



**Virender Sodhi, M.D. (Ayurved), N.D.**  
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**Anju Sodhi, B.A.M.S., N.D.**  
 PANCHA KARMA TECHNICIAN:  
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## PATIENT INFORMATION AND RELEASE FORM

Patient: \_\_\_\_\_  
 Last Name First Name Middle

Address: \_\_\_\_\_  
 Street or P.O. Box City State Zip Code

Home Phone: \_\_\_\_\_ Work : \_\_\_\_\_ Mobile/Other: \_\_\_\_\_

Email: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Gender:     Male                     Female                     Other

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_ Relationship: \_\_\_\_\_

Payer's Home Phone: \_\_\_\_\_ Payer's Work Phone: \_\_\_\_\_

Payer's Address: \_\_\_\_\_  
 Street or P.O. Box City State Zip Code

Payer's Employer: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
 Street or P.O. Box City State Zip Code

How did you hear about Ayurvedic & Naturopathic Medical Clinic?  
 \_\_\_\_\_  
 \_\_\_\_\_

### PRESENT HEALTH CONDITION

In your opinion, what are your most important health concerns? Please list these below in order of their significance. Please indicate the problem that motivated you to come today:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

What other health care are you currently receiving?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### YOUR HEALTH HISTORY

Health as a Child:     Good                       Fair                       Poor

Childhood Illnesses:     Scarlet Fever             German Measles         Measles         Mumps  
                                  Bronchial Problems     Rheumatic Fever         Diphtheria         Other

Hospitalizations (Year & Reason): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries (Year & Type): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Immunizations /Vaccinations:     Smallpox                       Polio                       Typhoid  
    Mumps                       Tetanus/DPT             Influenza

Any Vaccination Reaction: \_\_\_\_\_

### GENERAL SYSTEMS REVIEW

Date of Last Physical Examination: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Weight One (1) Year Ago \_\_\_\_\_ Max Weight: \_\_\_\_\_ When? \_\_\_\_\_  
Diagnosis Current or Past: \_\_\_\_\_

Medications or Supplements – prescription and non-prescription drugs, herbs, & homeopathies you currently take:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies – Food, Drugs, Chemicals, Other (please list all known):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GENERAL SYSTEM REVIEW continued**

<b>FAMILY HISTORY</b>	Father	Mother	Brothers	Sisters	Spouse	Child	Other
Age (if living)							
Age (at death)							
Cause of Death							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Stroke							
Epilepsy							
Mental Disorder							
Asthma, Hay Fever							
Hives, Urticaria							
Anemia							
Kidney Disease							
Glaucoma							
Tuberculosis							
Syphilis							
Other (specify)							

Habits:     Alcohol                       Caffeine                       Tobacco                       Cannabis  
 Other Recreational Drugs                      Other: \_\_\_\_\_

Diet History:  
Any Dietary Restrictions? \_\_\_\_\_  
How is Your Appetite? Do You Eat                       Slowly                       Rapidly  
How many meals per day do you eat? \_\_\_\_\_                       Snacks?                       Are You a Thirsty Person?  
Do you prefer foods to be                       Hot In Temperature                       Cold In Temperature  
Do You Crave:                       Hot In Temperature                       Cold In Temperature  
 Sweet                       Sour                       Spicy                       Bitter                       Starches                       Butter or other Fats  
Do You Like Any Particular Foods? \_\_\_\_\_ Dislike Any? \_\_\_\_\_

<b>DO YOU LIKE TO EAT THE FOLLOWING FOODS:</b>	Daily	Weekly	Monthly	Never
Grains/Cereals				
Vegetables				
Fruits				
Dairy				
Eggs				
Poultry				
Meal				
Seafood				
Sugar / Honey				
Desserts				
Juices				
Other				

## GENERAL SYSTEM REVIEW continued

How is Your Sleep?     Good         Fair         Poor        Average Hours of Sleep/Night \_\_\_\_\_

Do You Exercise Regularly?  Yes         No    If Yes, How Frequently & How Long? \_\_\_\_\_

What Type of Exercise Do You Like? \_\_\_\_\_

### Other Information

**Please Check All That Apply**

	PAST	CURRENT		PAST	CURRENT
<b>ENERGY</b>			<b>EARS</b>		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Ringing, Hissing, Buzzing	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Earaches, Itching	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Drop in Energy	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
			Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
<b>SKIN &amp; HEAD</b>			<b>NOSE &amp; SINUSES</b>		
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Stuffiness	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Growths	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Pimples	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Hair	<input type="checkbox"/>	<input type="checkbox"/>	<b>MOUTH &amp; THROAT</b>		
Use of Hair Dye	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Nails	<input type="checkbox"/>	<input type="checkbox"/>	Sore Tongue	<input type="checkbox"/>	<input type="checkbox"/>
			Gum Problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAD</b>			Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>			
			<b>DIGESTION</b>		
<b>EYES</b>			Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Change in Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Night Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>
			Loose Stools	<input type="checkbox"/>	<input type="checkbox"/>
<b>NECK</b>			Blood in Stools:	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	Belching or Gas	<input type="checkbox"/>	<input type="checkbox"/>
Pain & Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
<b>BLOOD</b>				PAST	CURRENT
Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
Easy Bleeding, Bruising	<input type="checkbox"/>	<input type="checkbox"/>			

## Other Information Continued

Please Check All That Apply

	PAST	CURRENT		PAST	CURRENT
<b>URINARY</b>			<b>HEART</b>		
Pain with Urination	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Increase in Frequency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Frequency at Night	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGIC</b>			<b>CIRCULATION</b>		
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Deep Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<b>MUSKULOSKELETAL</b>		
Numbness or Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			<b>EMOTIONAL</b>		
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Difficult Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>
Pain with Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness Lying Down	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness at Night	<input type="checkbox"/>	<input type="checkbox"/>			
Positive TB Test	<input type="checkbox"/>	<input type="checkbox"/>			

## AYURVEDIC PSYCHOSOMATIC BODY TYPES & IMBALANCE QUESTIONNAIRE – page 1

Please Answer All Questions

		PAST	CURRENT
<b>ABILITY TO WITHSTAND STRESS</b>			
<b>V</b>	Poor	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Moderate	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Strong	<input type="checkbox"/>	<input type="checkbox"/>

**TEMPER**

<b>V</b>	Easily Irritated or Provoked	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Emotional Outbursts or Short Circuit	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Very Tranquil or Peaceful	<input type="checkbox"/>	<input type="checkbox"/>

**APPETITE**

<b>V</b>	Variable	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Large	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Little	<input type="checkbox"/>	<input type="checkbox"/>

**TYPICAL MEAL SIZE**

<b>V</b>	Small	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Medium	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Large	<input type="checkbox"/>	<input type="checkbox"/>

**NUMBER OF MEALS TYPICALLY  
CONSUMED PER DAY**

<b>V</b>	_____
<b>P</b>	_____
<b>K</b>	_____

**BOWEL MOVEMENTS**

<b>V</b>	Irregular or Hard/Constipated	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Irregular or Loose	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Regularly Formed	<input type="checkbox"/>	<input type="checkbox"/>

**NUMBER OF BOWEL MOVEMENTS  
AFTER TAKING PURGING AGENT**

<b>V</b>	<b>1</b> Usually One	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	<b>4</b> Or More	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	<b>2-3</b>	<input type="checkbox"/>	<input type="checkbox"/>

**SLEEP PATTERNS**

		PAST	CURRENT
<b>V</b>	<b>6</b> Hours or Less	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	<b>6-8</b> Hours	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	More than <b>8</b> Hours	<input type="checkbox"/>	<input type="checkbox"/>

**MENTAL CONCENTRATION**

<b>V</b>	Strong	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Moderate	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Weak	<input type="checkbox"/>	<input type="checkbox"/>

**SEXUAL DESIRE**

<b>V</b>	Little	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Moderate	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Large	<input type="checkbox"/>	<input type="checkbox"/>

**PHYSICAL BUILD**

<b>V</b>	Thin/Hard Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Medium	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Heavy/Easy Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>

**TASTE PREFERENCES**

<b>V</b>	Sweet	<input type="checkbox"/>	<input type="checkbox"/>
<b>V</b>	Sour	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Salty	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Bitter	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Astringent	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Pungent (Spicy)	<input type="checkbox"/>	<input type="checkbox"/>

**RELIGIOUS BELIEF**

<b>V</b>	No Established Belief	<input type="checkbox"/>	<input type="checkbox"/>
<b>P</b>	Belief as per Convenience	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Established Belief in God	<input type="checkbox"/>	<input type="checkbox"/>
<b>K</b>	Other Established Belief	<input type="checkbox"/>	<input type="checkbox"/>

## AYURVEDIC PSYCHOSOMATIC BODY TYPES & IMBALANCE QUESTIONNAIRE – page 2

Please Answer All Applicable Questions

	PAST	CURRENT
<b>FEMALE REPRODUCTION</b>		
Age Menses Began	_____	
# of Days per Menstrual Flow	_____	
Bleeding Between Periods	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Cycles	<input type="checkbox"/>	<input type="checkbox"/>
Pain during Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>
Pre- or Peri-Menstrual PMS	<input type="checkbox"/>	<input type="checkbox"/>
Date of Last PAP	_____	
Date of Last Menstrual Period	_____	
No. of Pregnancies	_____	
No. of Miscarriages	_____	
No. of Abortions	_____	
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
If Yes What Type	_____	
Difficulty Conceiving	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal Symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Active	<input type="checkbox"/>	<input type="checkbox"/>
 <b>BREAST</b>		
Regular Self-Exams	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pain or Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Discharge	<input type="checkbox"/>	<input type="checkbox"/>

	PAST	CURRENT
<b>ENDOCRINE</b>		
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Hunger	<input type="checkbox"/>	<input type="checkbox"/>
Easy Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
 <b>MALE REPRODUCTION</b>		
Hernias	<input type="checkbox"/>	<input type="checkbox"/>
Testicular Masses	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Discharge or Sores	<input type="checkbox"/>	<input type="checkbox"/>
Problem Starting Urination	<input type="checkbox"/>	<input type="checkbox"/>
Problem Stopping Urination	<input type="checkbox"/>	<input type="checkbox"/>
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
If Yes What Type	_____	
Sexual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Active	<input type="checkbox"/>	<input type="checkbox"/>
 <b>The Following Question</b>		
Regarding Sexual Preference is Optional		
And is Important to us in Assessing your		
Risk Factors & Making Proper Recommendations		
Heterosexual	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>	<input type="checkbox"/>
Homosexual	<input type="checkbox"/>	<input type="checkbox"/>



**Ayurvedic & Naturopathic Medical Clinic**

**2115 112th Ave NE Ste 4 Bellevue WA 98004**

**Disclosures and Consent Forms - Please read and sign all forms below:**

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**Financial Policies and Disclosures Statement**

**Please read and sign this form**

1. Dr. Virender Sodhi is contracted with and bills Regence, Premera Blue Cross, Coordinated Care, First Choice Health and Bridgespan Insurances only.
2. Dr. Shailinder Sodhi is contracted with and bills for Premera Blue Cross, Regence, United Health, Cigna and Aetna Insurances only.
3. Dr. Anju Sodhi is contracted with and bills for Premera Blue Cross, Regence, United Health, Cigna and Aetna Insurances only.
4. All services are to be paid at the time of service. All co pay's, deductible, supplements and non-covered services IV's, Labs, Spa treatments, Panch Karma will be collected at time of service, and we will use the credit card on file that you have provided to us.
5. All practitioners hold active license(s) or certifications as required in the State of Washington.
6. If a collection service becomes necessary for payment of the account, you agree to pay all collection fees in addition to any balances due.
7. A late fee of 1.5% per month may be added to delinquent balances.
8. Medicare does NOT cover services or supplies provided in this office.
9. All other insurance companies do NOT cover supplies provided in this office.
10. Release of information: By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This does not give permission for any other release of information by this office, which has not been authorized by me.

**I have read, understand, and agree to the above policies:**

\_\_\_\_\_  
Signature (Parent / Guardian, if under 18 years old)

\_\_\_\_\_  
Date

**PLEASE INITIAL THE FOLLOWING:**

\_\_\_\_\_ Notice of Privacy Practices:

The Ayurvedic and Naturopathic Medical Clinic complies with the most recent HIPAA Privacy Practices. If I am not the above named person, my relationship to the patient is:

\_\_\_\_\_



\_\_\_\_\_ Consent to Routine Clinical Services: I consent to all services rendered by the doctor, or any other licensed doctor(s) or therapist who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. As in all medical practices I understand that there are risks to **manipulation and other routine procedures** including but not limited to fracture, injury, stroke, dislocation and sprain. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to any procedure. I understand that no guarantees have been made to me as to the result or cures that may be obtained from examination or treatment. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that I am responsible for knowing where my personal items are at all times while in the office and if I choose to remove or place any of my personal items I am doing it voluntarily and the Ayurvedic and Naturopathic Medical Clinic is **NOT** responsible or liable for any lost, stolen or misplaced items.

\_\_\_\_\_ Consent to Injections; Ligament and Trigger Point: I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

\_\_\_\_\_ Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that IV treatments are **NOT covered** by insurance and will **NOT** be billed to insurance companies.

\_\_\_\_\_ Consent to Panchakarma program treatments: I consent to all Panchakarma program procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with the Ayurvedic and Naturopathic Medical Clinic. I understand that there are risks to Panchakarma and do not expect the doctor(s) to anticipate and or explain all risks and possible complications. I rely on doctor(s) to exercise judgement during the course of treatment for my present condition and any future conditions for which I seek treatment. I understand that the Panchakarma treatment programs are **NOT covered** by insurance and will **NOT** be billed to insurance companies.

\_\_\_\_\_ For ANY patient who may be consulting in this office with regard to cancer / integrative oncology care, they should be aware that the laws of the State of Washington restrict the

primary treatment of cancer for patients with cancer diagnoses to physicians who are MD or DO licensed. The physicians at the Ayurvedic and Naturopathic Medical Clinic are licensed naturopathic physicians (ND or NMD).

Any involvement in diagnosis, treatment or other means by healthcare providers who do not have MD or DO qualifications should be considered adjunctive or ancillary care. It is always advisable for patients with cancer to seek the advice and care of a qualified Oncologist, but to fulfill the requirements for Washington must at least have a health care relationship with an MD or DO physician.

BY INITIALING ABOVE I acknowledge that I have been informed of the law in the State of Washington regarding primary cancer treatment, and as a patient will direct my healthcare in whatever way best suits my own personal needs and desires.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

I understand that as part of my healthcare, the Ayurvedic and Naturopathic Medical Clinic creates and maintains health records describing my health history, symptoms, examination with test results, diagnoses, treatment and any plans for future care and treatment. I

I understand and have been provided a copy of Notice of Health Information Privacy Practices summary to review, which provides a description of information uses and disclosures. I understand I have the right to request a complete copy of the Notice of Health Information Privacy Practices.

I understand that the Ayurvedic and Naturopathic Medical Clinic reserves the right to change their notice and practices. Changes will be posted in the reception area.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or normal healthcare operations and that the Ayurvedic and Naturopathic Medical Clinic is not required to agree to restrictions I have requested.

By signing below, I agree that I have reviewed the Notice of Health Information Privacy Practices at the Ayurvedic and Naturopathic Medical Clinic.

Signature:

Date:

---

Printed Name:

---

If signed by person other than patient, check relationship to patient:

Guardian Durable Power of Attorney Parent:

---

Adult Child Spouse/Domestic Partner Adult Sibling:

---

**CONSENT FOR LEAVING MESSAGES**

**CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY AND FRIENDS**

I understand that my healthcare information at the Ayurvedic and Naturopathic Medical Clinic is protected and I have received a copy of their Notice of Health Information Privacy Practices.

**CONSENT for LEAVING MESSAGES** (please check box)       YES                       NO

I consent to information regarding myself (or my child's/under the age of 18) test results or detailed appointment reminders/instructions to be left on my voice mail or answering machine, text messages, and email.

If yes, please list allowed phone numbers and/or email:

Cell \_\_\_\_\_

Home \_\_\_\_\_

Work \_\_\_\_\_

Email \_\_\_\_\_

I consent to information regarding workshops, lectures, events, and radio show to be left on my voice mail or answering machine, text messages, and email.

If yes, please list allowed phone numbers and/or email:

Cell \_\_\_\_\_

Home \_\_\_\_\_

Work \_\_\_\_\_

Email \_\_\_\_\_

## CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family or friends to have access to my health care information. The name(s) listed below are family or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem is minimally necessary. I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Protected Health Information Form.

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
	_____	_____

Patient Name

Date of Birth

\_\_\_\_\_

Patient/Parent Signature

\_\_\_\_\_

Date

If signature is not by the patient, please indicate Name and Relationship:

\_\_\_\_\_

This consent will be considered valid until such time as I cancel it in writing. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only be applied to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.

### Consent Highlights

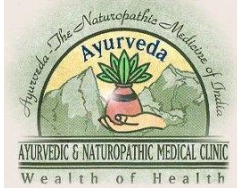
A basis for planning my care and treatment

A means of communication among the many health professionals who contribute to my case

A source of information for applying my diagnosis to my bill

A means in which a third-party payer can verify that services billed were actually rendered

A tool for routine healthcare operations such as assessing quality and reviewing competence of health care professionals.



May 24, 2023

## **MISSED APPOINTMENT AGREEMENT**

### **PLEASE NOTE:**

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that you cancel your New Patient scheduled appointment a minimum of 48 hours in advance. That way the open slot can be filled with someone needing an appointment. Failure to cancel the appointment 48 hours in advance will result in a missed appointment fee of \$265.00.

For existing patients, we request that you cancel your appointment a minimum of 24 hours in advance. Failure to cancel the appointment 24 hours in advance will result in a missed appointment fee of \$140.00.

The fee is not covered by insurance carriers and will be your responsibility to pay.

NAME: \_\_\_\_\_

SIGN: \_\_\_\_\_

DATE: \_\_\_\_\_