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**PATIENT REGISTRATION**

Confidential questionnaire to determine the best treatment plan. Please fill out as completely as possible.

**Personal Information**

Name_____Age_____ Date _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____E-mail_____

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

Emergency Contact: Name_____ Contact Phone:_____

Relationship to Patient:

☐Self ☐ Parent ☐ Legal Guardian ☐Personal Representative ☐Other:_____

**Child Only** (under the age of 18)

Mother's Name_____ Address (if different from above)_____

City_____ State_____ Zip_____

Father's Name:_____ Address (if different from above)_____

City_____ State_____ Zip_____

**Health Information**

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

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

**Please indicate if any of the following pertain to you (marking "yes" does not make you ineligible for treatment):**

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

Vaccinations _____

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

#1 _____#2 _____

#3 _____#4 _____

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**Please indicate the use and frequency of the following:**

Coffee _____ Soft Drinks _____Water _____

Alcohol_____ Recreational drugs _____ Tobacco_____

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

| Medication | Reason |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Allergies _____What is your reaction? _____

**Health History**

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

How long have you had this condition? _____

What other forms of treatment have you sought_____

What helps your condition? _____

What aggravates your condition? _____

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

_____

Additional Information _____

_____

What would you like to achieve with treatment?

_____

_____

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## Symptom Survey

**Please "check" the symptoms or conditions you experience <u>frequently</u>:**

□ **I am always hot** □ **I am always cold**

□ excessive appetite □ insomnia □ cough □ low back pain □ eye problems

□ loose stool/diarrhea □ palpitations □ short of breath □ knee problems □ jaundice

□ digestive problems, indigestion □ cold hands and feet □ decreased sense of smell □ hearing impairment □ difficulty digesting oily food

□ vomiting □ nightmares □ nasal problems □ ear ringing □ gall stones

□ belching, burping □ mentally restless □ skin problems □ kidney stones □ light colored stool

□ heartburn/reflux □ laughing for no reason □ claustrophobia □ decreased sex drive □ soft or brittle nails

□ stomach bloating □ chest pains □ colitis/diverticulitis □ hair loss □ easily angered

□ obsession in work, relationships □ poor memory □ constipation □ urinary problems □ difficulty making decisions

□ fatigue □ sadness □ blood in stoo □ easily bruised □ high cholesterol

□ lack of appetite □ edema □ hemorrhoids □ dental problems □ dizziness

□ get sick easily □ asthma □ headaches □ allergies □ bitter taste

□ recent use of antibiotics

## ♀ For Women

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

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

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

**Other symptoms related to menses:**

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

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

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**Symptom Survey/Family History**

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

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

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

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**POLICIES AND PROCEDURES**

The PIHMA Homeopathy Clinic is a teaching and research clinic. All of the students will have had a minimum of 350 hours of homeopathic training before being invited to participate in the clinic.

Each of the visits to the PIHMA Clinic will be video recorded, strict confidentiality is maintained of this material. Students may be watching clinical as part of the teaching clinic through a secure internet connection.

Each patient in the clinic will be assigned to the homeopathic practitioner who is working on that day. Each homeopathic practitioner is supervised by the a qualified homeopathic practitioner.

Research data from the clinic will be collected and used for clinical outcomes research. All such data will be held strictly confidential and any identifying information will be removed.

**Payment**

PIHMA asks all patients to pay at the time of the visit. PIHMA does not accept insurance. If no arrangement or payment is made, and account is then referred for collections, the patient will pay all reasonable collection fees and legal costs incurred.

**Appointments**

Walk-in patients are welcome. PIHMA Acute Care Clinic is open Monday - Friday 9:00AM to 3:00PM.
(602) 347-7950 Please contact office Monday through Friday 8AM - 5PM to schedule your appointment.

PIHMA Chronic Care Clinic is by appointment only.
(602) 347-7950 Please contact office Monday through Friday 8AM - 5PM to schedule your appointment.

**Fee Schedule**:

| | |
|---|---|
| Acute Care | $50 |
| Follow-up Visit | $25 |
| Chronic Care | $150 |
| Follow-up Visit | $75 |

**Canceling Appointments**:

We have a 24-hour cancellation/reschedule policy. If you do not call the Clinic within 24 hours prior to your scheduled appointment to cancel or reschedule, you will be charged a $25.00 fee for the appointment.

**No Shows**

For no shows, a full charge of $50 will be billed. Note that these fees must be paid before your next appointment.

**Late Arrivals for Follow-Ups**:

We make every effort to remain on schedule so that patients are not inconvenienced. Please be on time. If you are late, the visit will be shortened or may have to be rescheduled.

**Concerns After Hours and Emergencies**:

In emergency situations please use common sense. If the condition is life threatening or it becomes severe, please take one of the following precautions:

1) Contact your primary care physician
2) Contact your local hospital emergency room

Please follow the medical advice you are given by these people. Homeopathic medicines do not interfere with standard medical treatment.

**Phone Consultations**:

Fees are charged for phone consultations under the following conditions:

1) When specific medical prescriptions or recommendations are made and
2) The call exceeds ten minutes

Fees are not charged for phone calls made to clarify issues discussed during an office visit, questions concerning treatment or brief progress reports on the effectiveness of treatment. The fee is $15 for every ten minutes of time.

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**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPAA)**

This document (the Agreement) contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**LIMITS ON CONFIDENTIALITY**

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

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

- You should be aware that we practice with other health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

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

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided you, such information is protected by the physician-patient privilege law. We cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

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

- If we have reason to believe that a child under 18 who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that we file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that we file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.

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

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and will limit our disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS**

The laws and standards of the homeopathic profession require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to us confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence. If you refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. We are happy to discuss any of these rights with you.

**MINORS & PARENTS**

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records.

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**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)**

Original to be maintained in Patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices for Protected Health Information (HIPAA).

_____ _____

Patient Or Legally Authorized Individual Signature Date

Printed Name _____

Relationship to Patient:

☐ Self ☐ Parent ☐ Legal Guardian

☐ Personal Representative ☐ Other: _____

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**CONSENT TO TREATMENT**

I authorize PIHMA Clinic to treat my medical conditions and to order diagnostic tests as needed. I recognize that the treatments I receive may include homeopathic nutrient, herbal, integrative, alternative, preventive and/or conventional (allopathic) therapies. This consent is intended to provide an opportunity for me to make an informed decision so that I may give or withhold my consent to treatment that may be considered alternative by physicians trained in the United States.

I understand that:

- The safety and efficacy of alternative therapies has not always been established with controlled studies to the satisfaction of conventional medicine
- Side effects to homeopathic treatment (although uncommon) may include temporary worsening of present symptoms (aggravations) or temporary development of new symptoms (proving symptoms)
- No claim to cure has been made to me
- PIHMA and associates will NOT be providing hospital or emergency care for me from this clinic
- The therapies I receive will complement the care I receive from my primary care physician, and will not replace such care.
- Homeopathic students and faculty supervisors may be involved in my care.
- My case will be recorded and used for teaching purposes only.

I realize I have sought care from the PIHMA Homeopathy Clinic and they have explained fully in detail the services I am choosing to get today. Interactions, reactions and side effects have been fully explained to me regarding the treatments I am receiving today, conventional or non-conventional.

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

_____ Signature_____Date_____

Patient Name (printed)

Relationship to Patient:

☐Self ☐ Parent ☐ Legal Guardian ☐Personal Representative ☐Other:_____

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**CONSENT TO VIDEO RECORD PATIENT VISITS**

AMCofH at PIHMA video records all of its cases. Video recordings are used to study the case and are used in teaching PIHMA students.

I authorize AMCofH at PIHMA to video record my office visit. I understand that it will use this video recording only to study my case and in teaching. The recording will not be used for any other purpose and will not be distributed or seen beyond PIHMA.

_____ _____

Sgnature Date

Relationship to Patient:

☐Self ☐ Parent ☐ Legal Guardian ☐Personal Representative ☐Other:_____

**RESEARCH SUBJECT INFORMED CONSENT**

**Project Title: National Homeopathic Research Network**

**You are being asked to read the following material to ensure that you are informed of the nature of this research study and of how you will participate in it, if you consent to do so. Signing this form will indicate that you have been so informed and that you give your consent. Federal regulations require written informed consent prior to participation in this research study so that you can know the nature and risks of your participation and can decide to participate or not participate in a free and informed manner. If you choose not to participate, your refusal will involve no penalty or loss of benefits which you would normally experience.**

**PURPOSE**

You are being invited to participate voluntarily in the above-titled research project. The purpose of this project is to study cost effectiveness and success in homeopathic treatment. Patient data from the PIHMA Acute Care Clinic will be entered into a database where information will be analyzed and used to evaluate these outcomes.

**SELECTION CRITERIA**

Not participating in the study or withdrawing from the study will in no way affect clinical care, student standing or employment of PIHMA students, faculty or staff. The Principal Investigator (PI) will review all pertinent information and make the final decision regarding participation in the study.

**ALTERNATIVE TREATMENT(S)**

You have the option at any point of terminating the study and not permitting information from your treatment to be used in the research study.

**PROCEDURE(S)**

Data from the homeopathic medical record will be entered into a national homeopathic database. The data will be depersonalized so that no identifying information about you personally will be used (e.g. name, address, phone number, email).

**RISKS**
There are no risks to participating in this study. Every effort will be made to ensure that the privacy of research subjects will be maintained.

**BENEFITS**
There is no expected benefit to participation in this study. It is our intent and hope that through this research, there will be the development of a better understanding of success rates and cost effectiveness of homeopathic practice.

**CONFIDENTIALITY**
Representatives of regulatory agencies (including the PIHMA Research Foundaion) may access your records to ensure quality of data and study conduct. Throughout the study, access to identifying data will only be available to the main researcher (Dr. Iris Bell) and the Research Assistant. This data will not leave the confines of the college and not be accessible to any other agency. All data will be stored in locked file cabinets and security-protected locked files on the PIHMA computer.

**PARTICIPATION COSTS AND SUBJECT COMPENSATION**
There is no cost to you for participating in this study. There is no time involvement. You will not be paid for your participation.

**CONTACTS**
You can obtain further information about the research or voice concerns or complaints about the research by calling the main researcher Iris Bell MD, MD(H), PhD at (602) 274-1885. If you have questions concerning your rights as a research participant, have questions, complaints, or concerns about the research and cannot reach the Dr. Bell, or want to talk to someone else, you may call the PIHMA Foundation at 602-274-1885.

**AUTHORIZATION**
**Before giving my consent by signing this form, the methods, inconveniences, risks, and benefits have been explained to me and my questions have been answered. I may ask questions at any time and I am free to withdraw from the project at any time without causing bad feelings or affecting my medical care. My participation in this project may be ended by the investigator or by the sponsor for reasons that would be explained. New information developed during the course of this study which may affect my willingness to continue in this research project will be given to me as it becomes available. This consent form will be filed in an area designated by the Human Subjects Protection Program with access restricted by the principal investigator, Iris Bell MD, MD(H), PhD or authorized representative of the PIHMA Foundation Research Department. I do not give up any of my legal rights by signing this form. A copy of this signed consent form will be given to me.**

_____ _____
Subject's Signature Date

**INVESTIGATOR'S AFFIDAVIT**:
Either I have or my agent has carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who signed this consent form was informed of the nature, demands, benefits, and risks involved in his/her participation.

_____ _____
Signature of Primary Investigator Date