

Good Health | It's a matter of fact.

Welcome to Integrative Health. Here, we gather the facts necessary to treat the root cause of your symptoms, identify early risks then empower you with the information you need to claim a positive and active role in your health.

We look forward to getting to know you. Here is some information to help you prepare for your initial appointment:

- o To keep the clinic running 'on time' throughout the day, we carefully schedule appointments; therefore late cancellations or missed appointments with the doctors will be billed for the full cost of the visit. Late cancellations or missed appointments for a shot or IV will be billed a fee of \$50 - \$100 depending on the treatment cost. If you need to cancel or reschedule, please do so by calling at last 48 hours prior to your appointment. If you arrive 9 minutes late, please be prepared to reschedule and pay the appropriate fee.
- o As we are a 'fee-for-service' office and are not contracted with any insurance companies, we require payment to be made at the time of service or prior to service. You are 100% responsible for all fees. Cash, checks and major credit cards are accepted.
- o I understand that any expenses incurred with Integrative Health (Integrative Health or IH) for myself or any of my minor dependents are my responsibility and not that of any other person or insurance group.
- o I understand that payment is due in full at the time of service.
- o I understand that I will be billed for any appointment missed or changed with less than two-business days' notice.
- o I understand that no claims or guarantees have been made by Integrative Health personnel for future insurance reimbursement or particular medical outcomes.
- o I understand that not all treatments or products used by Integrative Health are FDA approved.
- o I understand there are times a phone consultation with the doctor may be necessary and that such a consultation are placed on the doctor's schedule and billed as a regular appointment.
- o I understand that all information given to Integrative Health now or at any point in the future is entirely confidential. It is Integrative Health's policy to follow HIPAA guidelines and IH requires a signed medical release form before releasing medical records to anyone other than myself unless legally required to do so. I may choose to keep a release form on file to expedite the handling of my records.
- o At times, e-mail or fax may be the best option to communicate confidential medical information between myself and my doctor.
- o My signature below gives Integrative Health permission to fax or email medical records to myself at a fax number or email address given to Integrative Health by myself. I understand these are not secure forms of communication and my records will not be protected when using these forms of communication.
- o I will tell my doctor about any medication I am currently taking so that drug/herb/supplement interactions are minimized. Potential side effects of any herb/supplement recommended to you will be discussed by your doctor.

Once again, welcome. And thank you for inviting us to be a part of your health care team; we look forward to partnering with you for many healthy years to come.

Signed..... Date

(Please give responsible guardian's signature if patient is a minor)



This form is designed to present benefits and risks of the therapies offered at Integrative Health (IH) and must be signed before treatment is rendered. *Ask your doctor if you have any questions or concerns regarding your consent to treat prior to signing this Informed Consent form.* **Treatments, procedures and/or products used in your treatment at Integrative Health may or may not be FDA approved.**

Treatments may include one or a combination of the following:

- o Dietary and nutritional counseling
- o Nutritional and other supplementations, either orally, topically or as injection/IV therapy such as: vitamins, minerals, enzymes, amino acids, essential fatty acids, homeopathic remedies, homotoxicological preparations and others
- o Physical medicine (manipulation), acupuncture, trigger point injection, nutritional or other IV therapy, chelation ('detox') therapy, hormone replacement therapy and more.

I am seeking medical health care services, including alternative medical therapies at IH. I hereby request and consent to the performance of physical medicine (including but not limited to various modes of physical therapy and diagnostic testing/examination) or to the performance of acupuncture (including but not limited to needle puncture, point injection, and infrared therapy) or to the performance of naturopathic procedures (including but not limited to examination, diagnostic testing and the use of natural substances such as vitamins, minerals, botanical medicines and prescription drugs) on me (or on the patient named, for whom I am legally responsible) by the doctors and staff of naturopathic medicine at Integrative Health.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, supplements, prescribed medications, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results.

I understand a referral to another physician or specialist may be necessary due to the nature of my condition and limitations in the scope of practice of Naturopathic Medicine.

I acknowledge that the scope of practice of a Naturopathic Physician has limitations including limited prescription privileges and lack of hospital privileges. Consequently a referral to a specialist or emergency room may be deemed necessary under certain circumstances and is in my best interest. Referrals may not be covered by your insurance carrier.

I understand that this medical practice uses diagnostic and treatment methods that are known as investigational, complementary, alternative, holistic, nutritional, and herbal oriented. Some of these methods have not been accepted by consensus mainstream medicine or the FDA.

I understand that I am in no way obligated to purchase the products or run labs recommended by physicians or staff at IH. I am free to purchase these products from any source that I may choose.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and I wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of medicine, naturopathic medicine, spinal manipulative care, intravenous therapy, acupuncture, prolotherapy, nutritional and other supplementation, hormone therapy, and/or any treatment we administer or order there are some risks.



Some of the potential side effects to treatments and therapies are but are not limited to:

- o Bruising/Local Tenderness (with venipuncture, acupuncture, manipulation, and other)
- o Allergy (with drugs, supplements, anesthesia, nutritional IVs, chelation, and other)
- o Drug Side-effects (with drug, supplements, herb-drug interactions)
- o Fainting (with supplements, acupuncture, nutritional IVs, chelation, and other)
- o Infection (with acupuncture, minor surgeries, venipuncture, implants, injections and other)
- o Burns (with cryosurgery, infrared therapy, and other)
- o Scars (with cryosurgery, acupuncture, moxabustion, venipuncture, hormone implants, minor surgery, and other)
- o Vaginal Bleeding in females (with hormone balancing and replacement therapy)
- o Fractures, Dislocation, Sprains, Disk Injuries (with manipulation, and other)
- o Strokes (with manipulation, and other)
- o Organ Puncture (with acupuncture, prolotherapy, minor surgery, and other)
- o Organ Failure (with IV chelation, detox, and other)
- o Dizziness, weakness, lightheaded (with injections, IV, prolotherapy, PRP, hormone implants, and other)

We have a wonderful referral network. Your doctor will inform you of alternatives to the above-mentioned therapies. Your health and well-being is our first concern. Please inform your doctor of any medication change, new allergies or if there is a possibility of pregnancy at any time during your treatment.

Integrative Health is a facility that occasionally finds it necessary to prescribe medications deemed “controlled” by the Drug Enforcement Agency (DEA). They have been given this designation because of their risk for causing dependency. For your own protection, it is important that you understand that these types of medicines can be used safely and can help to improve your ability to complete your daily activities; however, all medications have possible side effects. Please be sure to understand these potential side effects before starting any medication but especially any controlled substance.

Hormone Replacement Therapy

All medical treatments have potential side effects. The most common side effects are generally mild and temporary, and may include: overproduction of red blood cells, decreased testosterone and/or sperm production and testicular shrinkage, fluid retention, acne and hair thinning.

I acknowledge, understand and agree that testosterone is intended to lessen or eliminate the signs and symptoms of low testosterone, and to lessen the risk of diseases associated with testosterone deficiency. I acknowledge, understand and agree that testosterone therapy is not accompanied by any guarantees, promises or warranties.

I hereby consent to get a full physical exam including PSA lab testing, digital rectal exam, PAP, mammogram, complete wellness panel as my doctor orders.

I acknowledge and understand that hormone replacement therapy, specifically testosterone, is DEA schedule III controlled substance and will require a follow up with my physician and follow up with my physician every 6 months to continue the prescription.

I have read this document and understand it. The staff has answered all of my questions. I consent to use controlled substances and I understand that my treatment with them will be carried out in accordance with the conditions stated above. I understand that if I do not follow the conditions of this consent that I can endanger my health as well as my life.

Signed. Date

(Please give responsible guardian’s signature if patient is a minor)



Patient Information – Integrative Health | Consent for Use of Controlled Medications

Informed consent for intravenous nutrition therapy with or without chelating agents for heavy metal toxicity. Informed consent for intravenous treatment for arteriosclerosis disease and/or for prevention of disease. Informed consent for intravenous treatment of flu/colds, cancer, chronic fatigue syndrome, immune system support, multiple sclerosis, auto immune diseases, endocrine dysfunction, fibromyalgia, gulf war illness, scleroderma, revitalization after chemo, chronic Lyme disease, shingles, Epstein-Barr, cardiovascular disease, infections, Alzheimer, hepatitis C and AIDS, heavy metal contamination, allergies and others.

I give consent to the doctors and staff at Integrative Health to perform intravenous nutrient therapy, intravenous chelation therapy, intravenous arteriosclerosis therapy and/or any other intravenous therapy deemed by my IH doctor to be beneficial to my care. I understand that the intravenous treatment may contain vitamins, minerals, amino acids, chelating agents (such as DMPS and/or EDTA), glutathione, N-Acetyl-Cysteine, DMSO, procaine, H2o2, alpha lipoic acid, preservative agents, and/or other ingredients as deemed beneficial by my doctor. I understand that any or all of these ingredients may or may not be FDA APPROVED for use intravenously or otherwise.

I have been informed of possible risks and side effects of intravenous therapy including but not limited to severe allergic reactions, discomfort at the injection site, painful and long lasting inflammation of the vein (thrombophlebitis), muscle aches or cramps, bone pain, body odor, low blood calcium, transient dizziness, hypoglycemia, mineral loss, skin rash, kidney irritation and inflammation, nephrotoxicity, congestive heart failure and liver disease. I have disclosed to my physician any known significant clinical conditions including liver, kidney, heart disease, allergies or current pregnancy. I understand that it is my responsibility to report to my treating physician any adverse reactions to the treatment and any changes in my health condition.

I understand that the benefits of intravenous therapy are greater if I eat a healthy diet, drink plenty of water, take extra fiber, get appropriate exercise, get proper sleep and do not smoke. I have not been guaranteed any specific outcome. I understand that I am free to discontinue therapy at any time. I am aware that conventional medicine has other drugs and treatments used for my condition that may differ from the approach I am choosing to use at IH. I understand that I am free to consult with other health care providers at any time regarding my condition. I have not been asked to discontinue care with any other physician or specialist.

I have read this consent and have had the chance to have my questions answered to my full satisfaction regarding the prescribed treatment. I have considered the information given to me in this document, verbally by my provider and IH staff, that which I may have researched outside of this office, including on the Internet and I understand the risks of intravenous and/or chelation therapy. I desire to undergo intravenous and/or chelation therapy as prescribed by my IH provider.

I feel that I fully understand what I am signing and I hereby request and consent to receive intravenous and/or chelation treatments at IH. This signed consent is to remain in effect indefinitely unless revoked by me in writing.

Signed..... Date

(Please give responsible guardian's signature if patient is a minor)

We are happy to provide this phone consultation opportunity to patients who are unable to come into the office. Telephone consultations are no substitute for seeing a physician in person and having a regular physical exam. Evaluating a patient in person using the appropriate exams and diagnostic testing is the only way to appropriately diagnose and treat a patient. This cannot be done over the phone.

This informed consent for telephone consultation is a contractual agreement between you and Integrative Health. All fees are due at the time of scheduling and may be paid by debit or credit card over the phone. If your appointment has not been paid in full prior to your appointment time, your visit will be considered a cancellation.

You will receive a call from your physician at the number you provided at the time of your scheduled visit (Arizona Standard Time).

Due to the high demand for appointments, we require at least 24 hours notice for the changing or cancelling of appointments. A 'no show' or cancellation without 24 hours notice will result in a charge for the full fee of your appointment.

By signing below I attest that I have read, and understand that I, not my health insurance, will be billed for the above services. I have received a copy of this information and agree to abide by the financial policy of Integrative Health.

Signed Date
(Please give responsible guardian's signature if patient is a minor)



integrativehealth

A FRESH APPROACH TO LIVING WELL

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Scottsdale, Arizona 85260

📞 480-657-0003

📞 480-657-8693

A FRESH APPROACH TO LIVING WELL

Patient Information-Integrative Health | Patient Contact Information

In order to provide you with the most appropriate treatment, please complete the following questionnaire.

All information is strictly confidential.

Name Date of Birth Gender Male Female

Address.....

City State Zip

Occupation Preferred Pharmacy Name Phone

Marital Status: Single Married Divorced Widowed Name of Spouse/Significant Other:

If you are the parent or guardian of patient, what is your name?

Relationship to patient Your phone number

Please check circle below of preferred method on contact.

Home(.....)..... Cell(.....)

E-mail Address Can we email you medical information? Yes No

How did you hear about us (if referred, by whom)?
(Let us know if it was a friend – we would like to thank them 😊)

- Newsletters
- Podcast
- YouTube
- Facebook
- Internet Search

Other (please specify)

What are your HEALTH GOALS

1. 2.

3. 4.



PERSONAL AND FAMILY HEALTH HISTORY

Disease	Self	Parent	Grandparent	Sibling
Allergies/sinus				
Arthritis				
Cancer/type				
Diabetes				
Depression/anxiety				
Heart disease				
Thyroid disorder				
Gastro disease				
Other				

Women: Last Pap Mammogram Menses DEXA Colonoscopy. Hysterectomy Y/N

Men: Last Digital Rectal Exam (Prostate health) Colonoscopy

Drug or Food allergies and reactions you have

Please list all current prescription medications, over the counter meds, herbs and dietary supplements you take:

Medication/ Supplements	Dosage	Purpose	How long have you taken it?	Side Effects

To what extent are you open and willing to make changes in your lifestyle and diet?



CONTEXT OF CARE REVIEW

What are your long term expectations in working with Integrative Health?

.....

Whom or What helps you daily?

.....

What is holding you back?

.....

What do you love to do?

.....



Please mark if you experience any of the following symptoms

1 --- rarely, 2 --- monthly, 3 --- weekly, 4 --- daily

If you do not experience a symptom, leave the space blank

1 2 3 4

Thyroid	00000000	I gain weight easily and cannot lose it
	00000000	My hair is dry and thinning
	00000000	I am more tired than I should be throughout the day
	00000000	I am sometimes depressed for no specific reason
	00000000	I get cold more easily than others
	00000000	I tend to have bouts of constipation or bowel irregularity
Adrenal	00000000	My sleep is inconsistent
	00000000	I crave sugar and or salt
	00000000	I am more tired than I should be at certain times during the day
	00000000	I am more tired after exercise and struggle to recover
	00000000	I am prone to anxiety or overwhelm
	00000000	I feel dizzy if I stand up too quickly
Gastrointestinal Symptoms	00000000	I have gas and/or bloating
	00000000	My bowels are irregular
	00000000	I cannot digest common foods very well
	00000000	I often have painful joints
	00000000	I feel nauseous at random times
	00000000	Certain foods upset my stomach
Detox	00000000	I get colds and flus easily
	00000000	I often sneeze when around strong odors
	00000000	I am prone to headaches / migraines
	00000000	I am sensitive to many supplements and/or medications
	00000000	I get tremors or twitches
	00000000	I have memory loss, foggy thinking or mood changes
Male/Female Hormones	00000000	I get hot flashes and/or night sweats
	00000000	My libido is poor
	00000000	My skin is thinning or sagging
	00000000	I have a hard time growing or maintaining muscle easily
	00000000	I am edgy or irritable
	00000000	I do not tolerate stress well
		<u>MEN</u>
	00000000	I have erectile dysfunction
		<u>WOMEN</u>
	00000000	I am prone to PMS symptoms
	00000000	My menstrual cycles are irregular
		TOTALS

Thyroid	
Adrenal	
Gastrointestinal Symptoms	
Detox	
Male/Female Hormones	



Patient Information-Integrative Health | Patient Rights

- o You have the right to be treated with courtesy, respect and dignity.
- o You have the right to know the process through which services are offered, including the general course of treatment, and with whom you will be working.
- o You have the right to full confidentiality. All transactions and records within this office are kept strictly confidential. Your records may be released to other parties only when requested in writing by you, or when required by law.
- o You have access and may request copies of your information at any time.
- o You have the right to know and understand the practitioner's assessments and recommendations. These will be given to you at each visit including therapeutic goals, success of treatment, and proposed duration of treatment. If this is unclear please ask.
- o If a medication is prescribed, or any other specific treatment is recommended, you have the right to know what the medication or treatment is, why it is being prescribed, what is the expected outcome, and general side effects which might be reasonably expected. Please ask your physician to explain prior to treatment.
- o You have the right to access other community services and also the right to select and change practitioners. If you are interested in other practitioners or therapeutic modalities, please ask.
- o You have the right to refuse service.
- o You have the right to assert your rights as described within this document at any time without retaliation or fear of negative consequence.
- o You as a patient have the right to full knowledge of fees.
- o You have the right to know of any changes to services or charges and you will be notified.