

Client Contact Information

(office use:) **MR#** _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: _____

Phone: (day) _____ (evening) _____ (cell) _____

E-Mail Address: _____

Do you wish to receive newsletters from the Center? ___yes ___no

Place of Employment: _____

Address: _____

Emergency Contact: _____

Emergency Contact Phone _____:

Emergency Contact Relationship: _____

Primary Care Physician _____

Health Insurance Company _____ ID# _____

Health Insurance Phone Number _____

Referred By (check one): ___friend; ___doctor; ___print ad; ___radio ad; ___internet; ___tel
book; ___walkby.

STATEMENT REGARDING CRISIS MANAGEMENT and EMERGENCY MEDICAL CARE

As a CIHH client, I understand that the Center for Integrative Health and Healing does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis, I must obtain services that are appropriate to the type of crisis I am experiencing. If I am experiencing severe acute symptoms or a feel of life-threatening illness, I will call:

- 911
- My local hospital emergency room
- My local police or fire department
- Albany County Mobile Crisis Team 518-447-9650 (mental or emotional distress)

FINANCIAL AGREEMENT

As a CIHH client, I understand that I am responsible for the payment of services received through CIHH. I agree to keep my account current and will pay at the time of service unless I make some other arrangement.

I will notify the office 24 hours in advance if a cancellation is necessary. Pre-paid follow up visits must be scheduled within 3 months of initial appointment, otherwise a fee for a new office visit will be charged.

Client Signature: _____ Date: _____

The Center for Integrative Health and Healing
Ronald L. Stram, MD, Director
388 Kenwood Ave, Delmar, NY 12054 Tel: (518-689-2244)/Fax:689-2081/www.cihh.net

Name: _____ MR# _____ (office use)

To provide the best possible healthcare, we the doctors need to completely understand the patient's physical, mental and emotional condition. By providing us with this information, we will be able to understand and assist you with your health needs and goals. Please print your answers to each question as completely as possible and either mark or leave blank any questions you are unsure of.

When did you last go to a doctor's office, medical clinic or hospital? _____

What was the reason? _____

What are your most important health concerns? _____

Please list any hospitalizations and surgeries you have had:

Do you have any allergies to foods, drugs, or other allergens in your environment (cats, mold, dust)? If yes, please explain: _____

Please mark any of the following that you are taking:

- | | |
|---|---|
| <input type="checkbox"/> Pain relievers (aspirin, Tylenol, ibuprofen) | <input type="checkbox"/> Diet Pills/Appetite suppressants |
| <input type="checkbox"/> Cortisone (cream or pills) | <input type="checkbox"/> Thyroid Medication |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Antacids (Rolaids, Tums) |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Blood pressure medication | <input type="checkbox"/> Heart medication |
| <input type="checkbox"/> Blood Thinner(coumidin, plavix, aspirin) | <input type="checkbox"/> Antidepressants |

Please list any herbal supplements that you are currently taking:

Please mark if you or family members have experienced the following (please indicate which family member ie: self, mother, brother etc)

Cancer: _____

Diabetes: _____

Heart Disease: _____

Blood Pressure: _____

Mental Illness: _____

Lung Condition: _____

Allergies: _____

Other: _____

Please list issues you may have regarding each category or leave blank if not applicable:

Skin: _____

Head/Neck: _____

Respiratory: _____

Cardiovascular: _____

Gastrointestinal: _____

Urinary: _____

Female Reproductive: _____

Male Reproductive: _____

Musculoskeletal: _____

Neurologic: _____

Psychiatric: _____

What are your main interests and hobbies? _____

Do you exercise? Yes No
How often? _____

What types of exercise? _____

Do you eat three meals a day? Yes No
Awake rested? Yes No
Sleep well? Yes No
Average hrs/night of sleep? _____
Spend time outside? Yes No
Take vacations? Yes No
Television - _____ hrs/day
Reading - _____ hrs/day
Use tobacco? Yes No
Use illegal drugs? Yes No
Have you ever been treated
For substance abuse or any kind?
(alcohol, drugs) Yes No

Weight _____

Weight 1yr ago _____

Maximum Weight _____

When? _____ Height _____

What is/are your support system(s)? _____

What is your occupation and do you enjoy it? _____

What are the major stresses in your life? _____

What do you do to relax/recreate/socialize/cope with stress? _____

When are you happiest, what gives you joy? _____

Client Signature: _____ Date: _____

Thank you for your effort. Welcome to The Center, we look forward to serving you

New Office Policy

Effective Date: September 2, 2011

Dear Patient,

We would like to inform you of recent updates to our office policy. The following are helpful guidelines and information that will allow us to better assist our patients. Please read carefully!

Missed Appointments

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so that we can accommodate our other patients with a vacant appointment. You may also reschedule your appointment at that time. Failure to provide our office with 24 hour notification will incur a \$50 charge. Being more than 15 minutes late will result in needing to reschedule your appointment.

Notification of Lab Results

Patients are asked *not* to call the office for results of lab work and imaging. If you are getting lab work, it is best to schedule a follow-up appointment at the time of your visit. **Reports are not given over the phone.** Please allow ample time for laboratories to report test results in full and for your medical practitioner to review your labs when complete. If the results of your labs require consultation, our office staff will contact you in order to schedule a follow-up appointment. In the event that we receive critical laboratory results, a practitioner or office staff will contact you directly. If you are concerned that you did not have your lab work done in time for your appointment, please let us know so that we can reschedule the appointment if needed.

Prescription Refill

Please try to request new prescriptions or refills at the time of your appointment, when possible. To aid in getting your prescription filled on time, please call for refills at least 3 days prior to taking your last dose in order to give us ample time to review your medical chart and write/call-in the script. We cannot guarantee a script will be filled the same day the request is made. Please have your pharmacy's phone number available. We are not able to prescribe new medications over the telephone, as an office visit is needed for an accurate diagnosis. Also, we cannot provide refills by phone for patients who have not had an appointment within the last 12 months or at the practitioner's discretion.

Letters/Forms

Disability forms, social security forms, etc. are very complex and require time. There may be a \$20 fee for completing such forms. Please try to request letters relating to work and/or school from your provider at the time of your visit, when possible, and allow up to 2 weeks for turnaround. For release of medical records, please allow 7-10 days from the time your written request is received by our office for your request to be processed and completed. This request must be signed by you, authorizing us to release medical information. Please note, we only send medical information originating in our office, ie. your practitioner's medical office notes and/or ordered labs.

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Patient Responsibilities

The care a patient receives depends partially on the patient. Patients have a responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.

Financial Responsibilities

Most insurance plans require a co-pay that we are legally required to collect at the time of your visit. Please come to your visit prepared to pay your co-pay. Patients paying out-of-pocket for services are responsible for handling their own reimbursement issues with insurance companies. If further information is needed such as procedural codes or diagnostic codes, we will be happy to provide that. In the event that you need assistance in dealing with reimbursement issues with your insurance company, please contact the Health Care Bureau of the NYS Attorney General at 1-800-428-9071. For additional resources, please call Healthcare Advocates, Inc. at (215)-735-7711, or visit their website: www.healthcareadvocates.com.

Questions for your Practitioner

We understand you may have questions for your practitioners. As practitioners are seeing scheduled patients during the day, there is not always ample time for them to take your calls directly. Please leave a detailed message with one of the office staff who will give your message to your practitioner. Please allow us 24-48 hours to return your call answering routine questions. **If it is an urgent matter during business hours, do not leave a voice message but rather communicate your needs directly to office staff.** Our regular office hours for phone calls are 8:30am-4:30pm Monday through Friday, with a break from Noon-1pm. After regular office hours, please utilize our voice mail system following the instructions given.

Thank you for your understanding and cooperation. Please contact Nadine at (518) 689-2244 with any questions or concerns.

CIHH Therapeutic Agreements

STATEMENT OF COLLABORATION

As a CIHH practitioner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of the people who I work with. I believe it is my responsibility to:

- Assess each person's situation based on the information they provide
- Assist them to sort through their health-related challenges
- Provide information and options about treatment modalities that are available
- Support them to make conscious decisions regarding their health
- Develop, implement and support a plan of care that will promote physical, mental and spiritual health
- Evaluate the effectiveness of a plan of care
- Make referrals to community resources as appropriate

As a CIHH client, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

- Provide my CIHH practitioner(s) with information that is relevant to my health
- Be willing to sort through my health-related challenges
- Ask questions related to treatment options and information that is provided
- If supplements are mutually agreed as part of my treatment plan, take them only according to directions given to me and discontinue use if side effects ensue and report this to my CIHH practitioner(s)
- Work together with my CIHH practitioner(s) to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and spiritual health
- Make conscious decisions to nurture intrinsic healing and promote balance in my life
- Evaluate the effectiveness of my plan of care
- Participate in all scheduled treatment sessions

CONFIDENTIALITY STATEMENT

As a CIHH client, I understand that what I discuss with my CIHH practitioner(s) will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release of information.

I understand that if my safety or the safety of someone else is at risk, my CIHH practitioner(s) are legally obligated to respond by sharing this information with the appropriate resources. For example:

- Licensed Social Workers, Nurses and Physicians are mandated by New York State Law to report any suspicion of child abuse to the New York State Registry
- Inform someone close to the client if they feel the client might harm him/herself or anyone else

CIHH practitioners believe that the concept of integrative medicine works best when CIHH practitioner discuss their work in team meetings, peer review, and/or supervision. This allows each client to benefit from the combined insight, knowledge, skill and experience of CIHH practitioners and those who supervise them. I understand that discussions of this nature would not include identifying information beyond a "need to know" basis, and such discussions would have the same privilege of confidentiality as sessions with each individual practitioner.

Finally, I have read and understand the Office Policy dated September 2, 2011.

Client Signature: _____ Date: _____