NEW PATIENT HEALTH SURVEY

Welcome to our practice. As a new wellness patient, please answer the questions below completely. The Initial Consult Fee is $ 199.00

Date ____________________
Patient Name ______________________________ **Birth Date** ______________________________
Home Phone ______________________________ **Work or Cell Phone** ______________________________ **Email** ______________________________

Address ______________________________ **City** ______________ **State** __________ **Zip Code** ____________

Do you have any medically diagnosed health conditions?

____

MEDICAL HISTORY:

Are you under the care of a physician for any reason? If yes, what is the reason?

____

Who is your current family physician? ______________________________ **Specialist?** ______________________________

Date of your last physical exam ____________________ **When did you have your last blood tests?** ______________________________

List any surgeries or major illness with date of occurrence ______________________________

Have you had any infectious diseases? ______________________________

Have you been hospitalized for any condition? What?______________________________

Do you have any allergies to ANYTHING? ______________________________

Have you ever reacted to medications? Which ones? What happened

____

MEDICATIONS: List all prescription or over-the-counter drugs you are taking ______________________________

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FAMILY HISTORY: Please indicate if your mother, father, or sibling has had any of the following conditions?

Heart or coronary arterial disease (congestive heart failure, angina, etc.) ______________________________

Atherosclerosis (hardening of the arteries) ______________________________

High cholesterol or other form of abnormal lipids ______________________________

Heart attack or stroke ______________________________

Diabetes or any form of metabolic disease or obesity ______________________________

Cancer and list type(s) ______________________________

Osteoporosis or any form of bone disease ______________________________

Thyroid disease ______________________________

List any other diseases in your family ______________________________

In case of emergency, notify ______________________________ **Phone No.** __________________**Relationship** ______________

I understand that all fees for consultations, examinations, treatments, and supplies are to be paid for as they are received. My signature is consent for consultation and treatment.

PATIENT'S SIGNATURE: ______________________________ **Date** ________________

INFORMED CONSENT FOR TREATMENT

________I understand that Root Causes Holistic Health and Medicine LLC is an Integrative Medicine practice focusing primarily whole body health and wellness through the use of naturally occurring compounds as much as possible, while using pharmacologic interventions when necessary and in the best interest of the client. Integrative Medicine is personalized care that blends conventional medicine with evidence-based complementary/integrative therapies. Therapies are individualized to the patient. Recommended therapies may include, but are not limited to, traditional prescription medication, mind-body modalities such as meditation, yoga, and guided imagery, biologically based therapies such as vitamins, herbs and other supplements in oral, injectable and intravenous forms, MESO therapy, PRP treatments, injections of various prescriptive compounds for therapeutic purposes, nutritional recommendations, exercise recommendations, other systems of medicine-based therapies such as homeopathy, and oxygen therapies including hyperbaric, ozone insufflation and intravenous ozone.

_______Individualized treatment plans are evidence-based, safe, and custom-designed to meet the patient's needs and goals. Evidence base changes frequently for Integrative Medicine and recommendations are done with the evidence base available at that time for your particular condition. These recommendations will very likely not be what is considered to be the medical/legal "standard of care". Your primary care practitioner is likely the person you will want to see for "standard of care" protocols. Root Causes Holistic Health and Medicine LLC never recommends stopping conventional medical care or treatment. Please retain your primary care provider.

_______I understand that Doreen DeStefano is an Advanced Practice Registered Nurse (Nurse Practitioner) with a **Doctorate in natural health** and that **she is not Medical Doctor.** The Medical Director for Root Causes Holistic Health and Medicine is Barry Butler MD. The IV therapy physician is Richard Wilson, DO.

________An integrative medicine consultation may include: Individualized consultation with lifestyle and nutrition recommendations, Individualized recommendations for supplements, vitamins/herbs, bio-identical hormone evaluations, individualized protocols for your specific concerns, lab testing of blood, sputum, stool or urine, a physical examination and referral to other therapeutic providers for care not provided by Root Causes Holistic Health and Medicine. Some modalities are not the "standard of care" by legal definition of such. For standard, primary care medicine, please see your primary care provider.

__________ I understand that services at Root Causes Holistic Health and Medicine are not covered by insurance. I understand that Root Causes Holistic Health and Medicine, LLC, does not accept insurance nor does Root Causes provide billing codes to submit claims to insurance. I am responsible for payment at the time of service. Payment accepted is in the form of cash, check, or credit card.

_______I understand that labs studies conducted on my behalf confer a professional responsibility to the practitioner. Lab tests require diagnostic codes and interpretation. Therefore, lab slips are not

given without an appointment to determine medical diagnosis/necessity, and a lab review appointment to interpret and act on results.

_______I understand that I have the right to choose which recommendations to incorporate into my treatment plan and that I should always communicate any new treatments, including vitamins, herbs, and supplements to my entire healthcare team.

________I understand that Root Causes Holistic Health and Medicine, LLC implies no guarantee of outcomes from any treatment and/or recommendations provided to me, that I have the right to choose my treatment plan and that I may refuse any or all treatment recommendations at any time. There are no guarantees that your condition will improve or resolve. No guarantees have been given to me by Doreen DeStefano or any of her personnel regarding cure or improvement of my condition.

_______ I understand that not following the entire protocol recommended to me may affect the results and that I may not achieve the stated goals if the protocol is not followed.

________I acknowledge that I have not been asked to stop/discontinue care provided by my specialty or primary care medical teams.

_______ I understand that this is a fee for service practice and Initial consultations **may be** up to $425.00 and payment is expected at the time of service.

________I understand that integrative medicine information is constantly updated and that Doreen DeStefano may not be able to anticipate and explain all potential risks and complications due to the ever-changing nature of the field. I agree to allow Doreen DeStefano to exercise her best clinical judgment in my case based on the information available to her at my time of visit.

_________I understand all the facts given to me in this form. I give my consent to Doreen DeStefano and Root Causes Holistic Health and Medicine, LLC to provide Integrative Medicine services for me. I acknowledge that no guarantee of services have been made to me regarding any treatment and/or recommendations provided to me. I have read and understand the information on this form. I have had the chance to ask questions, and all of my questions have been answered.

_______ I hereby acknowledge that I understand that my Insurance coverage, including Medicare, will not pay for this Noncovered service, and that all services ancillary to this treatment may also be Non-covered services and Non-reimbursable. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

________ I acknowledge that Root Causes Holistic Health and Medicine has a 24 hour cancellation policy. If it is necessary to cancel my appointment, I will do so with more than 24 hours' notice. I acknowledge and give my permission that on the third time I cancel within 24 hours, or do not show up for my appointment, Root Causes Holistic Health and Medicine LLC will charge my card the full amount of the scheduled visit.

_______ I understand that all nutrient supplement and service purchases are final. In any case of a dispute of charges, I authorize all medical information to be released to all credit card companies.

Patient's Name (Please print)____

Signature of patient:____ Date:________________

Signature of Provider:____ Date:________________