

09/19/13

**Choices Integrative Healthcare of Sedona**

95 Soldier Pass Rd, Suite B  
Sedona, AZ 86336  
Telephone - 928-203-4844  
Fax - 928-203-4497

**Dear Patient**

**Thank you for choosing CHOICES for your healthcare needs. We are pleased to have you as a part of our practice family. We understand that you may receive health care services from other providers, and we will do our best to coordinate and communicate what we are doing with you to those providers if that is your wish. If you were sent for a consultation for a specific problem, we will always communicate with the referring doctor or practitioner in a timely fashion. Please read the CHOICES policy guidelines and let us know if you have any questions about the procedures.**

**When you are making an appointment we will try to accommodate your schedule whenever possible within the limits of the practitioners' schedules. CHOICES general office hours are from 8:00 a.m. to 4:30 p.m. Monday through Friday. However each practitioner has specific days and hours of business.**

**After regular business hours and during the lunch hour (12 – 2), we provide voice mail for urgent matters. For urgent matters that require a doctor's attention after business hours and on weekends, an answering service will take your call if you dial 1-928-202-3232. When you do call after hours, please do limit your calls to those of an urgent nature.**

**Thank you again for your confidence in CHOICES INTEGRATIVE HEALTHCARE OF SEDONA. We wish you optimal health!**

**Best regards,**

**Devin A. Mikles, M.D., M.D.(H), FACP  
Medical Director**

**REMEMBER TO RETURN THIS PACKET AS SOON AS POSSIBLE TO SET UP YOUR NEW PATIENT APPOINTMENT. PLEASE REQUEST YOUR MEDICAL RECORDS BE SENT TO OUR OFFICE USING THE FORM PROVIDED. THANK YOU.**

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CONSENT TO RELEASE MEDICAL RECORDS & INFORMATION

I, \_\_\_\_\_ ,  
Printed Name

authorize the following physicians, laboratories and hospitals to release my records including diagnosis, treatment, exams and reports pertaining to services rendered to me to Devin A. Mikles, MD at Choices Integrative Healthcare of Sedona. I acknowledge that such records may possibly contain information related to mental health problems, drug or alcohol use, sexually transmitted diseases or HIV/AIDS testing and treatment.

PLEASE PRINT THE NAMES (AND ADDRESSES IF OUTSIDE OF ARIZONA) FOR THE FOLLOWING:

Physicians

Hospitals

Laboratories

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This consent will expire on \_\_\_\_\_ or sixty days after the date signed. I may revoke this consent at any time.


Patient Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Choices*   
*Integrative Healthcare  
of Sedona*

WELCOME TO CHOICES

It is with great pleasure that the staff of CHOICES welcomes you to a new experience in health care. We are confident that you will find your experience delightful, comfortable and life changing. We look forward to serving you and your family with health and healing therapies and programs that are individualized to your needs. Our chosen task is to optimize your well being, no matter what health challenges you may face. Our intention is to do this using the least invasive, safest, least toxic and most effective methods of health promotion and therapeutic modalities.

**What is Integrative Medicine?**

As an “integrative” practice, CHOICES is responding to the growing number of requests from the people in our communities to unite the best of many systems of healing and health promotion available into one system using scientific approach, and to provide this system in one location. Our goal is to provide a rational system of evaluation and treatment that will assist you in achieving the highest level of wellness for your mind, body and spirit. At CHOICES, we use a variety of different systems and modalities of healing. In addition to conventional practices of Medicine, we offer Traditional Chinese Medicine (including Acupuncture and Chinese Herbal Medicine), Physical Therapy, Chiropractic, Mind / Body Therapies, Nutritional Therapy, Homeopathy and Western Botanical (Herbal) Medicine. Please visit our website at [www.choiceshealthcare.com](http://www.choiceshealthcare.com) for a full explanation of these therapies.

**CHOICES Policies and Your Personal Evaluation:**

Whether you are intent on becoming a primary patient of CHOICES, or are coming by referral from your primary provider for special evaluation and treatment, we ask that you familiarize yourself with the policies of CHOICES and complete the comprehensive, personal health evaluation forms that you will find enclosed. We understand this is a time consuming task, and appreciate your commitment to your health. To achieve the best results from your experience at CHOICES, please return the fully completed forms prior to your initial appointment. It would be helpful if you would have pertinent medical records with you; we have a release form in this packet to assist you. Time for your initial evaluation may take 1 - 1 and 1/2 hours with the doctor, physician’s assistant or nurse practitioner. *Please be advised that a “Well Woman Exam” will not be performed on your “New Patient” visit. This will be scheduled at a later time due to the constraints of time and the requirements of many insurance companies.*

If the information in this packet does not answer all of your questions or if you require any clarifications please call us during regular business hours at 928-203-4844.

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## **Welcome To Choices Healthcare**

It is with great pleasure that Choices welcomes you to our office. As an “integrative” practice, Choices provides the best of many systems of healing and health promotion available in one location. In order for you to become familiar with our office, we ask that you familiarize yourself with the following information. Choices staff will be happy to answer any questions you have.

### **Office Hours**

General office hours are from 8:30 am – 12:30 pm and 2:00 pm to 4:30 pm, Monday through Friday. We do not answer the telephone from 12:00 noon to 2:00 to accommodate staff lunches. However, you may leave a message on our answering machine. We will return your call after 2:00 pm.

### **After Hours Coverage**

An answering service will take your call if you dial 800-813-8431. Either Dr Mikles or Dr Ansorg will return your phone call. This should be limited to emergency situations **only**.

### **Diagnostic Testing**

*Radiology services* are not available on site. If needed, tests will be arranged for you at Sedona Medical Center, Verde Valley Medical Center, Verde Valley Imaging or Flagstaff Medical Center.

Most *Laboratory services* are now available at Choices. If not available at Choices, tests ordered may be drawn at other draw stations. Occasionally your physician will desire that you have a lab study that is only available from a specialized lab. Special instructions will be given to you to complete these tests. **If you are unsure whether your insurance will cover these, you should contact your insurance company.** Remember you are ultimately and solely responsible for payment of these services. Most test results are normally available within 4-5 working days. **If tests are normal and you would like a copy of them, please speak with your provider during your appointment or contact the nurse by phone. If test results are significantly out of the normal range you will be notified by Choices.** *For all testing, billing will come from the providers for these services.*

### **Telephone Calls**

Telephone calls for advice regarding your health are billable services where applicable by law. For some patients, a telephone interview may be a reasonable method of follow-up for specific problems. Telephone calls for urgent problems will be referred to Choices nurses for assessment and triage.

### **Prescription Refills**

We do not accept prescription refill requests over the phone from patients or from pharmacies. In order for a prescription to be refilled the patient must make an appointment at the Nurse Clinic. At that time we will provide the prescription to either the patient or to the pharmacy. Patient will need to schedule refill appointments one to two weeks prior to running out of medication.

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For refills of botanical or other natural medicines, please call Choices Store at 928-203-4456, email at [store@choiceshealthcare.com](mailto:store@choiceshealthcare.com) or visit our website at [www.choiceshealthcare.com](http://www.choiceshealthcare.com) to check on availability. In general, you may pick up these refills at any time on a walk-in basis without notice.

When a patient is prescribed a controlled substance there are certain protocols the healthcare providers follow. The patient must be compliant with the practitioner's orders when receiving a controlled substance prescription.

### **Product Returns**

Only unopened products will be accepted for exchange or return credit within 60 days of purchase accompanied by a receipt.

### **Cancellations and No Shows**

Due to the amount of late cancellations and patients not showing up for their appointments, Choices Integrative Healthcare of Sedona has decided to change our policy. We now find it necessary to implement the following policy regarding:

### **Missed or Canceled Appointments**

When you fail to contact us of your inability to keep a scheduled appointment, another patient is prevented from seeing a provider and the provider's time is wasted.

Without 24 hours prior notification through the office or voicemail that you will be unable to keep your appointment you [not your insurance company] will be charged. The amount is determined by which provider the visit was with.

For Dr Mikles, Dr Ansorg, Bonnie Elkair, FNP, Jessica Caulkins, FNP or Kris Metzler the charge for a new patient appointment is \$50 and for a follow up visit for any missed or late cancellations is \$25.

For Dr Mary DeRose for a new patient appointment the cost is \$30 and \$15 for a follow up visit.

For IV Therapy there will be a \$25 charge for no shows or late cancellations.

Thank you for your consideration.

*Here is a brief description of our providers and practitioners at Choices.*

## **PRIMARY CARE PROVIDERS**

**DEVIN A. MIKLES, MD(H), F.A.C.P.** – is a Board-Certified Internist, and is the Medical Director of Choices. Since 1969, Dr. Mikles has been engaged in the study and practice of the therapeutic effects of diet and nutrition, skeletal manipulation and many forms of yoga, Western and Eastern herbalism and various types of bodywork therapies. He is currently practicing full time at Choices and is the Medical Director of Northern Arizona Healthcare Hospice. He espouses the belief that many systems of healing are gifts, to be used for our body, mind and spirit to meet their unique individual requirements for healing and support.

**HENNING ANSORG, MD** – is a Board-Certified Internist, and began his medical career in Germany. He graduated from Giessen University Medical School in 1984 and completed postgraduate training in Munich, and additionally completed an internal medicine residency at the University of Arizona in Tucson. He relocated to Sedona in 2002 He has a long interest and has much experience in integrative medicine. He is trained in acupuncture and also neural therapy for treatment of painful problems.

**Bonnie Elkhair, FNP-C, CNS** is a board certified Family Nurse Practitioner who specializes in helping patients live long, healthy, happy lives. Her focus is disease prevention and early detection of chronic illnesses. She is especially interested in working with patients and their families to prevent cancer, diabetes, and heart disease. She is experienced in managing women's health, including use of compounded bio-identical hormones when appropriate. Ms. Elkhair is also experienced in medical management of psychiatric illnesses.

Ms. Elkhair views her patient's health status within the context of the patient's personal goals, and in consideration of family, cultural, and environmental factors. She listens to her patients, and collaborates with them to formulate individualized strategies to achieve optimal wellbeing.

**Jessica Caulkins, FNP** is a board certified family nurse practitioner. Jessica has been serving the primary care needs for adults in Northern Arizona for the past year. She has a variety of experience working with adults with chronic illnesses, hospital acute care treatment, long term care and rehabilitation management. She has a special interest in the management of hypertension and diabetes.

## **ACUPUNCTURE PROVIDERS**

**BEVERLY COLEMAN, M.P.H., L.A.c.**—is a licensed acupuncturist, herbalist and nutritionist. She received her bachelor's degree in sociology/anthropology at Cal State University in Los Angeles and a master's of public health (MPH) in Behavioral Science/Health Education/Gerontology at UCLA. Beverly then earned a second master's in Traditional Chinese Medicine at Emperor's College in Santa Monica, California. Beverly has been an avid researcher and student of health-related matters for over 40 years and health care practitioner for the past 35 years.

## **SKELETAL MANIPULATION PROVIDERS**

**MARY DEROSE, D.C., R.N.** – is Advanced Certified in the Activator Technique of chiropractic medicine which delivers a very safe and effective low force adjustment appropriate for all body types and musculoskeletal disorders, allowing a more natural healing to occur.

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## **HOMEOPATHY PROVIDERS**

**JANA SHILOH, M.A., C.C.H.** (Certified in Classical Homeopathy), RSHom (NA- Royal Society of Homeopaths or North America), and HMA (Homeopathic Medical Assistant). – is one of the premiere homeopathic educators in the United States. She has lectured and taught homeopathy in various forums throughout the United States and in India. She also taught for a yearlong course at the University of Arizona Medical School in Tucson in a course co-sponsored by Dr. Andrew Weil. She assisted Medical Doctors, Chiropractors, Dentists and Naturopaths in the field of homeopathic treatment and homeopathic education over the past 24 years, as well as having written two books in homeopathy. She was honored with the title of “Honorary Homeopathic Clinical Associate” to Dr. Ronald Davey, the Official Homeopathic Physician to the Queen of England.

Jana Shiloh specializes in classical homeopathy; she looks for one remedy that can release the stored patterns on a physical, mental and emotional level that give rise to symptoms that cause disease and imbalance on one or more of those levels. In addition to the deep “constitutional” work, Jana has helped many with common illnesses, viral conditions and injuries- old and new- to assist in non-drug therapy. She works closely with Dr. Mikles in the “Integrated model” of health care. You may email her with any questions related to her work at [lighlife@gmail.com](mailto:lighlife@gmail.com), or call Choices and leave her a message.

## **BODY WORK PROVIDERS**

**KRIS METZLER, PT** -- has been working in the field of Physical Therapy since 1993. Kris treats people of all ages in need of assistance with physical ailments, pre and post-op surgical care and management of disabilities. As a "hands-on" orthopedic physical therapist, he also enjoys educating patients on techniques to manage and heal the symptoms of pain.

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**PATIENT INFORMATION:**

Name (Last) \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Local/Temporary/Visiting Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Telephone ( ) \_\_\_\_\_ Local Telephone ( ) \_\_\_\_\_  
 Fax Telephone ( ) \_\_\_\_\_ E Mail Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

**WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?**

Name: \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

**EMPLOYER INFORMATION:**

Name: \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

**Acknowledgement of Receipt of Privacy Notice**

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

Name of Patient: \_\_\_\_\_

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship to Patient  
(parent, legal guardian, personal representative, etc.)



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**Names of Family Members and Friends to Whom Choices may provide Information**

Currently we are prohibited from giving anyone who is not involved in your care any information about you.

Examples of issues we see are:

1. We are prohibited from giving anyone else a prescription for you to be picked up by someone else.
2. We may not give a family member a copy of your lab results that are requested by you but picked up by, perhaps, your spouse.

Please list the person(s) who may be given health information about you. Think about giving Choices Healthcare permission to provide information to your spouse and/or child(ren).

**You may provide information to the following persons:**

\_\_\_\_\_  
Printed Name Relationship to Patient

\_\_\_\_\_  
Printed Name Relationship to Patient

\_\_\_\_\_  
Printed Name Relationship to Patient

\_\_\_\_\_  
Printed Name Relationship to Patient

\_\_\_\_\_  
Patient or legally authorized individual signature Date

\_\_\_\_\_  
**Printed Name if signed on behalf of the patient Relationship to Patient**

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**INFORMED CONSENT REGARDING E-MAIL:**

I may use e-mail communication

- To request prescription refills
- To request appointments
- To request test results
- To request medical advice
- To share medical information with the doctor
- To discuss billing questions

I agree to comply with the following guidelines

- I will put the category of transaction in the subject line of the message for filtering: Prescription, Appointment, Test Results, Medical Advice, Medical Information, or Billing Questions
- I will put my full name and date of birth in the body of the message
- I will use an auto-reply feature to acknowledge reading the doctor's message
- I will try to keep messages concise

I understand that

- E-mail communication cannot be guaranteed to be entirely secure or confidential
- E-mail communication is not always read in a short time period after it is sent, so the telephone should be used for more 'urgent' communications
- Office staff may process my messages during usual business hours
- Turnaround time for messages received from me during business hours will typically occur within 1 business day, except when the doctor is out of town or on vacation
- E-mails are printed and retained as a part of my medical record
- When e-mail messages become too lengthy or the correspondence is prolonged, I may be called or notified to come in to discuss the matter
- I may be reminded by the Choices when I do not adhere to the guidelines
- The e-mail relationship may be terminated if I repeatedly do not adhere to the guidelines
- Any liability of harm for any information loss due to technical failures is waived by Choices

Choices Integrative Healthcare of Sedona agrees

- To provide automatic reply to acknowledge receipt of my messages
- To send new messages to inform me of completion of my request
- Not to send group mailings where recipients are visible to each other. Blind copy features are used
- To have security systems in place, e.g., password-protected screen savers on all desktop workstations in every location that e-mail can be viewed
- E-mails will not be forwarded to any third party without my expressed permission . That my e-mail account will never be used in any marketing schemes, nor shared with physician's family members
- That any patient identifiable information, social security numbers or birth dates are only sent via encryption if the communication is wireless

I will receive a copy of this e-mail informed consent and another is included in my medical record

Patient Name \_\_\_\_\_ Witness Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Witness Signature \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_

Choices Integrative Healthcare of Sedona  
Statement of Patient Financial Responsibility

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Choices Integrative Healthcare of Sedona appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Choices Integrative Healthcare of Sedona, for providing healthcare services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Choices Integrative Healthcare of Sedona, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Administrative Fee

I understand in order to be a patient of Choices Healthcare; I will pay an annual \$100 fee. This fee covers administrative costs that are not covered by insurance companies or cash fees.

Patient/GuarantorSignature \_\_\_\_\_ Date \_\_\_\_\_

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Deductible Policy

Some health insurance carriers require the patient to pay a deductible before the insurance carrier will pay for services rendered. It is expected and appreciated that the patient pays their portion at EACH VISIT until the deductible is met for the year. Thank you for your cooperation in this matter.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent for Treatment and Authorization to Release Information

I hereby authorize Choices Integrative Healthcare of Sedona, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Choices Integrative Healthcare of Sedona, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Advance Beneficiary Notice

Medicare, Supplemental and private insurance companies requires issuance of an ABN whenever the medical service provider expects Medicare or other insurance companies might not pay for a medical treatment, service or supply. Providers make ruling based on Medicare Program and other insurance standards, which outline reasonable and necessary services. Medicare and other insurance companies can exclude payment for such items and services as eye examinations, tests related to screening procedures, chiropractic services, self-administered medications (typically noninjected medications) and immunizations.

I understand that I will need to sign an ABN, if I have Medicare, or an Advance Medical Services Payment agreement, if I have a replacement or private insurance, if the provider of services deems it necessary for me to do so. Doing so, I understand that I am ultimately responsible for any test, procedures or immunizations performed during my visit.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Non-Sufficient Funds

I understand that if for any reason a check or credit card payment is denied or returned to Choices Integrative Healthcare of Sedona, I will be responsible to pay a \$35 fee.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. I understand there is also a \$25 charge per no show or late cancellation that will be billed to me by the practice.

Choices Integrative Healthcare of Sedona will notify you in writing, via certified mail, if you are discharged from care.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Choices Integrative Healthcare of Sedona. I agree to pay Choices Integrative Healthcare of Sedona, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

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Our clinic is participating in a national initiative to measure and improve the quality of care people receive. We are asking about your ethnicity and race for demographic purposes. However, providing this information is completely voluntary and will not affect your health care

Circle appropriate selection(s)

Hispanic or Latino

Not Hispanic or Latino

Circle appropriate selection(s)

Asian

African American

Native Hawaiian or Other Pacific Islander

Native American/Alaska Native

White (Caucasian)

Other \_\_\_\_\_

Language Spoken at Home:

\_\_\_\_\_

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**History of Present Illness**

1. What is (are) the *main* problem(s) you would like us to help you with?

Date Started

Problem A - \_\_\_\_\_  
Problem B - \_\_\_\_\_  
Problem C - \_\_\_\_\_  
Problem D - \_\_\_\_\_

2. For each problem you listed above please tell us:

**Problem A**

Symptoms	Treatments That Work	Treatments That Don't Work	Diagnosis You Have Been Given	Daily Activities Interfered With

**Problem B**

Symptoms	Treatments That Work	Treatments That Don't Work	Diagnosis You Have Been Given	Daily Activities Interfered With

**Problem C**

Symptoms	Treatments That Work	Treatments That Don't Work	Diagnosis You Have Been Given	Daily Activities Interfered With

**Problem D**

Symptoms	Treatments That Work	Treatments That Don't Work	Diagnosis You Have Been Given	Daily Activities Interfered With







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8. Family Medical History – Please complete the following table for your father, mother, and your maternal and paternal grandparents, as well as your children, brothers and sisters, and maternal and paternal aunts and uncles.

Write in any of your Family members named above with <b>any</b> of the following health problems.	Mother	Maternal Grandmother	Maternal Grandfather	Mother's Sisters	Mother's Brothers	Father	Paternal Grandmother	Paternal Grandfather	Father's Sisters	Father's Brothers	Other Immediate Family	Sibling	Sibling	Sibling	Sibling	Son	Son	Daughter	Daughter
	Year of Birth																		
Age at death																			
Alcoholism																			
Anemia																			
Arthritis																			
Asthma																			
Bleeding Disorder																			
Cancer																			
Chemical Dependency																			
Diabetes																			
Epilepsy/Seizure Disorder																			
Gall Bladder Disease																			
Glaucoma																			
Heart Disease																			
Hepatitis/Jaundice																			
High Blood Pressure																			
Kidney Disease																			
Liver Disease																			
Lung Disease																			
Lupus																			
Migraines																			
Psychiatric Disorder																			
Reaction to Anesthesia																			
Rheumatic Fever																			
Stomach Problems																			
Stroke																			
Thyroid Disease																			
Tuberculosis																			
Ulcer Disease																			
Other																			

## Review of Systems

Please check any of the following problems that you have or have had in the past.

	X		X		X		X
<b>General Complaints</b>		<b>Emotional/Mental Complaints</b>		<b>Digestive Complaints</b>		<b>Head, Eyes/Ears/Nose Throat Complaints</b>	
General Stiffness		Cry Easily		Hypoglycemia		Frequent Sties	
Hernia		Poor Concentration		White Stools		“Floaters” in Vision	
High Sex Drive		Unwanted Thoughts		High Cholesterol		Voice Disorder	
Poor Sex Performance		Irritable		Gout		Lump in Throat	
Fatigue		Immobilizing Fears		Pancreatitis		Stuttering	
Head Feels Too Heavy		Suicide Thoughts		Bitter Mouth Taste		Loss of Smell	
Hay fever		No Interests/Goals		Gurgling Abdomen		Loss of Taste	
Excessive Perspiration		Grief Over a Loss		Hungry All the Time		Tightness in throat	
Diabetes		Nervousness		Irritable Bowels		Inflammation of Throat	
Cancer		Inner Tension		Nervous Stomach		Loss of Vision	
Cold Feet		Psychiatric Treatment		Liver Trouble		Glasses	
Rapid Weight Loss		Depression		Gallbladder Trouble		Glaucoma	
Rapid Weight Gain		When Upset or Nervous:		Ulcers		Cataract	
Weakness		<i>Use Alcohol</i>		Difficulty Swallowing		Retinal Disease	
Fevers		<i>Use Drugs</i>		Frequent Heartburn		Macular Degeneration	
Night Sweats		<i>Use Too Much Food</i>		Nausea or Vomiting		Double Vision	
Headaches		Anxiety/Restlessness		Blood in Stool or Urine		Hearing Loss	
Thyroid Problem		Quick Temper		Black Stool		Hearing Aids	
Insomnia		Excess Daydreams		Colon Polyps		Ringing in the Ears	
Allergies		Hear Voices		Constipation		Ear Pain	
Exposure to Toxins		See Visions		Diarrhea		Sinus Problems	
Excessive Thirst		Empty of Feelings		Hepatitis/Jaundice		Nosebleeds	
Loss of Appetite		Frequently Very Sad		Bad Breath		Nasal Polyps	
Chills		Bad Dreams		Belching		Dental Problems	
Localized Weakness		Must Be With People		Chronic Laxative Use		Gum Disease	
Bleed or Bruise Easily		Great Loneliness		Abdominal Pain/Cramping		Hoarseness	
Odd Tastes or Smells		Feel Uninvolved		Rectal Pain		Facial Pain	
Thirst		Isolate Self		Hemorrhoids		Night Blindness	
No Desire to Drink		Dread Social Events		Other Digestive Problems		Eye Pain	
Sudden Energy Drop		Overdo at Work		Other _____		Eye Strain	
Edema in _____		Phobias		<b>Nervous System</b>		Eye Dryness	
Change in Appetite		Strong Hatreds		Paralysis		Excessive Tears	
Poor Appetite		Can't Take Stress		Shooting Pain in Head		Discharge from Eyes	
Other _____		Other _____		Twitching in Face		Discharge from Ears	
<b>Respiratory Complaints</b>		<b>Contagious Diseases</b>		Loss of Balance		Nasal Drainage	
Emphysema		HIV/AIDS		Light Bothers Eyes		Grinding Teeth	
Pneumonia		Rheumatic Fever		Tremors		Jaw Clicks	
Night Coughing		Dysentery (Runs)		Seizures		Recurrent Sore Throats	
Dry Cough		Herpes		Serious Head Injury		Sores on Lips or Tongue	
Blood in Sputum		Venereal Disease		Dizziness		Other _____	
Asthma Symptoms		Tropical Disease		Memory Problems		<b>Kidney/Bladder Complaints</b>	
Production of Phlegm		Tuberculosis		Loss of Consciousness		Bladder Infection	
<b>Color?</b>		Mononucleosis		Numbness or Tingling		Kidney Infection	
Bronchitis		Other		Vertigo		Kidney Stones	

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Other _____				Lack of Coordination		Other _____	
				Other _____			
	X		X		X		X
<b>Hair/Skin/Nail Complaints</b>		<b>Muscle/Bone/Joint Complaints</b>		<b>Blood/Heart/ Circulation Complaints</b>			
Psoriasis		Muscles Weak		Stroke			
Nails Break and Split		Leg Spasms		Left Arm Pain			
Boils		Rib Pain		Irregular Heartbeat			
Nail Fungus		Neck Muscle Spasms		Arteries Hardening			
Rashes or Itching		Grating in the Neck		Sickle Cell			
Change in Skin or Hair		Tightness in Shoulders		Congestive Heart Failure			
Ulcerations		Cold Hands		Face Flushed			
Oozing on Skin Lesions		Swollen Joints		Low Blood Pressure			
Hives		Herniated/Bulging Discs		Blood Clots, Phlebitis			
Pimples		Sciatica		Varicose Veins			
Recent Moles		Neck Pain		Chest Pain			
Hair Breakage		Back Pain		High Blood Pressure			
Cysts		Elbow Pain		Heart Murmur			
Loss of hair		Hand/Wrist Pain		Shortness of Breath			
Dandruff		Hip Pain		Swelling Feet/Ankles			
Other _____		Knee Pain		Anemia			
		Foot/Ankle Pain		Bleeding Problems			
		Muscle Pain		Other _____			
		Other _____					



**Men's Health Assessment**

1. Please answer the following questions.

Are you sexually active?  No  Yes  
 What type of contraception do you use? \_\_\_\_\_  
 When was your last prostate (digital rectal) exam? \_\_\_\_\_  
 When was your last prostate specific antigen (PSA) test? \_\_\_\_\_  
 Have you had a vasectomy?  No  Yes \_\_\_\_\_ Date  
 Any complications? \_\_\_\_\_  
 Do you wake up to urinate?  No  Yes How Often? \_\_\_\_\_

2. Please check any of the following problems that you have or have had in the past and list ages or occurrence(s):

X	Age of Occurrences	Problem
		Pain on Urination
		Urgency to Urinate
		Frequent Urination
		Decrease in Urine Flow
		Unable to Hold Urine
		Dribbling
		Burning During Urination
		Urination Difficulty
		Unpredictable Erections
		Wet Dreams
		Premature Ejaculation
		Sterility
		Impotence
		Change in Sexual Drive
		Diminished Sexual Drive
		Pain in the Groin Area
		Pain in Testicles
		Irregular Growth on Penis
		Tumors or Cysts
		Discharge
		Sores on Genitals
		History of Prostate Trouble
		Prostate Infection

**Women's Health Assessment**

1. Please answer the following questions:

Are you sexually active?  No  Yes  
 What type of contraception do you use? \_\_\_\_\_  
 Are you presently pregnant?  No  Yes If so, # of weeks? \_\_\_\_\_  
 Have you ever been pregnant  No  Yes  
 Number of Pregnancies? \_\_\_\_\_ Complications? \_\_\_\_\_  
 Number of Premature Births? \_\_\_\_\_ Complications? \_\_\_\_\_  
 Caesarian Section(s)? \_\_\_\_\_ Complications? \_\_\_\_\_  
 Miscarriages? \_\_\_\_\_ Complications? \_\_\_\_\_  
 Terminated Pregnancies? \_\_\_\_\_ Complications \_\_\_\_\_  
 Have you had a tubal ligation?  No  Yes Complications? \_\_\_\_\_  
 Have you had a hysterectomy?  No  Vaginal  Abdominal \_\_\_\_\_  
 If yes, complications? \_\_\_\_\_  
 Have you had your ovaries removed?  No  Yes Complications? \_\_\_\_\_  
 What is the date of your last pap smear? \_\_\_\_\_  
 What is the date of your last gynecological exam? \_\_\_\_\_  
 Do you perform breast self-examination  No  Yes  
 If yes, have you noticed and changes you are concerned about? \_\_\_\_\_  
 When was your last mammogram? \_\_\_\_\_  
 What was your age when you started menstruation? \_\_\_\_\_  
 What was the date of the first day of your last menstruation? \_\_\_\_\_  
 What is the period of time between menstrual periods? \_\_\_\_\_  
 What is the duration of your menstrual periods? \_\_\_\_\_ Days  
 Amount of menstrual flow  light  medium  heavy  
 What is the color of your menstrual flow? \_\_\_\_\_  
 Do you wake up to urinate?  No  Yes How often? \_\_\_\_\_

X	Problem	X	Problem	X	Problem
	Pain on Urination		Mood Swings on Menses		Infertility
	Urgency to Urinate		Body Change Before Menses		PID (Pelvic Inflamm Disease)
	Frequent Urination		Explain:		Change of Sexual Drive
	Unable to Hold Urine		Post Coital Bleeding		Menopause
	Dribbling		Impotence		Menopausal Symptoms
	PMS: Explain		Breast Discharge		(Hot Flashes, etc)
			Breast Cysts/Lumps/Growth		Please List:
	Premenstrual Tension/Depression		Breast Pain and/or Swelling at Menses		
	Painful Menstruation/Cramps		Uterine Fibroids		
	Menses Excessive/Prolonged		Ovary Cysts/Inflammation		
	Menses Scanty or Missing		Positive Pap Smear		
	Clots		Pelvic Infection		
	Abnormal Vaginal Discharge		Vaginal Infections		
	Color _____ Quantity _____		Vaginal Sores		
	Odor _____ Consistency _____		Endometriosis		

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**Choices Integrative Healthcare of Sedona**

95 Soldiers Pass Rd

Suite B

Sedona, AZ 86336

Telephone - 928-203-4844

Fax - 928-203-4497

## Joint 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.

If you have any questions about this notice please contact our privacy contact who is: **Office Manager**.

This "Joint Notice of Privacy Practices" describes how we may use or disclose your protected health information (medical records) to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of the Joint Notice of Privacy Practices. [We may change the terms of our notice at any time.] Any modification will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised notice of privacy practices by accessing our website ([www.choiceshealthcare.com](http://www.choiceshealthcare.com)) or asking for one at the time of your next visit to the office.

We must make a good faith effort to obtain your written acknowledgement that you have received our Joint Notice of Privacy Practices. If you refuse to acknowledge receiving the notice we must know why. This information must be documented in your protected health information.

You should also know that we are happy to take this opportunity to share our feelings about the responsibility we feel toward you and the private information you have entrusted to us. While your original medical chart belongs to the clinic, you have a right to know what is in it. You may request and receive information you request from your personal protected health information. The clinic requires twenty-four (24) hours notice to fulfill such a request.

This **Joint Notice of Privacy Practices** covers all health care providers at Choices Integrative Healthcare of Sedona which is considered an "organized health care arrangement." Choices Integrative Healthcare providers may be physicians, nurse practitioners, physical therapists, mental health counselors, chiropractors, acupuncturists, manual therapists and other therapists who provide alternative and traditional health services.

### I. USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

The primary use for your medical record remains to help your health care provider keep track of your health history including all the symptoms that have brought you to the clinic, your family health history, examination and test results, diagnoses made, treatments supplied and recommended and medications given. All health care providers at Choices Integrative Healthcare of Sedona may share your medical information with one another to carry out treatment, payment or health care operations.

**We are permitted by law to use your protected health information for "treatment, payment and health care operations without your consent.** What does this mean? It means that the information in your medical record may be used and disclosed by Choices Integrative Healthcare providers, our office staff and others outside of our office that are involved in your care for the purpose of providing health care services to you. The following examples are intended to inform you of some of the ways we might use your medical record without your consent. *This listing of examples is not intended to be exhaustive.*

#### TREATMENT

- ⇒ They might be sent to another doctor or therapist who you or we are asking to take part in your care.
- ⇒ They might be sent to a home health agency that provides care for you.
- ⇒ Information might be sent to a laboratory or other testing facility.
- ⇒ They might be used in a practitioner team meeting in order to evaluate and facilitate the coordination of your care.



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PAYMENT

- ⇒ Our billing personnel might review a progress note in order to accurately bill your insurance company.
- ⇒ We might send a copy of a course of treatment to an insurer who requests written support for a bill we have sent them for your care.
- ⇒ Your insurance may review your records for benefit or medical necessity determination, or utilization review activities.

HEALTH CARE OPERATIONS

- ⇒ We might use them as part of our quality assessment program in which we review the care our patients receive to be sure we are documenting well and that each provider is rendering medically appropriate care.
- ⇒ They might be used in activities related to training a medical or physical therapy student.
- ⇒ We may use a sign-in sheet at the registration desk and we may call your name when a provider is ready to see you.
- ⇒ We may contact you to remind you of an appointment.
- ⇒ Your records might be seen by business associates whom we hire to do such things as help us store our records electronically, devise better record systems or perform other jobs related to the efficient operation of our clinic.

To protect your privacy in these cases, we require all of these parties to demonstrate that they comply with our confidentiality requirements and to sign an agreement that limits what they can do with the records.

**Other uses and disclosures of your medical records will be made only with your written authorization unless required or permitted by law.** You may revoke this authorization, at any time, except to the extent that your provider or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.**

We may use and disclose your records in the following instances. You have the opportunity to agree or object to the use of all or part of your records. If you are not present or able to agree or object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

OTHERS INVOLVED IN YOUR CARE: We may disclose to a member of your family, a relative, a close friend or any other person you identify, information that relates directly to that person's involvement in your health care. We may use or disclose information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally we may use or disclose your information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

EMERGENCIES We may use or disclose your information in an emergency treatment situation.

COMMUNICATION BARRIERS We may use or disclose your information if your provider attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent to use and disclosure under the circumstances.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object.**

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

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**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports about abuse or neglect. In addition, if we believe you have been a victim of abuse, neglect or domestic violence we disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**FDA:** We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any tribunal judicial or administrative proceeding, in response to an order of the court or administrative tribunal (to the extent that such disclosure is expressly authorized), in certain conditions to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or to perform other duties authorized by law. We may also disclose such information to a funeral director in order for him/her to carry out their duties. We may also disclose such information in reasonable anticipation of death for cadaver organ, eye or tissue donation purposes.

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

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are armed forces personnel, or to authorized federal officials for conducting national security or intelligence activities.

**Workers Compensation:** we may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you 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 et. Seq.

## II. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of your medical, billing and other records that are contained in a designated record set for as long as we maintain the information. This information is used by the practice for making decisions about you.

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 information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be review able. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

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**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 operation. You may also request that any part of such 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 healthcare provider is not required to agree to a restriction that you request. If the healthcare provider believes it is in your best interest to permit disclosure of your protected health information, it will not be restricted. If your provider does agree to the requested restriction, we may not use or disclose the information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. You may request a restriction by completing the final section of this agreement. It will then be reviewed and attached to your medical record.

**You have the right to receive confidential communication from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to have your provider amend your protected health information.** This means you may request an amendment of your protected health information about you as a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**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 electronically.

### III 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 against us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Genevieve Samson (928) 203-4863 or [gsamson@choiceshealthcare.com](mailto:gsamson@choiceshealthcare.com) for further information about the complaint process. This notice was published and becomes effective on April 14, 2003.

**Choices Integrative Healthcare of Sedona  
95 Soldiers Pass Rd., Suite B  
Sedona, AZ 86336**

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