Chitra Bhakta, MD
Orange County Integrative Medical Center

801 N. Tustin Ave # 405, Santa Ana, CA 92705
Phone: (714) 667-5222 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

Dear Patient,

Welcome to Orange County Integrative Medical Center. We look forward to helping you address your health concerns and placing you on a path towards wellness. Enclosed are our current office policies, services and fee schedules. If you have any questions please feel free to contact our receptionist.

Understanding Lyme disease and Co- Infections

Chronic Lyme disease patients may face a long hard fight to wellness. People with Chronic Lyme disease can have many debilitating symptoms, including severe fatigue, anxiety, headaches and joint pain. Typically, chronic Lyme patients have a poorer quality of life than patients with diabetes or a heart condition.

Lyme is a complex disease that can be highly difficult to diagnose. Reliable diagnostics tests are not yet available which leaves many patients and physicians alike-relying on the so-called "telltale signs" of Lyme disease: discovery of a tick on the skin, a bull's-eye rash, and a possible joint pain. However, ILADS research indicates that only 50%-60% of patients recall a tick bite. The rash is reported in only 35% to 60% of patients, and joint swelling typically occurs in only 20% to 30% of patients. Given the prevalent use of over-the-counter anti-inflammatory medications such as Ibuprofen, joint inflammation is often masked.

Lyme disease is often referred to as the "great imitator" because it mimics other conditions, often causing patients to suffer a complicated maze of doctors in search of appropriate treatment.

Ticks also carry Babesia, Anaplasma, Ehrlichia, Bartonella, Mycoplasma, and other pathogens. The presence of these organisms complicates the diagnoses, testing and treatment of Lyme disease patients.

***(Excerpts from ILADS brochure)

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PATIENT DEMOGRAPHICS		
Name of Patient (Last, First, Middle):		
Age:	DOB: ____/____/_____ (MM)/(DD)/(YYYY)	Gender: _____ Female _____ Male
Name of Parent(s)/Guardian(s) (if applicable):		
Relationship to Patient:		
Home Address:		
City:	State, Zip Code:	

CONTACT INFORMATION
Home phone:
Cell Phone:
Work Phone:
Email:
Fax:
Skype Username (optional):

EMERGENCY CONTACT	
Primary	Name:
	Relationship:
	Phone:
Secondary	Name:
	Relationship:
	Phone
Tertiary	Name:
	Relationship:
	Phone:

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It is a policy of OC Integrative Medical Center for all patients to have a credit card on file. No charges will be made to this card without your permission. For expediting the payment process it is your option to authorize OC Integrative Medical Center to use the credit card listed below for future appointment or treatment payments.

*** Please print clearly ***

CREDIT CARD INFORMATION	
Cardholder's Name:	
Billing Address:	
City:	State, Zip Code:
Exact Name as it appears on card:	
Circle Card Type: VISA MC AMEX DISCOVER	
Card Number:	
Expiration Date: ____/____	CVV: _____
Cardholder's Signature:	Date: ____/____/____

INSURANCE INFORMATION					
PRIMARY INSURANCE			SECONDARY INSURANCE		
Company:			Company:		
Company Address:			Company Address:		
City:	State:	Zip:	City:	State:	Zip:
Insurance Phone (required):			Insurance Phone (required):		
Name of Insured:			Name of Insured:		
Relationship to patient: Self Spouse Dependent			Relationship to patient: Self Spouse Dependent		
Policy ID:			Policy ID:		
Group Name:			Group Name:		
Group #:			Group #:		

Front Copy of Insurance Card Here

Back Copy of Insurance Card Here

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PHARMACY INFORMATION & PRESCRIPTION REFILL REQUEST

Prescriptions will only be filled for two months at a time. Any request for medication beyond that time will require a follow up visit with the Doctor. You can request prescription refills by calling OCIMC. It may take up to 72 hours to process the refills. Please plan ahead to avoid any interruptions in your medications. It is your responsibility to arrange for follow up visits to allow for continued use of your medications.

PATIENT DEMOGRAPHICS	
Patient:	DOB:
Address:	
Phone:	Date
PRIMARY PHYSICIAN INFORMATION	
Contact Person:	Company:
Address:	Phone:
	Fax:
Email:	
SECONDARY PHYSICIAN INFORMATION	
Contact Person:	Company:
Address:	Phone:
	Fax:
Email:	
HOMECARE INFORMATION	
Contact Person:	Company:
Address:	Phone:
	Fax:
Email:	
PRIMARY PHARMACY INFORMATION	
Contact Person:	Company:
Address:	Phone:
	Fax:
Email:	
SECONDARY PHARMACY INFORMATION	
Contact Person:	Company:
Address:	Phone:
	Fax:
Email:	

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Authorization for Release of Medical Information

I hereby authorize _____Phone _____ Fax _____
(Name of Physician, Medical Group or Hospital)

To release my medical records to: Dr. Chitra A. Bhakta, MD
OC Integrative Medical Center
801 N. Tustin Ave, Ste 405
Santa Ana, CA 92705
Tel. 714-667-5222
Fax 949-242-4020

Information to be released:

_____ALL MEDICAL RECORDS
(initial here)

_____LABORATORY RESULTS
(initial here)

_____OTHER. Explain: _____
(initial here)

By signing this form, I hereby authorize reciprocal information to be shared between the above named parties or agencies. I hereby authorize the release of any and all information, including information regarding alcoholism, drug abuse, mental illness or HIV infection, pertaining to my medical condition. This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, the authorization expires 90 days from the date of SIGNING.

I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released. I may refuse to sign, but in that event, the records cannot be released. I further release my attending physician, consultants, the facility, and employees from any liability arising from the release of information to the person(s) or agency designated above.

I understand that I have a right to receive a copy of this authorization upon my request.
Patient's Name_____ Date of Birth_____

Address_____City_____

State_____ Zip_____ Phone No._____

Signed_____Date_____
(Signature of patient/Parent/Patient's Legal Representative*)

Relationship to Patient_____*Authorized representative must submit copies of legal documents supporting assignment of this authority.

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Office Information

It is the goal of Dr. Chitra Bhakta M.D and the staff of **OCIMC** to provide our patients with the best quality of health care in a professional setting with a personal touch. If we work together we can make change happen. Please tell us how we can better assist your needs. We appreciate your comments.

It is important to read all the enclosed information carefully.

Office Hours
Office hours are Mondays through Thursdays from 9:00 am to 4:00 pm
Phone: 1-714-667-5222
Fax: 1-949-242-4020
Address: 801 N. Tustin Ave. Ste. 405, Santa Ana, CA 92705

Medical Records
Medical records can only be released with your authorization. You may directly obtain previous medical records from other physicians or health care providers. Please contact your physician or other health care provider to obtain these records.

Prior to Office Visit – After you have downloaded this Patient packet, fill it out and either email it back to us, mail it directly before your first visit, or Fax at (949) 242-4020 .

It will be very helpful if you can write down in order of events, your medical history regarding your illness. **Please put together a log** of when you first became ill to the present. Include the first onset of symptoms, all tests done (blood tests, x-rays, scans, etc.), treatments received, all medications, doses, duration and any side effects. Bring copies of your medical records and provide a list of all names and phone numbers of all physicians that have treated you in the past or are currently treating you. Also include your Primary care physician information.

Billing / Payment Options – All charges are due at the time of your visit. We accept all major credit cards and cash. You are responsible for full payment at the time of your visit. We do not bill Medicare and are not Medicare providers. All current patients must have a credit card on file with the clinic. Payment authorization will be requested prior to follow-up phone consultations and will be billed the day of service.

Insurance
Dr. Bhakta is not affiliated with any insurance company, but we will provide you with an insurance claim super bill to submit to your insurance company requesting reimbursement. We will, however, still need a copy of your insurance card on file for laboratories accepting insurance and medication inquiries. We are not Medicare or Medicaid providers and do not bill these offices.

Appointments/Consultations

New Patients - Your initial visit will include at least a two-hour medical consultation with Dr Chitra Bhakta M.D at $650.00. **New Patients who are administered oral antibiotics or IV medications will be required to see the doctor 4 (four) weeks after their initial appointment.**

Follow Up Visits - In order to provide the highest level of health care to our patients we require a consult with Dr. Bhakta every **two months**. Tick- Borne diseases require a close observation of your response to treatment. Follow up appointments usually consist of 30-60 minutes at a rate of $80.00 per 15 minutes. **Minimum charge is $80.00**. The

consult consist of reviewing tests results, assessing progress and establishing a continued treatment plan. A credit card number is required to hold your appointment.

Phone Consults – Phone consults are available only if approved by Dr. Bhakta at a rate of $80.00 per 15 minutes. An office visit may still be required; however, to change medication.

*No charge for reasonable phone calls or e-mails with inquires that are kept to a minimum of two questions with no longer than a five minute response time. For non urgent matters please schedule an appointment or wait until the next scheduled appointment.

Confirmation and Cancellation of Appointments
Our staff will contact you for confirmation 24-72 hours prior to an appointment as a courtesy. Please provide with accurate contact information, and remember to update us with any changes. Please be considerate of other patients and contact us regarding a cancellation. There is a **2 business day cancellation policy on all** visits.

There is a $250 charge for all missed appointments including phone consults. Phone consults will be given only after approval of Dr. Bhakta. All follow-up appointments must be canceled 2 business days before your scheduled appointment. Cancellations must be phoned in **and** received by the receptionist. You may cancel your appointment by calling OCIMC at 714-677- 5222.

All visits and phone consultations are by appointment only and must be scheduled through our receptionist. Do not call the Doctor's emergency line to discuss scheduling.

Other Services
*504 letters (school accommodations) initial letter $15.00.
*Insurance letters starting at $50.00
*Insurance phone calls $90.00/30 minutes

Questions, Emails, and Prescriptions
For new patients, Dr. Chitra Bhakta will answer the **first five questions for free** outside of appointments. Every question she answers after that will be charged **$5.00**. Every refill prescription written outside of appointments will be charged **$5.00**. Every medical letter written or medical form completed outside of appointments will be charged **$50.00**. These charges will be made to the credit card listed in your file at the end of every month.

Lab Reports:
*Dr. Bhakta may order lab/diagnostic tests. Some tests take up to 4 weeks to complete. Fees for tests are billed directly between lab and patient. Dr. Bhakta is not involved with or does not profit with lab tees.
*We do offer blood draws that are charged at a $30.00 per 1 rate. This is the fee for drawing the blood and preparing the specimen for shipping only.
*Some of the laboratories use are: IGENEX laboratory does not accept insurance and charges $190.00 (credit card or check) for the
Lyme Western Blot (IgG and IgM). MDL Labs (Medical Diagnostic Laboratories) does accept most insurances and will bill you for services not covered by your insurance company. There may be other labs ordered to test for GI issues, Methylation, Hormones, Heavy Metals/Toxicity, KPU and Viral conditions.
* We do offer Vitamin IVs (Myer's Cocktail) at $ 100.00 rate.
* Saline IVs and Lactated Ringers IVs that are charged at $10.00 rate.
* Injections (B12, all other medications) are charged at $10.00 rate.
* Chelation IVs are charged at $200.00 rate.
*Glutathione are charged at $60 rate.
* All Labs results after being reviewed and signed off by Dr. Bhakta are scanned and sent via email to the concerned patient.

Patient Awareness and Responsibility
•Dr Bhakta will continue to update and inform you of all treatment options most relevant to your condition both conventional and alternative.
•It is your right to accept, refuse or terminate these therapies at any time.
•You are responsible for seeking professional medical attention from Dr. Bhakta or another facility for a worsening or any change of your condition.

Patient Initial: _____

•You are aware that many medical conditions require additional treatment and that Follow-up visits are often necessary.
* In order for us to provide the best patient care and updated research information on your condition at least a 30 minute consultation with the doctor is required every months for continued support.

******Side effects and symptoms that may worsen: Some patients may have flare-ups of symptoms when starting treatment. This affect is called a Jarisch-Herxheimer (Herx). This flare can last for several days. We will monitor this affect and will determine if it**
is caused by the medication, treatment failure or symptoms of a Herx. This is commonin Lyme patients.

*Light exercise is strongly recommended at least 2 days a week. Walking is a good example. Do not do any aerobic exercise as this can be harmful in Lyme patients. Please discuss any planned or current exercise protocol with Dr. Bhakta.
*Patients must agree to stop smoking to better their health and continue to improve.
*All alcohol is harmful to Lyme patients and can interact with medications.

Evening and Weekend Calls
•Dr. Bhakta does not maintain regular calls on the evenings and weekends.
•If you have a non-urgent question please call during clinic hours or feel free to email Dr. Bhakta directly at anytime or call and leave a message at the office and she will respond to your question during the work week.

Specialty Clinic Statement:
This is a specialty medical practice. Due to severe illnesses of our patients and the treatment they may require, there may be delays with your appointment.

Consent for Treatment:
I, the undersigned, a patient at OC Integrative Medical Center, do hereby authorize the physician and the staff to administer treatment as is necessary. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

Cancellation/No-Show Policy:
I understand that the cancellations should be made within 48 hours prior of their scheduled time. A $550.00 charge for no-shows on the initial visit, and a $100.00 charge for no-shows on all follow up visits are enforced. By signing below, I am agreeing to all the above terms and conditions. Additionally, I confirm that I have received a copy of OCIMC's Notice of Privacy Practices.

Out of Network Statement:
Dr. Chitra Bhakta is an out of network provider. Hence, our office does not deal with insurance companies. We do not guarantee authorization on treatment plans. For any pre-authorization phone calls made, there will be a charge of $45/half hour.

No Refunds:
All services provided by Dr. Chitra Bhakta and/or the staff, including (but not limited to) consultations, IV infusions, and supplement sales, are final and not subject to negotiation.

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Informed Consent for Treatment of Autism

Consent for Treatment:

I, the undersigned, a patient at OC Integrative Medical Center, do hereby authorize the physician and the staff , to administer treatment as is necessary. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

Cancellation/No Show Policy

I understand that the cancellations should be made within 2 business days prior of their scheduled time. A $50.00 charge for no-shows on the initial visit, as well as all follow up visits. By signing below you are agreeing to all the above terms and conditions. Additionally, I confirm that I received a copy of OC Integrative Medical Center's Notice of Privacy Practices.

I agree to the above mentioned policy.

Signature of Legal Guardian: _____ Date: ____/____/_____

Print Name of Patient: _____

Print Name of Guardian: _____

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Checklist of Current Symptoms

This is not meant to be used as a diagnosis scheme, but is provided to streamline the office interview. Note the format: complaints referable to specific organ systems and specific co-infections are clustered to clarify diagnoses and to better display multisystem involvement.

Have you had any of the following in relation to this illness? (CIRCLE "Y" OR "N")

Tick bite:	Y	N	"EM" Rash (discrete circle):	Y	N
Spotted rash over large area:	Y	N	Linear, red streaks:	Y	N

	CURRENT SEVERITY				CURRENT FREQUENCY				
SYMPTOM OR SIGN	**none**	**mild**	**moderate**	**severe**	**n/a**	**never**	**occasional**	**often**	**constant**
Persistent swollen glands									
sore throat									
fevers									
sore sole, especially in the AM									
joint pain									
Fingers, toes									
Ankles, wrists									
Knees, elbows									
Hips, shoulders									
Joint swelling									
Fingers, toes									
Ankles, wrists									
Knees, elbows									
Hips, shoulders									
Unexplained back pain									
Stiffness of the joints or back									
Muscle pain or cramps									
Obvious muscle weakness									
Twitching of the face or other muscles									
Confusion, difficulty thinking									
Difficulty with concentration, reading, problem absorbing new information									
Word search, name block									

Patient Initial: _____

Forgetfulness, poor short term memory, poor attention									
	CURRENT SEVERITY				**CURRENT FREQUENCY**				
SYMPTOM OR SIGN	**none**	**mild**	**moderate**	**severe**	**n/a**	**never**	**occasional**	**often**	**constant**
Disorientation: getting lost, going to wrong places									
Speech errors: wrong word, misspeaking									
Anxiety, panic attacks									
Psychosis (hallucinations, delusions, paranoia, bipolar)									
Tremor									
Seizures									
Headache									
Light sensitivity									
Sound sensitivity									
Vision: double, blurry, floaters									
Ear pain									
Hearing: buzzing, ringing, decreased hearing									
Increased motion sickness, vertigo, spinning									
Off balance,"tippy" feeling									
Lightheadedness, wooziness, unavoidable need to sit or lie									
Tingling, numbness, burning or stabbing sensations, shooting pains, skin hypersensitivity									
Facial paralysis - Bell's Palsy									
Dental pain									
Neck creaks and cracks, stiffness, neck pain									
Fatigue, tired, poor stamina									
Insomnia, fractionated sleep, early awakening									
Excessive night time sleep									
Napping during the day									
Unexplained weight gain									
Unexplained weight loss									

Patient Initial: _____

Unexplained hair loss									
Pain in genital area									
	CURRENT SEVERITY				**CURRENT FREQUENCY**				
SYMPTOM OR SIGN	**none**	**mild**	**moderate**	**severe**	**n/a**	**never**	**occasional**	**often**	**constant**
Unexplained menstrual irregularity									
Unexplained milk production, breast pain									
Irritable bladder or bladder dysfunction									
Erectile dysfunction									
Loss of libido									
Queasy stomach or nausea									
Heartburn, stomach pain									
Constipation									
Diarrhea									
Low abdominal pain, cramps									
Heart murmur or valve prolapse									
Heart palpitations or skips									
"Heart block" on EKG									
Chest wall pain or ribs sore									
Head congestion									
Breathlessness, "air hunger," unexplained chronic cough									
Night sweats									
Exaggerated symptoms or worse hangover from alcohol									
Symptom flares every 4 weeks									
Degree of disability									

DIAGNOSTIC CHECKLIST

To aid the clinician, a workable set of diagnostic criteria were developed with the input of dozens of front line physicians. The resultant document, refined over the years, has proven to be extremely useful not only to the clinician, but it can also help clarify the diagnosis for third party payers and utilization review committees. **It is important to note that the CDC's published reporting criteria are for surveillance only, not for diagnosis. They should not be misused in an effort to diagnose Lyme or set guidelines for insurance company acceptance for the diagnosis, nor be used to determine eligibility for coverag**

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep you medical information private
2. Give you this notice describing our legal duties, privacy practice, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right To:

1. Change our privacy practice and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practice and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practice

1. Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific listed written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.
For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

Patient Initial: _____

Additional Uses and Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes/

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility, your condition described in general terms, your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification*:* We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information about you.'

Disaster Relief*:* We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description and established protocol to ensure the privacy of medical information.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions, and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicate disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has been admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Patient Initial: _____

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You have the Right To:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person at the end of this notice.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that we be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Orange County Integrative Medical Center
801 North Tustin Avenue Suite 405
Santa Ana, CA 92705

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT

I have received the Notice of Privacy and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Patient Initial: _____

Chitra Bhakta, MD
Orange County Integrative Medical Center

801 N. Tustin Ave # 405, Santa Ana, CA 92705
Phone: (714) 667-5222 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

Doctor-Patient Arbitration Agreement

A signed copy of this document is to be given to patient. Original is to be filed in Patient's medical Records

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if then, must be arbitrated including, without limitation, claims for loss consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from a civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant of Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval or the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered the physician within 30 days of signature. It is the intent of this agreement to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of the first medical services. _____**Patients Initials**

If any provision of this arbitration agreement is held invalid for unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MAPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF CONTRACT.

Signature: _____ Guardian (if applicable): _____

Date: _____ Date: _____

Patient Initial: _____

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Patient Intake Flow Sheet

Initial treatment

Very Important Instructions:

1. Please be sure you read the attached consent form and bring the signed copy to your appointment.
2. Bring **copies** of all prior lab reports to your appointment. If you have requested these reports be sent to us from another doctor, be aware that this may take a month or more, and they are unlikely to come to our office in time. The single best way if for you to bring these to your appointment yourself.
3. Bring the actual bottles of your current supplements for our review.
4. **PLEASE ANSWER THE FOLLOWING QUESTIONS IN A COLORED FONT (SUCH AS RED OR BLUE) IF YOU CAN**
5. Please email this form to info@ocimc.com prior to your appointment

Date: **Email:**

Patient Name: **DOB:** **Weight:**

Mother's Name:

Father's Name:

History:

1. What exactly is your child's diagnosis?
2. At what age was your child diagnosed?
3. What doctor/doctors diagnosed your child?
4. At the time of diagnosis, was your child's condition milk, moderate, or severe?
5. Has your child's condition improved since you were given this diagnosis?
6. If so, what symptoms and behaviors have improved?
7. Looking back in hindsight, at what age did problems first appear?
8. Do you feel your child was born healthy and development was normal for a while and then your child began to regress?
9. If your child regressed, at what age did this occur?
10. Do you feel there was anything specific that triggered this regression? If so, what?
11. Do you feel your child was born with autism (or started to become autistic in the first few months) and has always had developmental issues from the beginning?

Patient Initial: _____

12. What treatments, if any, do you feel caused the greatest and fastest improvements in your child?
13. What treatments have you tried that you feel made your child worse?
14. Does your child have any trouble going to sleep or staying awake?
15. If you answered yes to the previous question, please describe.
16. Do you feel your child is more on the hyperactive side or the mellow side, or neither?

Please list any supplements you have tried in the past but are no longer doing:

_____ _____
_____ _____
_____ _____
_____ _____

Please list any behavioral or special education therapies your child is currently getting or you have done in the past:

_____ _____
_____ _____

What academic setting is your child currently involved in?

Nutrition:

1. Is your child on a Gluten and Casein free diet?
2. If so, at what age did you start?
3. Did you see any improvements?
4. If so, what types of improvements in specific behaviors did you see?
5. Were these improvements sudden over several days or more gradual over months?
6. Does your child have any food allergies that have shown up on any testing?
7. Please list the foods that your child eats most:

Bowel Movements:

1. How often does your child go poop?
2. Is it constipated?
3. Is it Diarrhea?
4. Describe the color/consistency of the poop
5. If your child is pooping normally now, describe any abnormalities in the past

Does your child speak?

Patient Initial: _____

Please list your child's current autistic symptoms:

_____ _____
_____ _____
_____ _____
_____ _____

Testing:

List any tests, such as hearing, x-ray, brain scans, etc., that your child has had and what the results were. Do NOT list any blood, stool, urine, or other lab tests:

_____ _____
_____ _____
_____ _____

Problem List:

Please list what you consider to be the problems and challenges that you feel need to be addressed: (for example, yeast, hyperactivity, sleep, behavioral)

_____ _____
_____ _____
_____ _____

Current Supplement List and Dosage:

_____ _____
_____ _____
_____ _____
_____ _____

Please list any prescription medication your child is currently taking:

_____ _____
_____ _____

What types of supplements will your child take (answer yes or no)?

Liquids:
Powders:
Capsules (even if not preferred):

What types of questions do you want answered during your visit?

I have answered the form to the best of my ability:

Signature: _____ Guardian:_____

Date: _____ Date: _____

Patient Initial: _____

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Pediatric Health History

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.

Date: _____ SS/HIC/Patient ID#: _____
Child's Name:_____ Gender (circle): M F DOB: _____Age: ____
Mother's Name: _____ Phone: Home (_____)_____ Work: (_____)_____
Father's Name: _____ Phone: Home (_____)_____ Work: (_____)_____
Home Address: _____
Email: _____ Phone: Cell #1 (_____)_____ Cell #2: (_____)_____
Child's School (Name and City): _____
Previous Physician: _____City/State:_____Phone: (_____)_____

Allergies:

Substance	Reaction
_____	_____
_____	_____
_____	_____

Medications:

Medication Name	Dosage
_____	_____
_____	_____
_____	_____

Medical History

Please "X" if your child has ever had any of the following:

____Anemia
____Asthma
____Bronchitis/Bronchiolitis
____Bronchopulmonary Dysplasia (BPD)
____Chicken Pox
____Hepatitis
____Immune Deficiency/HIV
____Measles (10-day)
____Measles, Rubella (3-day)
____Mumps
____Prematurity
____Rheumatic fever
____ Pneumonia
____Sickle Cell Disease
____Whooping cough
____Other:

GENERAL:
____Chills
____Depression
____Dizziness
____Fainting
____Forgetfulness
____Headache
____Loss of sleep
____Mood swings
____Nervousness
____Numbness
____Sweating
____Tiredness
____Weight gain/loss

CARDIOVASCULAR:
____Breathing problems
____Chest pain
____Irregular Heart beat

EYES:
____Crossed/wandering eyes
____Eye irritation
____Headaches
____Vision Problems

HEARING/SPEECH:
____Difficulty Hearing
____Earache
____Ear Infections
____Hoarseness
____Speech problem s

DENTAL:
____Bleeding Gums
____Grinding teeth
____Hot/cold sensitivity
____Thumb sucking
____last dental checkup date:
____Brush: how often:
____floss: how often

GASTROINTESTINAL
____Appetite poor
____Bloody/dark stool
____Constipation
____Diarrhea
____Excessive hunger
____Excessive thirst
____Nausea
____Rectal bleeding
____Stomachaches
____Vomiting
____Worms

GENITO-URINARY
____Bed-wetting
____Blood in urine
____Diaper rash, persistent
____Discharge from vagina or penis
____Frequent urination
____Unusual urine odor

MUSCLE/JOINT/BONE
____Broken bones or sprains
____Coordination problems
____Posture problems
____Pain, weakness, swelling in:
___Arms ___Hips
___Back ___Legs
___Feet ___Neck
___Hands ___Shoulders

NOSE/THROAT/CHEST
____Difficulty breathing
____Difficulty swallowing
____Frequent colds
____Hoarseness
____Mouth-breathing
____Nosebleeds
____Persistent cough
____Sinus problems
____Sore throat
____Strep throat
____Tonsil infection
____Wheezing

SKIN
____Bruise easily
____Change in moles
____Hives
____Itching
____Rash
____Scars
____Sores that won't heal

Patient Initial: _____

Dietary Assessment

How often does your child eat the following?

	3 Times Daily	Daily	Weekly	Monthly
Beans, Peas	____	____	____	____
Breads, cereals, grains	____	____	____	____
Candy	____	____	____	____
Dairy Product	____	____	____	____
Eggs	____	____	____	____
Fruits	____	____	____	____
Meats	____	____	____	____
Poultry, fish	____	____	____	____
Sodas	____	____	____	____
Vegetables, yellow	____	____	____	____
Vegetables, green	____	____	____	____

What vitamin supplements does your child take? _____ How Often?_____
Is there fluoride in your water? Y N

Hospitalizations

Reason	Date	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Injuries

Serious Injury/Illness	Date	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever had a blood transfusion? Y N

IMMUNIZATIONS

Please "X" whether or not your child has been given the following immunizations. If yes, please fill in the dates given.

	Date		Date		Date
Y	N _____ Hepatitis B	Y	N _____ Polio, 3 series	Y	N _____ Measles Vaccine
Y	N _____ DPT, 3 shot series	Y	N _____ Polio booster shot	Y	N _____ Mumps Vaccine
Y	N _____ DPT booster shot	Y	N _____ Polio by mouth	Y	N _____ Rubella Vaccine
Y	N _____ Hib (Influenza)	Y	N _____ PCV7	Y	N _____Chicken pox vaccine

Family History

Please give information about your child's immediate family:

	Age	General Health		Age	General Health
Father:	_____	_____	Sibling:	_____	_____
Mother:	_____	_____	Sibling:	_____	_____
Have any of your children died? Y N			Sibling:	_____	_____

Please "X" conditions that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child:

Condition	Relationship	Condition	Relationship
___Alcoholism	_____	___HIV/AIDS	_____
___Allergies	_____	___Kidney disease	_____
___Anemia	_____	___Lung disease	_____
___Arthritis	_____	___Mental disease/disorder	_____
___Asthma/emphysema	_____	___Mental retardation	_____
___Birth Defects	_____	___Muscle disorder	_____
___Bone/joint disorders	_____	___Rheumatic fever	_____
___Cancer	_____	___Seizures/convulsions	_____
___Diabetes	_____	___Sickle cell anemia	_____
___Epilepsy	_____	___Skin disease	_____
___Eye/ear disorders	_____	___Stroke	_____
___Genetic Defects	_____	___Thyroid disease	_____
___Heart Disease	_____	___Tuberculosis	_____

Patient Initial: _____

___Hemophilia _____ ___Venereal disease _____
___High blood pressure _____ ___Other _____

PRE-NATAL AND INFANT HEALTH HISTORY

Place of birth: _____ Obstetrician: _____ Mother's age at birth: _____

During the pregnancy, which conditions did you have? Please "X" all that apply:

___Alcohol Use
___Anemia
___Diabetes
___Drug use, non-prescription drug (list)
_____
___Drug use, prescription drug (list)
_____
___Drug use, controlled drugs as narcotics (list)
_____
___Edema (Swelling)
___Exposure to chemical or radiation
___Fever
___German measles
___Hepatitis
___High blood pressure
___Protein in urine
___Tobacco use
___Urinary Tract infection
___Venereal disease
___Other illnesses or infections: _____

Delivery: Please "X" all that apply:

___On time ___Premature ___Late
___Normal ___Induced ___Prolonged
___Breech ___C-section

Please describe: _____

Infant Health
Birth weight: _____ Length: _____
Discharge weight: _____ Age when discharge_____
Infant Health Problems ("X" all that apply)
___Birth Defects _____
___Breathing problems_____
___Infection _____
___Jaundice _____
___Transfusion _____
___Other_____
Feeding
___Breast fed
___Formula fed

Developmental Please note age at which your child:

Lifted Head:	_____Week
Rolled over:	_____Months
Cooed/laughed:	_____Months
Sat up:	_____Months
Stood up:	_____Months
Walked:	_____Months
Finger fed	_____Months
Drank from cup	_____Months
Spoon fed	_____Months
First word	_____Months
Toilet changed	_____Months
Dressed self	_____Months

EDUCATION AND SOCIAL HISTORY

Please explain any problems or concerns you have about your child in any of the following areas:
Appearance/Weight/Height _____
Behavior _____
Friends _____
Grades/learning ability _____
Sexuality _____
How many hours per day does your child watch television or play video games? _____Get exercise?_____
Do you suspect that your child is involved with ____Drugs ____Alcohol ____Tobacco ____None

Have you noticed any of the following warning signs of drug abuse?

Angry behavior	N	Y	Depression	N	Y
Changes in appearance	N	Y	Signs of drugs in house	N	Y
Changes in attitude	N	Y	Skipping School	N	Y
Changes in friendship	N	Y	Withdrawal from friends/family	N	Y

CHILD SAFETY INVENTORY

Adequate number of working smoke alarms?	Y	N	Safety plugs in unused wall sockets	Y	N
Does child use car seat/seat belt?	Y	N	Safety gate for stairs	Y	N

Patient Initial: _____

Cleaning supplies, chemicals out of reach	Y	N	Know danger of peeling paint, mice/rat	Y	N
Syrup of Ipecac in the home	Y	N	Does your child know how to swim	Y	N
Know poison control number	Y	N	Are guns in the home locked up	Y	N
Water heater set below 120F	Y	N	Does child use bicycle helmet?	Y	N

Parent Concerns Reason for visit today and any other concerns or questions you have about your child.

_____
_____
_____
_____

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor is my minor ever has a change in health.

Signature of Parent, Guardian, or Personal Representative: _____

Print name of Parent, Guardian, or Personal Representative: _____

Relationship to Patient: _____ Date: _____

DOCTOR COMMENTS:

_____
_____
_____
_____
_____

Physician Signature: _____ Date: _____

UPDATES: *to be filled in at future appointments*

Has there been any change in child's health since last appointment? Y N

Please describe _____

Parent/Guardian signature: _____ Date: _____

Physician signature: _____ Date: _____

Has there been any change in child's health since last appointment? Y N

Please describe _____

Parent/Guardian signature: _____ Date: _____

Physician signature: _____ Date: _____

Has there been any change in child's health since last appointment? Y N

Please describe _____

Parent/Guardian signature: _____ Date: _____

Physician signature: _____ Date: _____

Patient Initial: _____

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NOTICE REGARDING DISABILITY AND INSURANCE FORMS

The Orange County Integrative Medical Center is not responsible for filling disability and/or insurance benefit forms since Dr. Chitra Bhakta is not a primary care physician. All patients should have their own primary care physician. If not, we can refer one to you. Primary care physicians are responsible for paperwork concerning disability or insurance benefits. Dr. Bhakta will provide the primary care physician with all the relevant labs and clinic notes if required.

Patient Initial: _____

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Consultation Fee Schedule

Effective **June 1, 2013**, the Orange County Integrative Medical Center "OCIMC" will charge the following fees for its services:

New Patients:

$650.00

Follow-Up Appointments:

$80.00 every 15 minutes

Emails, Letters, and Prescriptions:

For new patients, Dr. Chitra Bhakta will answer the **first five questions for free** outside of appointments. Every question she answers after that will be charged **$5.00**. Every refill prescription written outside of appointments will be charged **$5.00**. Every medical letter written or medical form completed outside of appointments will be charged **$50.00**. Disability forms are a charge of **$300.00,** or they can be filled out during an appointment for $80.00 every 15 minutes spent**.** These charges will be made to the credit card listed in your file at the end of every month.

Patient Initial: _____