Banyan Wellness Center

Name _____ Todays Date _____

Address _____

City _____ State _____ Zip Code _____

Tel: (c)_____ (w)_____ (h) _____

E-mail address: _____

Age _____ Date of Birth _____ Gender: female _____ male _____

Education _____

Married _____ Separated _____ Divorced _____ Widowed _____

Single_____ Partnership ____

Live with: Spouse _____ Partner _____ Parents _____ Children _____

Friends _____ Alone _____

Occupation _____ Hours per week _____ Retired _____

Employer _____S.S.# _____

Work Address:

_____

Health insurance co. name and address:

_____

Policy Holder's name:_____ Date of Birth: _____

Employer _____

Policy/Group #_____ Tel: (_____) _____

Identification/Social Security # _____

How did you hear about our Center?

_____

Has any other family member already been a patient at the clinic?

_____

Next of Kin or other to reach in case of an emergency?

_____

Relationship: _____ Phone: _____

Address: _____

_____

Please list with whom, other than yourself, we may discuss and/or release your personal medical information:

1.) Name: _____

Tel: _____

2.) Name: _____

Tel: _____

3.) Name: _____

Tel: _____

Signature:_____

In the event that we cannot speak to you directly do you wish for us to leave medical information on your voicemail or message system?

Yes_____ No _____

If yes, what number may we leave medical information?

(c) _____ (h) _____ (w) _____

Do you wish to receive newsletters in the form of e-mails from our office?

Yes _____ No _____

Do you wish to receive text messages about appointment reminders?

Yes _____ No _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

HEALTH HISTORY QUESTIONNAIRE

SUCCESSFUL HEALTH CARE AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE PHYSICIAN HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Are you currently receiving healthcare? Y N

If yes, where and from whom?

_____

_____

If no, when and where did you last receive medical or health care?

_____

_____

What was the reason?

_____

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

For all the following sections:

Y = a current condition **N** = never had **P** = a past condition

CHILDHOOD ILLNESSES

Scarlet fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German measles	Y N

GENERAL

Current Weight. _____
Maximum Weight _____
Goal Weight _____

Weight 1 year ago _____
When? _____
Height _____

SCREENING

	Date (most recent)	**Results** (circle)
Dexa	_____	Normal/Osteopenia/Osteoporosis
Pap	_____	Normal/Abnormal/Past Abnormal
Mammogram	_____	Normal/Abnormal
Physical Exam	_____	
Lab work	_____	
Stress Test	_____	Normal/Abnormal
Colonoscopy	_____	Normal/Polyps

HOSPITALIZATION AND SURGERY

What hospitalizations or surgeries have you had?

_____ year: _____

_____ year: _____

_____ year: _____

X-RAYS AND SPECIAL STUDIES

X-rays, CAT scans, or other studies you have had:

_____

_____

Electrocardiogram	Y N	Stress test	Y N
Electroencephalogram	Y N	Echocardiogram	Y N

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Other: _____	

ALLERGIES

Are you hypersensitive or allergic to...

Any drugs? _____
Any foods? _____
Any environmental? _____

CURRENT MEDICATIONS

Do you take or use?

Laxatives	Y N	Pain relievers.	Y N
Tranquilizers	Y N	Antacids	Y N
Cortisone	Y N	Sleeping pills	Y N
Antibiotics	Y N	Thyroid medication	Y N
Appetite suppressants	Y N		

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

FAMILY HISTORY

	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILD
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good P=poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____

Check (_) those applicable

Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hayfever/Hives	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Kidney Dz	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

TYPICAL FOOD INTAKE

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

To drink:

_____

HABITS

Main interests

and hobbies? _____

Do you exercise? Y N

If yes, what form? _____

How often? _____

Average 6-8 hrs. sleep?	Y		N	Enjoy your work?	Y		N
Sleep well?	Y		N	Take vacations?	Y		N
Awaken rested?	Y		N	Spend time outside?	Y		N
Have a supportive relationship?	Y		N	Watch television?	Y		N
Read?	Y		N	how many hours ? _____			
how many hours _____								
Have a history of abuse?	Y		N	Any major traumas?	Y	P	N
Use recreational drugs?	Y	P	N	Treated for alcoholism?	Y	P	N
Been treated for drug dependence?	Y	P	N	Smoked previously?	Y	P	N
Use alcoholic beverages?	Y	P	N	how long ago? _____			
Do you use tobacco?	Y	P	N	year quit? _____			
how many packs per day? _____								
how many years? _____								
Do you eat three meals a day?	Y		N	Do you eat out often?	Y		N
Do you go on diets often?	Y		N				
Do you drink coffee?	Y	P	N	Do you drink tea?	Y	P	N
Number of cups? _____				Number of cups? _____			
Do you drink cola or other sodas?	Y	P	N	Do you drink water?			
Number of ounces _____				Number of ounces? _____			
Do you eat refined sugar?	Y	P	N	Do you add salt?	Y	P	N

Do you have a religious or spiritual practice? Y N

If yes, what? _____

How does your condition affect you?

_____

_____

_____

What do you think is happening?

_____

_____

_____

Why?

_____

_____

_____

What do you feel needs to happen for you to get better?

_____

_____

_____

What do you enjoy most in your life?

_____

_____

_____

What are three goals that you would like to accomplish within the next year that you have not been a let to accomplish because of your current state of health?

1.) _____

2.) _____

3.) _____

How committed are you to make changes in your life so that you can accomplish the above goals?

MINIMAL SOME COMPLETE

REVIEW OF SYSTEMS
FOR THE FOLLOWING, PLEASE CIRCLE

Y = current condition **N** = never had **P** = a past condition

MENTAL/ EMOTIONAL

Treated for emotional problems?	Y P N	Depression?	Y P N
Mood Swings?	Y P N	Anxiety or nervousness?	Y P N
Considered/Attempted suicide?	Y P N	Tension?	Y P N
Poor concentration?	Y P N	Memory problems?	Y P N

ENDOCRINE

Hypothyroid?	Y P N	Heat or cold intolerance?	Y P N
Hypoglycemia?	Y P N	Diabetes?	Y P N
Excessive thirst?	Y P N	Excessive hunger?	Y P N
Fatigue?	Y P N	Seasonal depression?	Y P N

IMMUNE

Vaccinations?	Y P N	Reactions to vaccinations?	Y P N
Chronic Fatigue Syndrome?	Y P N	Chronic infections?	Y P N
Chronically swollen glands?	Y P N	Slow wound healing?	Y P N

NEUROLOGIC

Seizures?	Y P N	Paralysis?	Y P N
Muscle weakness?	Y P N	Numbness or tingling?	Y P N
Loss of memory?	Y P N	Easily stressed?	Y P N
Vertigo or dizziness?	Y P N	Loss of balance?	Y P N

SKIN

Rashes?	Y P N	Eczema, Hives?	Y P N
Acne, Boils?	Y P N	Itching?	Y P N
Color Change?	Y P N	Perpetual Hair Loss?	Y P N
Lumps?	Y P N	Night Sweats?	Y P N

HEAD

Headaches?	Y P N	Head Injury?	Y P N
Migraines?	Y P N	Jaw/TMJ problems	Y P N

EYES

Spots in Eyes?	Y P N	Cataracts?	Y P N
Impaired vision?	Y P N	Glasses or contacts?	Y P N
Blurriness?	Y P N	Eye pain/strain?	Y P N
Color blindness?	Y P N	Tearing or dryness?	Y P N
Double Vision?	Y P N	Glaucoma?	Y P N

EARS

Impaired hearing?	Y P N	Ringing?	Y P N
Earaches?	Y P N	Dizziness?	Y P N

NOSE AND SINUSES

Frequent colds?	Y P N	Nose Bleeds?	Y P N
Stuffiness?	Y P N	Hayfever?	Y P N
Sinus problems?	Y P N	Loss of smell?	Y P N

MOUTH AND THROAT

Frequent sore throat?	Y P N	Copious saliva?	Y P N
Teeth grinding?	Y P N	Sore tongue/lips?	Y P N
Gum problems?	Y P N	Hoarseness?	Y P N
Dental cavities?	Y P N	Jaw clicks?	Y P N

NECK

Lumps?	Y P N	Swollen glands?	Y P N
Goiter?	Y P N	Pain or stiffness?	Y P N

RESPIRATORY

Cough?	Y P N	Sputum?	Y P N
Spitting up blood?	Y P N	Wheezing	Y P N
Asthma?	Y P N	Bronchitis?	Y P N
Pneumonia?	Y P N	Pleurisy?	Y P N
Emphysema?	Y P N	Difficulty breathing?	Y P N
Pain on breathing?	Y P N	Shortness of breath?	Y P N
Shortness of breath at night?	Y P N	" " " " "lying down?	Y P N
Tuberculosis?	Y P N		

CARDIOVASCULAR

Heart disease?	Y P N	Angina?	Y P N
High/Low Blood Pressure?	Y P N	Murmurs?	Y P N
Blood clots?	Y P N	Fainting?	Y P N
Phlebitis?	Y P N	Palpitations/Fluttering?	Y P N
Rheumatic Fever?	Y P N	Chest pain?	Y P N
Swelling in ankles?	Y P N		

GASTROINTESTINAL

Trouble swallowing?	Y P N	Heartburn?	Y P N
Change in thirst?	Y P N	Change in appetite?	Y P N
Nausea?	Y P N	Vomiting?	Y P N
Vomiting blood?	Y P N	Bowel Movements:	
Blood in stool?	Y P N	Number/day _____	
Is this a change _____			
Pain or cramps?	Y P N	Constipation?	Y P N
Belching or passing gas?	Y P N	Diarrhea?	Y P N
Black stools?	Y P N	Gall Bladder disease?	Y P N
Jaundice (yellow skin)?	Y P N	Ulcer?	Y P N
Liver Disease?	Y P N	Hemorrhoids?	Y P N

URINARY

Pain on urination?	Y P N	Increased frequency?	Y P N
Frequency at night?	Y P N	Inability to hold urine?	Y P N
Frequent infections?	Y P N	Kidney stones?	Y P N

MEN'S HEALTH

Hernias?	Y P N	Testicular masses?	Y P N
Testicular pain?	Y P N	Prostate disease?	Y P N
Venereal disease?	Y P N	Discharge or sores?	Y P N
Are you sexually active?	Y N	Chlamydia?	Y P N
Sexual orientation: _____		Gonorrhea?	Y P N
Impotence?	Y P N	Condyloma?	Y P N
Premature ejaculation?	Y P N	Herpes?	Y P N
Birth control? Type? _____		Syphilis?	Y P N

WOMEN'S HEALTH

Age of first menses? _____			Age of last menses? _____		
Are cycles regular?	Y	N	Length of cycle? _____days		
Bleeding between cycles?	Y	P N	Duration of menses? _____days		
Pain during intercourse?	Y	P N	Painful menses?	Y P	N
Clotting?	Y	P N	Heavy or excessive flow?	Y P	N
Discharge?	Y	P N			
PMS?	Y	P N			
If yes, what are your symptoms?					
_____					
Birth control?	Y	P N			
What Type? _____					
Number of years? _____					
Number of pregnancies? _____			Number of live births? _____		
Number of miscarriages?_____			Number of Abortions? _____		
Endometriosis?	Y	P N	Ovarian cysts?	Y P	N
Difficulty conceiving?	Y	P N	Menopausal symptoms?	Y P	N
			If yes, what? _____		
Cervical Dysplasia?	Y	P N	Abnormal PAP?	Y P	N
Sexual difficulties?	Y	P N	Chlamydia?	Y P	N
Gonorrhea?	Y	P N	Condyloma?	Y P	N
Herpes?	Y	P N	Syphilis?	Y P	N
Are you sexually active?	Y	N	Sexual orientation: _____		
Do you do breast self exams?	Y	P N	Breast lumps?	Y P	N
Breast pain/tenderness?	Y	P N	Nipple discharge?	Y P	N

MUSCULOSKELETAL

Joint pain or stiffness?	Y	P N	Arthritis?	Y P	N
Broken bones?	Y	P N	Weakness?	Y P	N
Muscle spasms or cramps?	Y	P N	Sciatica?	Y P	N

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y	P N	Anemia?	Y P	N
Deep leg pain?	Y	P N	Cold hands/feet?	Y P	N
Varicose veins?	Y	P N	Thrombophlebitis?	Y P	N

BANYAN WELLNESS CENTER
1646 N. Litchfield Road, Suite 200
Goodyear, AZ 85395

Terms of Agreement

Patient Name: *Last*_____ *First*_____ *M.I.*___

Age:_____ Date of Birth:_____/_____/_____ Social Security #:_____/_____/_____

Welcome to *Banyan Wellness Center* and thank you for choosing us for your health care needs. We look forward to helping you recapture your life.

Office Hours: Our hours of operation are currently Monday-Thursday 8:30am - 5pm and Friday 8:30am - 4pm. We are closed daily from 12:00pm - 1:30pm. We reserve the right to change our office hours at any time without prior notification.

Active Patient: To be considered an active patient in the practice you must have been seen by one of the doctors within the last 3 years. If it has been over 3 years since you have had an appointment your chart will be moved to storage. After 3 years you will be starting as a new patient within the practice. We are required by law to maintain your records for 6 years, after 6 years we reserve the right to dispose of your medical information. If you would like to have a copy of your chart please see the records policy below. We will forward your information to another provider at no expense via fax, however, if a hard copy is required by your new physician there will be an applicable copy fee.

Visits: All visits with the providers at Banyan Wellness Center are based on time. Time blocks are based on 15 minute increments. Our staff tracks each appointment starting from the moment your doctor closes their office door, ending when all questions have been answered at the front of the office with your doctor. Once your appointment has gone 7 minutes past the 15 minute increment your visit will be billed at the next higher 15 minute increment. The staff tracks the duration of the visit to ensure that you are being charged appropriately, and only for the time spent with your doctor. This is to avoid any confusion as to why you are being charged more or less then the scheduled appointment time. We want to ensure that you are only charged for the time you spend with your doctor. The appointment charge is non-negotiable and will not be adjusted.

We do not take walk in appointments, however, we will do everything we can to accommodate urgent visits including same day visits, as long as a provider is available. Please understand that in the event of an urgent visit your appointment will be with the first available doctor which may or may not be your "regular" doctor, however, you will be given options.

Initial appointments: Initial appointments are scheduled for 60 minutes with Dr. Archambault and 75 minutes with Dr. Briante. If you should go over the allotted time for your initial appointment there will be an additional charge based on the additional amount of time spent with your doctor, again, based on 15 minute increments.

Follow up appointments: Follow up appointment are scheduled in 15 minutes increments. In the event that your appointment should go over your allotted time by 7 minutes you will be charged at the next 15 minute increment. For example, if you are scheduled for a 30 minute follow up appointment and your follow up lasted 38 minutes you will be charged for a 45 minute follow up appointment. Accordingly, if you are scheduled for a 45 minute appointment and you only spend 30 minutes with the doctor you will only be charged for the time that you spent with the doctor, in this case, 30 minutes. Rates are subject to change without notice, although we will do our best to make our patients aware of any changes to our fee structure in advance.

Phone consults: For your convenience we offer phone consults to existing patients. When it is time for your appointment our office staff will call you and collect a credit card for the payment of your appointment prior to being transferred to your doctor. Your card will only be charged after you have finished your appointment at which time we can ship out any supplements that may be needed as well. Phone consults are billed at the same 15 minute increment and rate as a face to face to consult.

Late for your appointment: In the event that you are 15 minutes late for your appointment you may be asked to reschedule your appointment, this will be at the discretion of your doctor. In the event that you are late and your doctor is able to see you, you may not be seen for the original scheduled follow up time as there is traditionally another patient scheduled after you. Thus, you may only get 30 minutes of your allocated 45 minute appointment. You will be billed for the amount of time spent with your doctor.

HCG follow up appointments: HCG follow up appointments are scheduled for 15 minutes with the doctor and is included in the price of your HCG program. In the event that your follow up should go over the allocated 15 minutes you will be charged for the additional time spent with the doctor.

After Hours Calls: All after hours calls made to any of the providers will be assessed a $95 fee and will be called upon to be collected the following business day.

Cancellations:
Initial appointment: If you should need to reschedule your initial appointment please be sure to provide us with 24 business hours notice prior to your scheduled appointment time. This means that if you are scheduled for a Monday you would need to cancel on the Friday before, same applies for holidays. You will receive a courtesy phone call reminding you of your initial appointment at the number provided at the time of booking your appointment, 48 hours prior to your scheduled time. If we do not receive notice of cancellation of your initial appointment 24 hours prior and you need to change your appointment or if you do not show up for your appointment the $25 deposit is forfeited.

If you reschedule your initial appointment 24 business hours in advance of your scheduled time the initial $25 deposit is honored. The deposit will be held on your account for 3 months, if you do not reschedule your initial appointment within 3 months, the deposit is forfeited and a new deposit will be required to schedule an initial appointment. In the event that you are a no show for your initial appointment and you would like to reschedule your initial appointment, we will retain the original $25 deposit and require a non-refundable deposit for the full amount of the initial appointment at the time we reschedule your appointment. Our office does not double book patients, the scheduled hour is time dedicated solely to you.

Follow up appointment:
If you fail to give 24 business hours notification for your scheduled follow up visit or do not show up for your appointment you will be responsible for to the full amount of your allotted appointment time. This will be invoiced to your account and it will be necessary for this invoice to be paid prior to scheduling another follow up. We give every patient the grace of one missed follow up appointment understanding that things happen in life, this visit is not invoiced, however, any future missed appointments will be.

HCG follow up:
If you do not show up for your HCG follow up visit (part of your package) or fail to cancel within 24 hours of your scheduled HCG follow up you will forfeit your complimentary follow up appointment.

IV therapy:
One of the treatments offered at Banyan Wellness Center is IV therapy. The IVs that we administer are vast and for a variety of conditions which may be recommended to you by your doctor. All IVs are custom made for you specifically. IVs are made the day of your appointment. You will receive a courtesy reminder of your scheduled IV appointment 48 hours prior to your IV. If you do not show up or do not cancel your IV appointment within 24 business hours of your scheduled time you will be charged for the full amount of your IV, even if you did not receive the infusion, as we must now discard the mix.

Fees & Financial Policy: Payment of fees is the direct responsibility of the patient. *Banyan Wellness Center* does not bill insurance, however we will provide you upon request with the necessary form so that you may submit directly to your insurance provider. You are responsible for contacting your insurance provider to verify your benefits. We cannot guarantee reimbursement. We are currently not recognized by Medicare, AHCCCS, HMO plans or TriCare and therefore are unable to provide any claim forms to submit for reimbursement for the aforementioned plans.

Health Insurance Claim Form:
Currently the health care providers at Banyan Wellness Center are not contracted with any health insurance providers. As the health care field is constantly changing, this also may change in the future. If you have a PPO plan and you would like to submit for reimbursement for your office visit, please inform one of our staff members at the time of your appointment. We cannot guarantee reimbursement, however, if you have a PPO plan and your deductible has been met there is a good possibility that your visit will be reimbursed at an out of network provider rate. The form will be filled out and mailed to you for you to submit to your insurance provider for reimbursement. Unfortunately, as it stands we currently cannot submit an insurance claim form for our patients who have Medicare, Medicaid (AHCCS), Tri-care or an HMO plan. Your health related expenses may be tax deductible including any supplements that have been prescribed for you. If you have an HSA of flex spending account you may be able to use those funds to pay for your visit, supplements or any other medically necessary expenses you incur within the office including procedures and IVs, please check with your health care plan administrator.

Medicinary: When you are in need of supplement refills please order through the website, www.wvncaz.com, and fill out the supplement order request form, for the products you need. This is the best method to ensure that we have the product in stock and that you will not be waiting. You will receive a confirmation email for your order and it will be ready for you to pick up or it can be mailed to you for an additional postal fee per your request. Of course you can always stop into the office to pick up your products, but it is recommended that you call ahead to confirm that we have everything that you need in stock. Please understand that there may be an additional wait time. There are no refunds for items purchased from our medicinary.

There are times when a patient may require or desires a specialty product that we do not routinely carry in stock. Please talk to our office manager about the possibility of placing a special order you for the particular item. When specialty orders are placed we will collect payment in advance for the item and you will be called once the item has arrived to the office for pick up.

Banyan Wellness Center carries physician grade supplements, manufactured from facilities with the strictest of standards. This allows us to ensure the potency, safety and efficacy of the products you are using. If you should choose to purchase product outside of the ones that have been recommended for you by your provider here at Banyan Wellness Center, you are taking on the risk and liability of the product including the possibility of heavy metal contaminants such as lead, mercury, PCBs, organocides, fungicides, herbacides and other chemicals. Understanding that these products may not only interfere with your capacity to recapture your life, but also impair your health.

Prescriptions: If you are in need of a prescription refill please contact your pharmacy and have them fax a refill request. Please allow 72 hours for this process to ensure that you will not run out of your medication. Our doctors require a face to face visit at a minimum of every 12 months in order to be able to continue to refill your mediations. Your doctor may require more frequent visits, ranging from monthly to quarterly appointments depending on the medication being prescribed, which occurs frequently when prescribing hormones, thyroid, pain medication and/or controlled substances.

Labs: Most insurance providers provide coverage for laboratory testing, however, the amount of coverage varies greatly. In some circumstances you may have a copay or a deductible that needs to be met prior to your insurance covering the laboratory fee. It is your responsibility to call your insurance provider and to be familiar with your coverage as well as the preferred laboratory for your insurance plan. In the event that labs are ran through one of the commercial testing facilities (LabCorp or Sonora Quest) and your insurance does not cover your testing they will bill you at the insurance rate which is usually 2-3 times higher then the cash labs that we have available to you. We will provide you with a cash price quote for labs when asked, so that you may better understand your options. Many times the cash price is a significant savings to you.

At Banyan Wellness Center we have a wide array of testing available to better assess your current medical needs include; food allergy testing, neurotransmitter testing, hormone testing, genetic testing and environmental exposure testing. Unfortunately, these labs are traditionally not coved by insurance and are a cash pay.

Lab Copies:
It is the office policy that when your doctor runs labs a follow up appointment is scheduled to go over those labs. This is to ensure that you understand all aspects of your labs as well as an opportunity for your doctor to raise any concerns seen. Your doctor will make recommendations based on your lab work and also give you an opportunity to ask any questions. If you would like to have a copy of your labs without seeing your doctor you will be asked to sign a document stating that you understand the risk in not having a follow up with your doctor to discuss the labs and accept responsibility.

Copies of your labs will be provided to you at the time of your visit. Should you require hard copies of past labs, they will be provided to you at a charge of $.30 per page. If you would like to have your labs faxed or emailed to you, this will be done at no additional charge.

Records: In the event that you should require a copy of your personal health records there will be a $.30 charge per page and a $10 copy fee. You must allow one week for this process. In the event that a transfer of records needs to occur, we will forward your health records to the physician you have chosen at no expense via fax.

Release of Records: Please see the attached separate paperwork acknowledging with whom we may share your protected medical information. If this information is not present we will require a signed document prior to being able to release your records.

Terms: We shall collect payment for services and products at the time of service.
We accept cash, check, Visa, Master Card and Discover as forms of payment. We will charge 20% of the total for any insufficient funds checks that are returned.

Statement: I have read and understand the above policies of Banyan Wellness Center and West Valley Naturopathic Center LLC and agree to them. I consent to treatment from Dr. Brian Archambault NMD and/or Dr. Carla Briante NMD and accept full responsibility for all expenses incurred by or on my patient account. In the event of non-payment, I will bear the cost of collection and/or all court costs and legal fees should it be required.

_____ _____

Signature of Patient or Guardian Date (DD/MM/YY)

Authorization for use or disclosure of protected health information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and164)

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I authorize West Valley Naturopathic Center to use and disclose my healthcare information to:

Individual/Facility/Provider Name: _____

Self: _____ (place check mark here)

Phone: _____

Address: _____

This authorization shall be in force and effect until _____(date), at which time this authorization expires.

This authorization for release of information covers the period of healthcare from

_____ to _____ or ____ all past, present and future periods

You must initial each of the following individually for the information to be released:

_____ HIV/AIDS

_____ Mental HealthRecords

_____ Drug/alcohol diagnosis and treatment.

_____ Genetic Testing

Federal Regulation requires a description of how much information and what kind of information you would like disclosed: _____

I understand that I have the right to the following:

- Revoke this authorization by sending written notice to this office. I understand that a revocation is not effective to the extend that any person or entity has already acted in reliance of my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and insurer has a legal right to contest a claim
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization and a a result of authorization
- Inspect a copy of Patient Health Information being used or disclosed under Federal Law
- Refuse to sign this authorization
- Receive a copy of this authorization
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on wether I sign this authorization
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law

_____ _____

Signature of patient or personal representative **Date**

_____

Printed name of personal representative

Notice of Privacy Policy Summary
West Valley Naturopathic Center
1646 N. Litchfield Road, Suite 200
Goodyear, AZ 85395

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but **we must provide you with the following important information:**

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1) To public health authorities and health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar proceedings in response to a court or administrative order.
3) If required to do so by a law enforcement official.
4) When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5) If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6) To federal officials for intelligence and national security activities authorized by law.
7) To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8) For Workers Compensation and similar programs.

Your rights regarding your health information:

1) You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2) You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law,

in emergencies, or when the information is necessary to treat you.

3) You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to West Valley Naturopathic Center, LLC, 1646 N. Litchfield Rd Suite 200, Goodyear, Az 85395.

Note: We must respond to this request within 30 days.

4) You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to West Valley Naturopathic Center, 1646 N. Litchfield Rd, Suite 200, Goodyear, Az, 85395. You must provide us with a reason that supports your request for amendment.

Note: We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.

5) Your health information will not be used for marketing or fundraising purposes unless authorized by you to do so. Additionally, we will not sell patient health care information to 3rd parties unless instructed to do so by you.

6) Should we begin utilizing electronic medical records, you have the right to receive them in an electronic form.

7) We will obtain written authorization from you should we wish to utilize information in your health records for research purposes.

8) We must obtain your permission to disclose immunization records to schools or other requesting parties.

9) You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

10) If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Christian Archambault at West Valley Naturopathic Center. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

11) Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Christian Archambault at West Valley Naturopathic Center.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES SUMMARY

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that West Valley Naturopathic Center has provided me with a copy of its Notice of Privacy Practices Summary that summarizes how medical information about me may be used and disclosed. I further acknowledge that a complete copy of Privacy Practices Policies (approx.13 pages) is available upon request and in the waiting area.

I understand that if I have questions or complaints I may contact:

Privacy Officer: Christian Archambault
Tel: 623.643.9598

I also understand that I am entitled to receive updates upon request if West Valley Naturopathic Center amends or changes its Notice of Privacy Practices in a material way. Privacy Practices Policy effective July 1, 2004.

_____ _____

Signature

Relationship to Patient, if signed by someone other than patient.

_____

Date

THIS SECTION IS TO BE COMPLETED BY STAFF OF WEST VALLEY NATUROPATHIC CENTER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices Summary from the above-named patient, but was unable to because:
[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): _____

_____ _____

Name and title of employee

Date