopathic Doctors are not yet licensed in the State of Texas, I require that you maintain a relationship with your primary care physician.

_____ _____

Signature of Client or Guardian **Date**

_____

Name of Client or Guardian

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ARBITRATION AGREEMENT for Dr. Amy Neuzil

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the

claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here_____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____

Patient Signature (or representative) Relationship to Patient Date

_____ _____

Office Signature Date

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General Symptoms

Name:_____ **Date:**_____

Instructions

Please answer the following questions carefully, thoughtfully, and accurately. Many of the questions will not seem directly related to your main concern, however, each helps to determine which homeopathic remedy is best suited to you. **All information in this questionnaire is kept strictly confidential**.

There are different types of questions in this part of the paperwork.

Some questions will ask you to rate how much you are troubled by a spectrum of conditions such as cloudy/ clear. In this example, circling number "1" means you are extremely troubled by cloudy weather, circling number "10" means you are extremely troubled by clear weather, and circling "5" means that you are not troubled by either. **For example:**

Which weather conditions are you most troubled by?

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Some questions will ask you to rate how much you are troubled by a single symptom or how much this quality characterizes you in general. **For example**:

Do you worry about any of the following?
Circling closer to "10" means that you are very worried about your health. Circling closer to "1" means that you are not worried about your health at all.

1 2 3 4 5 6 7 8 9 10 Health

Some questions will ask you to circle the answer which fits you the best. **For example**:

What are your feelings toward disease?

Optimistic
Doubtful of Recovery
Fearful
Despair of Recovery

Please answer to the best of your ability – we will go over the paperwork during your first visit.

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The following questions pertain to you as a <u>whole</u> person.

Which weather conditions make you uncomfortable (please circle any that apply)?

Cloudy	Clear
Wet	Dry
Damp cold	Snow (Dry Cold)
Humid Heat	Dry Heat
Storms	Wind
Fog	Hot Sun

Circle which seasons cause you the most trouble?

Winter	Spring
Fall	Summer

Do you feel better (circle one):

In the Mountains	At the Seashore
Both	Neither

Are you sensitive to and/or troubled by(circle all that apply):

Bright Light	Darkness
Open Air	Stuffy Rooms
Tight Clothing	Noise
Odors	Drafts

Are you generally chilly or warm?

Chilly Neutral Warm

Does it bother you more to be too hot or too cold?

Too Cold No Preference Too Hot

How do you experience sympathy or consolation?

Like sympathy Neutral Dislike sympathy

Do you prefer to be alone or with people?

Alone With Others
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

Sad
Apathy/Indifferent
Up and Down
Happy
Excitement
Exhilaration

What time(s) of day are you usually worst (mood, energy, symptoms, etc.)?

Worst:_____

What time(s) of day are you generally best (mood, energy, symptoms, etc.)?

Best:_____

Circle <u>all</u> symptoms you experience during sleep.

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Sleepwalking
Arms or legs out of the covers

What position do you sleep in most often?

Right Side	On Back
On Knees	Knee to Chest
Left Side	On Abdomen

Is there a position you can not sleep in?

Right Side	On Back
On Knees	Knee to Chest
Left Side	On Abdomen

How much do you perspire?

Never Sometimes Most of the Time All the Time

Do you have difficulty waking?

Never Sometimes Most of the Time All the Time

Do you wake unrefreshed?

Never Sometimes Most of the Time All the Time

Do you wake-up at the same time many nights?

Time: _____

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Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. ***If you strongly desire or crave a food or taste, mark 10. If you detest or are averse to a food or taste, mark 1.***

Tastes:

1 2 3 4 5 6 7 8 9 10	Sweet
1 2 3 4 5 6 7 8 9 10	Sour
1 2 3 4 5 6 7 8 9 10	Salty
1 2 3 4 5 6 7 8 9 10	Bitter
1 2 3 4 5 6 7 8 9 10	Spicy (hot)
1 2 3 4 5 6 7 8 9 10	Smoked
1 2 3 4 5 6 7 8 9 10	Juicy
1 2 3 4 5 6 7 8 9 10	Refreshing

Foods:

1 2 3 4 5 6 7 8 9 10	Alcohol
1 2 3 4 5 6 7 8 9 10	Apples
1 2 3 4 5 6 7 8 9 10	Bacon
1 2 3 4 5 6 7 8 9 10	Bread alone
1 2 3 4 5 6 7 8 9 10	Bread with butter
1 2 3 4 5 6 7 8 9 10	Butter alone
1 2 3 4 5 6 7 8 9 10	Cheese
1 2 3 4 5 6 7 8 9 10	Chocolate
1 2 3 4 5 6 7 8 9 10	Coffee
1 2 3 4 5 6 7 8 9 10	Pastries
1 2 3 4 5 6 7 8 9 10	Eggs
1 2 3 4 5 6 7 8 9 10	Fat (meat, chicken pork, etc.)
1 2 3 4 5 6 7 8 9 10	Fruit
1 2 3 4 5 6 7 8 9 10	Fruit (sour)
1 2 3 4 5 6 7 8 9 10	Grain products (Pasta, bread, cereal)
1 2 3 4 5 6 7 8 9 10	Ham
1 2 3 4 5 6 7 8 9 10	Ice
1 2 3 4 5 6 7 8 9 10	Ice cream
1 2 3 4 5 6 7 8 9 10	Indigestible things (chalk, clay, paper)
1 2 3 4 5 6 7 8 9 10	Lemonade
1 2 3 4 5 6 7 8 9 10	Meat
1 2 3 4 5 6 7 8 9 10	Milk
1 2 3 4 5 6 7 8 9 10	Nut butters
1 2 3 4 5 6 7 8 9 10	Oysters
1 2 3 4 5 6 7 8 9 10	Pickles
1 2 3 4 5 6 7 8 9 10	Vegetables
1 2 3 4 5 6 7 8 9 10	Vinegar

Which do you prefer?

Warm Food	No Preference	Cold Food
Warm Drinks	No Preference	Cold Drinks

Do you notice any specific tastes in your mouth? Please Circle:

Metallic	Bitter	No Taste
Sweet	Sour	Salty

How thirsty are you generally?

Never Somewhat Medium Often Always

Do you feel better or worse from physical exertion?

Much Better Better No Change Worse Much Worse

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How strong in general are the following emotional symptoms? (1 = not strong, 10 = overwhelming)

1 2 3 4 5 6 7 8 9 10 Anxiety (worry and fear)

Do you worry about any of the following?
(1 = not at all, 10 = very much)

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals/Past Indiscretions

1 2 3 4 5 6 7 8 9 10 Others (family and close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 Future Work

Answer as honestly as you can about your personality traits.

Frightened Easily	Neutral	Never Afraid
Stingy	Neutral	Overly Generous
Thrifty	Neutral	Extravagant
Hurried/Impatient	Neutral	Slow
Messy	Average	Fastidious
Calm	Average	Restless
Lazy	Average	Always busy
Shy/Timid	Average	Outgoing
Bad Temper	Average	Mild/Yielding
Never to Blame	Sometimes	Always My Fault
Stubborn	Average	Yielding
Reckless	Average	Cowardly

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

Resolved Grief
Dwells on Past
Inconsolable
Remorse
Guilt

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward life:

Love life
Changeable
Indifferent
Bored/Weary of life
Loathing of life
Desires death
Suicidal thoughts or actions

Feeling toward spouse/lover/partner:

Loving
Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment
Hatred

How much do you experience the following?
1 = hardly ever, 10 = all the time.

1 2 3 4 5 6 7 8 9 10 Capriciousness

1 2 3 4 5 6 7 8 9 10 Irresolution

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

1 2 3 4 5 6 7 8 9 10 Moodiness

1 2 3 4 5 6 7 8 9 10 Selfishness

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Please rate yourself on the following scales:

Quiet Average Talkative

Not trusting Average Trusting

How often and easily do you weep?

Never Occasionally Regularly Often

How often do you experience clairvoyance?

Never Occasionally Regularly Often

How is your level of self-confidence?

Very Low Low Average High Very High

How impulsive are you?

Not at all Average Very Impulsive

Are you forgetful of any of the following?

Dates Names Numbers

What someone just said to you Words

What you just said Directions/Location

Do you often make mistakes with the following?

Numbers Words (reading)

Words (speaking) Words (writing)

How sensitive are you to the following?
(1 = not at all, 10 = extremely sensitive)

1 2 3 4 5 6 7 8 9 10 Beauty

1 2 3 4 5 6 7 8 9 10 Criticism

1 2 3 4 5 6 7 8 9 10 Cruel Stories

1 2 3 4 5 6 7 8 9 10 Frightening things

1 2 3 4 5 6 7 8 9 10 Being made fun of

1 2 3 4 5 6 7 8 9 10 Music

1 2 3 4 5 6 7 8 9 10 Reprimand

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 The suffering of others

1 2 3 4 5 6 7 8 9 10 The suffering of animals

How afraid are you of the following?
(1 = never afraid. 10 = terrified)

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative's Death

1 2 3 4 5 6 7 8 9 10 Disease

1 2 3 4 5 6 7 8 9 10 Downward Motion

1 2 3 4 5 6 7 8 9 10 Evil

1 2 3 4 5 6 7 8 9 10 Falling

1 2 3 4 5 6 7 8 9 10 Ghosts

1 2 3 4 5 6 7 8 9 10 Heights

1 2 3 4 5 6 7 8 9 10 Insanity

1 2 3 4 5 6 7 8 9 10 Misfortune (bad luck)

1 2 3 4 5 6 7 8 9 10 Of a Crowd

1 2 3 4 5 6 7 8 9 10 People

1 2 3 4 5 6 7 8 9 10 Robbers/Intruders

1 2 3 4 5 6 7 8 9 10 Snakes

1 2 3 4 5 6 7 8 9 10 Spiders

1 2 3 4 5 6 7 8 9 10 Strangers

1 2 3 4 5 6 7 8 9 10 Having a Stroke

1 2 3 4 5 6 7 8 9 10 That something will happen

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Thunderstorm

1 2 3 4 5 6 7 8 9 10 Water

1 2 3 4 5 6 7 8 9 10 Wind

How do you usually handle conflict?

Quarrelsome Average Yielding

How are you with regards to authority?

Hate Authority Bossy Average Yielding

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How critical are you of others?

Not at All Average Always Critical

How critical are you of yourself?

Not at All Average Always Critical

How often do you reproach (find fault, scold, or blame) others?

Not at All Rarely Often All the Time

How often do you reproach yourself?

Not at All Rarely Often All the Time

How honest are you?

Always Lie Sometimes Lie Always honest

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Biting Nails

1 2 3 4 5 6 7 8 9 10 Breaking Things

1 2 3 4 5 6 7 8 9 10 Contradictory

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolence (insulting, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Striking or injuring others

1 2 3 4 5 6 7 8 9 10 Striking or injuring yourself

Do any of the following pertain to your dreams (during sleep)?

Do not remember dreams Dreams are prophetic

Dreams continue after brief waking (to use restroom etc…)

Dreams cause waking Dreams happen while awake

Do you dream (during sleep) of any of the following?

Accidents Business Dead People

Death (your own) Events of the Day

Falling Fire Ghosts

Misfortune The Future (visionary)

Robbers Water Embarrassment

Other:_____

My Sexual Desire is:

Low Below Average Average High Very High

My Sexual Desire has Changed From Normal:

Yes Maybe No

I have Concerns About My Sex Life:

Yes Maybe No

Thank you for taking the time to fill out this paperwork accurately. We will use it in the initial visit to help determine the best course of action. Some of the questions may seem unrelated, but often they bring information to light that you might not otherwise talk about in a doctors visit. The more information you share, the more accurately I can design a plan for you that will work in your circumstances. I look forward to working with you!

-Dr. Amy Neuzil, ND