# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 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)



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

| 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: |



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

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*

Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

## 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: | |



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

## 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.



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

## 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**.
Patient Initial: _____

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 $25.00.
*Insurance letters starting at $50.00
*Insurance phone calls $80.00/15 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.
*Glutathione is charged at a $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 month 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 common in 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.



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com


## Informed Consent for Treatment of Persistent Lyme Disease

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two standards of care is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

**Your Diagnosis:** The diagnosis of Lyme disease is primarily a clinical determination made by your doctor based on your exposure to ticks, your report of symptoms, and your doctor's observation of signs of the disease, with diagnostic tests playing a supportive role.

Doctors differ in how they diagnose Lyme disease:

- Some physicians rely on the narrow surveillance case criteria of the CDC for clinical diagnosis even though the CDC cautions against this approach. These physicians will fail to diagnose some patients who actually have Lyme disease. For these patients, treatment will either not occur or will be delayed.
- Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of a patient to assist in their diagnosis.

Your doctor also may need to rule out other possible causes of your symptoms, such as arthritis, lupus, syphilis, Reiter's syndrome, MS, CFS, and FMS. If you are unclear of your diagnosis, be sure to discuss this with your doctor.

**Your Treatment Choices:** The medical community is divided regarding the best approach for treating persistent Lyme disease. Some physicians think that the long-term effects of Lyme disease are caused by damage to the immune system and are therefore unaffected by antibiotics. Others believe that the infection persists, is difficult to eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination doses.

Your treatment options include:

1. Not pursuing antibiotic treatment and, if appropriate, seeking symptomatic relief for your continuing symptoms;
2. Treating your illness with antibiotics until clinical resolution of your symptoms, regardless of duration of your treatment; or
3. Treating your illness with antibiotics for thirty days, only

If you elect to pursue antibiotic treatment, you will be treated with antibiotics selected to address the Lyme bacteria as well as any other tick-borne infections you may have, such as Ehrlichiosis, Babesiosis, or Bartonellosis. Your doctor will sometimes recommend IV medications when there is neurological involvement, carditis, complicated Lyme arthritis, or inadequate response to oral medications. Sometimes treatment consists of IV antibiotic treatment followed by oral antibiotics. Other classes of drugs may be needed to treat non-bacterial tick-borne diseases such as babesiosis.

Patient Initial: _____

**Potential Benefits of Treatment:** Antibiotic treatment may result in improvement in your clinical condition. Although there is substantial evidence that most patients improve with continued treatment, not all patients improve with treatment.

Patient response varies widely:

- Some patients experience substantial improvement of their symptoms and do not require further treatment
- Some patients feel worse initially during treatment, before improving
- Some patients improve with antibiotic treatment, but relapse when treatment is stopped, and
- Some patients do not respond to antibiotic treatment. Sometimes persistent symptoms represent permanent changes to a patient's body, in which case further antibiotic treatments may be of no further benefit. Other times the illness progresses but, for unknown reasons, does not respond to additional treatment.

**Risks of Treatment:** There are potential risks involved in using any treatment. Some of the problems with antibiotics can include allergic reactions, which may manifest as rashes, swelling, and difficulty breathing. These problems may require medications to reverse the allergic reaction and may require emergency treatments. Other potential complications include stomach and bowel upset, abdominal pain, diarrhea, or bowel irritation, which may require interruption of the antibiotic and prescribing other medications to manage the digestive upset. It is also possible that secondary infections such as yeast infection of the skin, mouth, intestinal, and genital tracts may occur in some people, causing discomfort and the need for corrective therapies. Although unlikely, it is possible that other problems such as adverse effects on liver, kidneys, or other organs may occur. For oral antibiotics, it is estimated that the risk of major side effects is 1 in 10,000 (very small) and the risk of minor side effects is 4 in 100 (slightly greater).

**Factors to consider in your decision:** No one knows the optimal treatment of symptoms that persist after being diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy. By taking antibiotics for longer periods of time, you place yourself at greater risk of developing the side effects. By stopping antibiotic treatment, you place yourself at greater risk that a potentially greater serious infection will progress. Antibiotics are the only form of treatment shown to be effective for treating Lyme disease, but not all patients respond to antibiotic therapy. Other forms of treatment designed to strengthen your immune system may be important. Some forms of treatment are only intended to make you more comfortable by relieving your symptoms and do not address any underlying infection.

Your decision about continued treatment may depend on a number of factors and the importance of these factors to you. Some of these factors are listed below:

- The severity of your illness and degree to which it impairs the quality of your life
- Whether you have co-infections, which can complicate the treatment
- Your ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment
- Whether you have been responsive to antibiotics in the past
- Whether you relapsed or your illness progresses when you stop taking antibiotics
- Your willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse

For example, if your illness is severe, significantly affects the quality of your life, and you have been responsive to antibiotic treatment in the past, you may wish to continue your treatment. However, if you are willing to accept the risk that the infection may progress or if you are not responsive to antibiotics, you may wish to terminate treatment. Be sure to ask your doctor if you need any more information to make this decision.

If you do decide to treat your Lyme disease with antibiotics, it is required by the State Medical Board that you continue monthly follow ups with Dr. Chitra Bhakta to monitor your progress.



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave. Ste 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

## Informed Consent for Treatment of Persistent Lyme Disease

**Based on this mentioned information, I have decided (CHECK ONE):**

_____ To treat my Lyme disease with antibiotics until my clinical symptoms resolve

_____ Only to treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms

_____ Not to pursue antibiotic therapy

**To my knowledge, I am not allergic to any antibiotics except those listed below:**

_____ _____

_____ _____

_____ _____

**I am aware of the additional risks involved in antibiotic treatment and consent to the use of treatment. I further agree to do my monthly follow ups with Dr. Chitra Bhakta.**

Signature: _____ Date: ____/____/_____

Print Name: _____



Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave # 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com


## 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 | | | | | | | | | |

Patient Initial: _____

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Unexplained weight loss | | | | | | | | | |
| 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 coverage**

Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave. Ste 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

## 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

1525 Superior Ave. Ste 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

## IV Treatment Consent Form

In certain situations, IV medications are preferred or may be used to supplement oral medications. IV treatment is sometimes recommended when there is neurological involvement, carditis, complicated Lyme arthritis, or inadequate response to oral medications. Because the GI systems are bypassed, IV dosing guarantees adequate medication blood levels and reduces gastrointestinal symptoms. IV antibiotics also may penetrate the blood brain barrier more effectively.

There are additional risks associated with IV treatment. IV treatment usually involves the installation of some type of catheter (PICC line, Hickman catheter, and/or port) in your vein to allow easier IV treatment. Catheters inherently carry a low risk of infection as well as blood clots. In the case of an infection, the catheter may be removed. If a clot forms, the catheter may be removed and you may be hospitalized for the initiation of anticoagulation therapy. The risk of clot development is decreased by flushing the catheter twice daily with saline and heparin* and also by avoiding vigorous repetitive motion activity of the body location in which the catheter is inserted.

The responsibility of obtaining monthly check-ups, completing monthly lab workups, daily wound checks at the insertion site, and dressing changes as per instructions rests solely on the patient. If the patient notices any fever, chills, headaches, rash, or swelling/tenderness/bleeding from the wound site, the patient must proceed immediately to the Emergency Room and may require hospitalization and treatment including, but not limited to, IV antibiotics. The clinic is not responsible for these responsibilities and if it is felt that the patient is non-compliant, the clinic has the right to stop IV antibiotics at any time and order removal of the central or peripheral IV line immediately. If the patient has problems obtaining help for dressing changes or wound checks, it is the responsibility of the patient to come to the clinic so that it can be taken care of.

Our antibiotics commonly used to treat Lyme disease are not known to have gallbladder side effects. Monitoring your blood may help detect the development of any liver or gall bladder problems.

Due to the above mentioned side effects, the State Medical Board requires ALL patients undergoing long-term IV antibiotics to do monthly blood work and monthly follow ups with their practicing physician.

*Side effects of heparin include: bloody/black stool, chest pain, shortness of breath, coughing up blood, fever/chills, headache, nausea, vomiting, increased menstrual bleeding, large blue & purple patches in skin, numbness or weakness in body, increased menstrual bleeding, red/brown urine, severe headaches, problems with vision/speech/walking, nosebleeds, unusual bleeding/bruising/weakness, vomiting of blood, and wheezing.

---

**To my knowledge, I am not allergic to any antibiotics except those listed below:**

_____ _____

_____ _____

_____ _____

---

**I am aware of the additional risks involved in IV antibiotic treatment and consent to the use of IV treatment. I further agree to do my monthly blood work and monthly follow ups with Dr. Chitra Bhakta.**

Signature: _____ Date: ____/____/_____

Print Name: _____

---

Patient Initial: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave. Ste 206, Newport Beach, CA 92663
Phone: (949) 642-3333 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: _____

# Chitra Bhakta, MD
# Orange County Integrative Medical Center

1525 Superior Ave. Ste 206, Newport Beach, CA 92663
Phone: (949) 642-3333 Fax: (949) 242-4020
Email: info@ocimc.com
Website: http://www.ocimc.com

**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.

OCIMC

Patient Initial: _____