ÔPTIM
CLINIC

REGISTRATION FORM

Primary Care Provider:	**Today's Date:**
Referring Physician:	**Preferred Pharmacy:**

DEMOGRAPHIC PATIENT INFORMATION

Patient's last name:	**First:**	**Middle**:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid

Street Address:	**PO Box:**	**City:**	**State:**	**ZIP Code:**
SSN:	**Birth Date:** / /		**Age:**	**Gender:** ❑ M ❑ F
Occupation:	**Employer:**		**Work phone :** ( )	
Primary Phone:		**Cell:**		
Primary Language:		**Email:**		

Preferred Communication: ☐ Phone ☐ Text ☐ Email | Would you like to be added to our promotional email list? ☐ Yes ☐ No

Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other Race ❑ Unknown ❑ White ❑ Declined

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑Declined

Do we have your permission to:

Leave a message on your primary phone? ❑Yes ❑No If no, alternate #:_____

Leave a message at your place of employment? ❑Yes ❑No If yes, work #:_____

Discuss your medical condition with any member of your household? ❑Yes ❑No If yes, whom: _____

Discuss your medical condition with members outside of your household? ❑Yes ❑No If yes, whom: _____

INSURANCE INFORMATION

Person responsible for bill:	Birth Date: / /	Address (if different):	Home phone number: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Work phone number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance:					
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Policy number:	Group number:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Secondary Insurance (if applicable):	Subscriber's name: Birth date: / /	Policy number:	Group number:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Phone number: ( )	

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Chesnut MD and associated providers. I am financially responsible for any balance due and I have read and understand Chesnut MD's Financial Agreement. I authorize the doctor or insurance company to release any information required for this medical claim. I understand that Chesnut MD's Notice of Privacy Practices is posted in the office and on the website for my information and is available to me upon request.

_____ _____

Signature of Patient or Legal Guardian **Date**

ÔPTIM
CLINIC

NEW PATIENT PAPERWORK

Required prior to scheduling an initial appointment. This is an extensive history form congruent with our medical model.

PATIENT NAME: _____ **TODAY'S DATE: _____/_____/_____**

DATE OF BIRTH: _____/_____/_____

How did you hear about ÔPTIM? : _____

At ÔPTIM CLINIC we believe in optimizing physical and cognitive potential. Utilizing cutting edge technologies, procedures, functional testing and analysis, provides the tools to assist in maximizing performance. A functional medicine approach seeks to identify and address the root cause of symptoms. In order to optimize your health, we need your participation. Do you agree with this model and are you willing to be an active member in your health journey, including being open to modifying your lifestyle (eg diet, exercise, etc) if indicated? Please circle: YES NO

CURRENT PRIMARY CARE PROVIDER: _____
CURRENT SPECIALTY MEDICAL PROVIDER(S): _____
PREFERRED PHARMACY: _____

LAST ANNUAL PHYSICAL: _____
LAST LAB WORK: _____

TOP 5 MEDICAL CONCERNS (In order of importance to <u>you</u>)	**SEVERITY 1-10 (1 MILD-10 SEVERE)**	**FREQUENCY (If applicable)**
1.		
2.		
3.		
4.		
5.		

CURRENT MEDICATIONS/SUPPLEMENTS (*to include Name/Strength/Frequency):*

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

IF YOU HAVE ANY ADDITIONAL MEDICATIONS OR SUPPLEMENTS, PLEASE INCLUDE THESE ON THE COMMENTS PAGE

ALLERGIES:

Medication/Food/Supplement/Other	**Date:**	**Reaction**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

GASTROINTESTINAL:	ONSET
□ Heartburn/GERD/Reflux	_____
□ Irritable Bowel Syndrome	_____
□ Stomach Ulcer	_____
□ Hepatitis	_____
□ Other_____	_____

CARDIOVASCULAR:	ONSET
□ Heart Attack	_____
□ Heart Disease	_____
□ Irregular Heart Rate/Afib	_____
□ Elevated Blood Pressure	_____
□ Elevated Cholesterol	_____
□ Other_____	_____

METABOLIC/ENDOCRINE:	ONSET
□ Type 1 or Type 2 Diabetes	_____
□ Thyroid Disease	_____
□ Eating Disorder	_____
□ Other_____	_____

GENITAL/URINARY:	ONSET
□ Urinary Tract Infections	_____
□ Kidney Stones	_____
□ Recurrent Yeast Infections	_____
□ Frequent Urination	_____
□ Kidney Disease	_____
□ Other_____	_____

MUSCULOSKELETAL:	ONSET
□ Osteoarthritis	_____
□ Fibromyalgia	_____
□ Chronic Pain	_____
□ Other_____	_____

RESPIRATORY:	ONSET
□ Asthma	_____
□ COPD	_____
□ Sleep Apnea	_____
□ Other_____	_____

AUTOIMMUNE/INFLAMM:	ONSET
□ Chronic Fatigue Syndrome	_____
□ Rheumatoid Arthritis	_____
□ Lupus	_____
□ Allergies	_____
□ Other_____	_____

ENT:	
□ Difficulty Clearing Ears	_____
□ Recurrent Sinusitis	_____
□ Other _____	_____

SKIN:	ONSET
□ Eczema	_____
□ Psoriasis	_____
□ Acne	_____
□ Cold Sores/Herpes Virus	_____
□ Other_____	_____

NEURO/PSYCH:	ONSET
□ Depression/Anxiety	_____
□ Stroke	_____
□ Migraines	_____
□ Multiple Sclerosis	_____
□ Seizures	_____
□ ADD/ADHD	_____
□ Other_____	_____

CANCER	ONSET
□ Lung	_____
□ Breast	_____
□ Colon	_____
□ Head/Neck	_____
□ Other_____	_____

Dental History	ONSET
□ Silver Mercury Fillings	_____
□ Root Canals	_____
□ Tooth Pain	_____
□ Bleeding Gums	_____
□ Problems chewing	_____
□ Other _____	_____

Environmental Exposures *In your home or work environment are you or have you been exposed to the following:*	ONSET ll
□ Mold	_____
□ Electromagnetic Radiation	_____
□ Damp Environments	_____
□ Old Paint	_____
□ Smokers	_____
□ Pesticides	_____
□ Harsh Chemicals	_____
□ Other _____	_____

Please describe any significant childhood health issues (eg prematurity, pregnancy/birth complications, recurrent infections): _____

How many times have you taken antibiotics? _____

How many times have you taken oral or injectable steroids? _____

HOSPITALIZATIONS *(Overnight in the hospital)*

Date:	Reason:
_____	_____
_____	_____
_____	_____

PREVENTIVE TESTS & IMAGING

Check box if yes, specify site and provide date

- ☐ Full Physical/Annual Exam: _____
- ☐ Bone Density: _____
- ☐ Cardiac Stress Test: _____
- ☐ EKG: _____
- ☐ Ultrasound: _____
- ☐ MRI: _____
- ☐ CT Scan: _____
- ☐ Colonoscopy: _____
- ☐ Upper Endoscopy: _____
- ☐ Other: _____
  _____

SURGERIES

Check box if yes and provide date

- ☐ Appendectomy: _____
- ☐ Gallbladder Removal: _____
- ☐ Hysterectomy +/- ovaries: _____
- ☐ Hernia Repair: _____
- ☐ Tonsillectomy: _____
- ☐ Dental Surgery: _____
- ☐ Joint Surgery (specify): _____
  _____
- ☐ Heart Surgery: _____
- ☐ Pacemaker: _____
- ☐ Other: _____

FEMALE HISTORY

Age at First Period: _____ Frequency: _____ Length:_____ Pain: Yes No Clotting: Yes No

Last Menstrual Cycle: _____ Sexually Active: Yes No Birth Control: _____ Last STD Screening: _____

Last Pap Smear: _____ Hx of Abnormal Pap: Yes No

Pregnancies: _____ Vaginal Deliveries: _____ Cesarean Deliveries: _____ Miscarriage: _____

Abortions: _____ Living Children: _____ Postpartum Depression? Y N Gestational Diabetes? Y N

Gynecologic Surgeries: _____ Other Hormone Therapy: _____

Mammogram (please provide most recent date): _____ History of Abnormal Mammogram: _____

Other Gynecologic History: _____

MALE HISTORY

Circle if applicable:

Testicular mass Testicular pain Prostate enlargement Prostate infection

Change in sex drive Erectile dysfunction Premature ejaculation Difficulty obtaining an erection

Difficulty maintaining an erection Urinary urgency/hesitancy/change in stream Vasectomy

Nocturia (urination at night) # times per night _____ Sexually transmitted infections (describe)_____

Last PSA test (date): _____ PSA Level: _____

Please list current or past hormone therapy or testing: _____

SOCIAL HISTORY:

Are you in the habit of:	Type	Frequency
☐ Tobacco Use	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Snuff	Amt Per Day: _____ How Long: _____ Quit (Date): _____
☐ Alcohol Use	☐ Beer ☐ Wine ☐ Liquor HISTORY OF ALCOHOL USE DISORDER? Yes No	Amount Per Day: _____ ***OR*** Per Week: _____ Quit Date: _____
☐ Drugs	☐ Marijuana ☐ Other _____ HISTORY OF DRUG USE DISORDER? Yes No	Amount Per Day: _____ Quit Date: _____
☐ Caffeine	☐ Coffee ☐ Soda ☐ Energy Drink ☐ Tea	Amount Per Day: _____
☐ Exercise Routine ☐ Special Diet (eg Vegan, Vegetarian, Paleo, etc)? Please describe. ☐ Do you fast? Please describe:	_____ _____ _____ _____ _____	Min Per Day: _____ Times Per Wk: _____

DIET - Please record what you eat in a typical day:

Breakfast/Time: _____

Lunch/Time: _____

Dinner/Time: _____

Snacks/Time(s): _____

Fluid(s): _____

Please list any food sensitivities and/or allergies and reaction: _____

ELIMINATION

How often do you move your bowels/stool (*please circle*): 1 EVERY OTHER DAY 1 DAILY 2-3 DAILY
OTHER: _____

Are you prone to (*please circle*): CONSTIPATION DIARRHEA/LOOSE STOOLS NEITHER

Are you prone to intestinal gas or bloating? YES NO If YES, please explain/how often: _____

SLEEP

How many hours of sleep do you get each night on average? _____
Do you have trouble falling asleep? YES NO
Do you have problems staying asleep? YES NO

Do you use sleeping aids? YES NO - If YES, please explain: _____
Do you snore? YES NO

STRESS

Do you feel you have an excessive amount of stress in your life? YES NO
Do you feel you can easily handle the stress in your life? YES NO
How much stress do each of the following cause on a daily basis (*Rate on a scale of 1-10, 10 being the highest*)
Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____
Do you use relaxation techniques (eg Yoga, Meditation, Breathing, Prayer, etc)? YES NO
If YES, please describe:_____

RELATIONSHIPS

Relationship status (*circle any that apply*):
SINGLE MARRIED DIVORCED GAY/LESBIAN LONG-TERM PARTNER WIDOW/ER OTHER_____

With whom do you live? _____
Do you have resources for emotional support? YES NO (*Check all that apply*)
SPOUSE/PARTNER FAMILY FRIENDS RELIGIOUS/SPIRITUAL PETS OTHER _____

Do you have a religious or spiritual practice? YES NO

Current Occupation: _____
Previous Occupation(s): _____

FAMILY MEDICAL HISTORY

Does your *family* have history of:	**Relation**
☐ Diabetes	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Thyroid Problems	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ High Blood Pressure	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ High Cholesterol	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Heart Disease	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Blood Clots/Blood Disorder	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Asthma/COPD/Lung Disease	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Allergies/Hives	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Breast or Cervical Cancer	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Other Cancer (specify)	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Depression/Anxiety	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Mental Illness (specify)	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Migraines	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Seizures	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Osteoporosis	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Arthritis	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Autoimmune Disorder (eg. Lupus, Rheumatoid Arthritis)	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Liver Disease	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other
☐ Other_____	☐Mother ☐ Father ☐Grandmother ☐Grandfather ☐ Other

REVIEW OF SYSTEMS:

Please check all current symptoms occurring or present:

GENERAL:
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Headaches
- ☐ Insomnia

EYES:
- ☐ Vision Loss
- ☐ Light Sensitivity
- ☐ Double Vision
- ☐ Blurring
- ☐ Eye Pain
- ☐ Irritation/Dryness
- ☐ Discharge

EAR/NOSE/THROAT:
- ☐ Ringing in Ears
- ☐ Decreased Hearing
- ☐ Congestion
- ☐ Earache
- ☐ Ear Discharge
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Runny Nose

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Difficulty Breathing Lying Down
- ☐ Ankle Swelling
- ☐ Leg Cramps During Exertion
- ☐ Fainting Spells

RESPIRATORY:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Sputum Production
- ☐ Snoring
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Waking Up Gasping for Breath

GASTROINTESTINAL:
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habit
- ☐ Black or Bloody Stools

GENITOURINARY:
- ☐ Pain with Urination
- ☐ Urinary Urgency/Frequency
- ☐ Blood in Urine
- ☐ Difficulty Starting Urination
- ☐ Loss of Bladder Control
- ☐ Discharge
- ☐ Genital Sores
- ☐ Decreased Libido

MUSCULOSKELETAL:
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Muscle Cramps
- ☐ Joint Swelling
- ☐ Joint Stiffness

SKIN:
- ☐ Rash
- ☐ Itching
- ☐ Hair Loss
- ☐ Dryness
- ☐ Suspicious Lesions
- ☐ Poor Skin Healing

NEUROLOGICAL:
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Headaches
- ☐ Speech Problems
- ☐ Seizures
- ☐ Tremors
- ☐ Balance Problems

PSYCHIATRIC:
- ☐ Suicidal Thoughts
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Mental Disturbance
- ☐ Paranoia

ENDOCRINE
- ☐ Increased Appetite
- ☐ Increased Thirst
- ☐ Excessive Urination
- ☐ Cold/Heat Intolerance

BLOOD/IMMUNOLOGICAL:
- ☐ Tendency Towards Bleeding
- ☐ Abnormal Bruising
- ☐ Persistent Infections

PLEASE LIST YOUR HEALTH GOALS:

_____

_____

_____

READINESS ASSESSMENT:

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet: _____

Take several nutritional supplements each day: _____

Modify your lifestyle (eg work demands, sleep habits): _____

Practice a relaxation technique: _____

Engage in regular exercise: _____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing changes? _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (eg telephone calls, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? _____

OTHER COMMENTS:

_____

_____

_____

_____

_____

_____

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help *to* ***identify the underlying causes of illness***, and helps you track your progress over time. Rate each of the following symptoms based on your health profile for the **past 30 days**.
If you are completing this **after your first time, then record your symptoms for the **last 48 hours ONLY**.

POINT SCALE: 0 = ***Never*** or ***almost never*** have the symptom
1 = ***Occasionally*** have it, effect is ***not severe***
2 = ***Occasionally*** have it, effect is ***severe***
3 = ***Frequently*** have it, effect is ***not severe***
4 = ***Frequently*** have it, effect is ***severe***

PLEASE CIRCLE: INITIAL ASSESSMENT (PAST 30 DAYS)

SUBSEQUENT ASSESSMENT (PAST 48HRS)

HEAD
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
Total _____

EYES
_____Watery or itchy eyes
_____Swollen, red, or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision (not including near or far sightedness)
Total _____

EARS
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears/hearing loss

Total _____

NOSE
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
Total _____

MOUTH/THROAT
_____Chronic coughing
_____Gagging, frequent throat clearing
_____Sore throat, hoarseness
_____Swollen/discolored tongue, gums, lips
_____Canker sores
Total _____

SKIN
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating
Total _____

HEART
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain
Total _____

LUNGS
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing
Total _____

DIGESTIVE TRACT
_____Nausea, vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching, passing gas
_____Heartburn
_____Intestine/Stomach pain
Total _____

JOINTS/MUSCLES
_____Pain or aches in joints
_____Arthritis
_____Stiffness, limitation of movement
_____Pain or aches in muscles
_____Feeling weakness or tiredness

Total _____

WEIGHT
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Water retention
_____Underweight
Total _____

ENERGY/ACTIVITY
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
Total _____

MIND
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Poor physical coordination
_____Difficulty in making decisions
_____Stuttering or stammering
_____Slurred speech
_____Learning disabilities
Total _____

EMOTIONS
_____Mood swings
_____Anxiety, fear, nervousness
_____Anger, irritability, aggressiveness
_____Depression
Total _____

OTHER
_____Frequent illness
_____Frequent or urgent urination
_____Genital itch or discharge
Total _____

GRAND TOTAL: _____

Optimal < 10 ***Mild Toxicity 10-50*** ***Moderate Toxicity 50-100*** ***Severe Toxicity >10***

ÔPTIM
CLINIC

FINANCIAL POLICY

If you do not have insurance, you must pay at the front desk prior to the time of service or make other arrangements with our billing staff. We accept cash, personal checks, and all credit cards including CareCredit.

If you have insurance, we will file claims for you. We will need your current insurance and policy holder information. You will need to authorize payment directly to Chesnut MD. If your insurance requires co-payments, you **must** pay that amount at the time of service. Co-pays *not* paid at the time of service will be subject to a $10 statement fee. You are responsible for paying Chesnut MD for any services not covered by insurance.

The nature of ÔPTIM services include treatments, packages, and memberships that are not billable to insurance, in which you will be responsible for prior to receiving these services.

We will send you a monthly statement so you will know your insurance company has made a payment and the remaining balance. Payment is due upon receipt of the monthly billing statement. Even if you have insurance**, payment to Chesnut MD is your responsibility.** You should know the details of your insurance plan, including which doctor your plan requires you to see. Many insurance plans require you to use certain doctors and may require pre-certification or referrals to another facility. We are not responsible if you are sent to the wrong facility.

Chesnut MD may bill you these additional charges:

- $25 for late cancellations and no-shows for office visits (24 hour notice required)
- $50 for a treatment modality (IV therapy, hyperbaric oxygen therapy, cryotherapy, etc) no show (24 hour notice required)
- $20 NSF fee for returned checks
- $10 statement fee for nonpayment of co-pay at time of service

Accounts not paid in full within 90 days may be turned over to an outside collection agency. If you cannot make regular monthly payments and pay in full within the 90 days, please contact us. If you have any questions about this information, please call (509) 252-1299.

***I have read and understand Chesnut MD Financial Policy:**

_____/_____

Signature & Date **Printed Name**

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Informed Consent for Integrative Medical Treatment

As a patient I have the right to be informed about my condition and recommended care. This disclosure is to help me become better educated so I may make the decision to give or withhold my consent (in regards to care) having had the opportunity to discuss potential benefits, risks, and hazards involved.

I hereby request and voluntarily consent to examination and treatment with integrative medical care. This possibly includes prescription medications, homeopathic supplements, vitamins, minerals, supplements, IV therapies, infections, hyperbaric oxygen therapy, LED light therapy, IR sauna, cryotherapy, injections, detoxification treatment modalities, ozone therapies, lab testing, nutrition recommendations, regenerative medicine, etc. for me (or for the patient named below, for whom I am legally responsible) by ÔPTIM Clinic/ChesnutMD and Cameron Chesnut, MD and/or Leah Streich, PA-C, and/or other licensed medical providers, or those working or training at the office who now or in the future may treat me while employed by, working or training with, or serving for back up for the aforementioned. I can request that students **not** be included in my evaluation and treatment. I can request further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.

I understand that the U.S Food and Drug Administration has not fully evaluated or approved nutritional, herbal and homeopathic supplements, vitamins, minerals, supplements, compounded IVs/injections, ozone therapies, and bio-identical hormone replacement therapies, etc; however, they have been widely used in the U.S and other countries for years. I understand that, as with drugs, these therapies may cause allergic reaction or side effects in certain individuals, may interact with certain allopathic medications or lab tests, or result in symptoms, due to certain pre-existing disease conditions. I do not expect the medical provider to be able to anticipate and explain all risks and complications, and I wish to rely on the medical provider to exercise judgment in recommending the dietary supplements, medications, and treatment/therapies, that the medical provider feels (at the time), based on the facts then known, is in my best current interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result.

It is my responsibility to keep my medical provider up to date with all of the current medications and supplements that I am taking, so that he/she can make the best informed recommendations for my care.
I have the opportunity to ask questions and discuss with my provider to my satisfaction:

- my suspected diagnosis or condition
- the nature, purpose, and potential benefit of the proposed care
- the inherited risks, complications, potential hazards, or side effects of the treatment or procedure
- the probability or likelihood of success
- reasonable available alternatives to the proposed treatment or procedure
- the possible consequences if treatment or advice is not followed and/or nothing is done

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I understand that integrative medicine, evaluation and treatment may include, but is not limited to: collecting specimens for laboratory evaluation, ordering diagnostic imaging, prescription of certain medications and nutritional supplements, IV therapy, medical ozone treatment/therapy, bio-identical hormone replacement therapy, injections, counseling, dietary therapies, infrared sauna, hyperbaric oxygen, cryotherapy and homeopathic or other alternative remedies.

I understand that the medical providers at ÔPTIM Clinic/Chesnut MD have been trained in a diverse range of diagnostic and treatment options. I understand that ÔPTIM Clinic/Chesnut MD is highly specialized and based upon evidence-based medicine, including functional medicine and holistic principles. As such, they may recommend different tests, may interpret standard tests differently, may propose different treatments, or may administer standard treatments differently than most conventional physicians as many perspectives exist in medicine and in some cases, there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Diagnosis and treatment may include some services that are considered non- traditional, non-conventional or alternative medicine. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence based functional and integrative medicine.

By signing this form, I acknowledge that I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by ÔPTIM Clinic/Chesnut MD and their staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment and I may ask my medical provider for a more detailed explanation.

_____

PRINT PATIENT NAME

_____

SIGNATURE OF PATIENT (OR GUARDIAN)

_____

DATE

_____

DATE OF BIRTH

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NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

Uses and Disclosures:
Treatment: Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on the dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support day to day activities and management of Chesnut MD. For example, information on the services your received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. Your health information may be used by staff to send appointment reminders or information regarding the treatment and management of you medical condition.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Chesnut MD is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. As permitted by law, we reserve the right to amend or modify our policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Upon requires, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing . You may obtain a form to require access to your records by contacting a receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

The rights of patient(s) include, but are not limited to:

1) Exercise these rights without regard to sex or cultural, economic, educational, or religious background or the source of payment for his/her care.
2) Be treated and cared for with dignity & respect.
3) Knowledge of the name of the physician or other medical provider who has primary responsibility for coordinating his/her care and the names and professional relationships of other medical providers who will see him/her.
4) Receive information from his/her physician or other medical provider about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.
5) Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
6) Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment.
7) Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
8) Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the center. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
9) Reasonable responses to any reasonable requests he/she may make for service.
10) Leave the center even against the advice of his/her physician(s) or other medical provider(s).
11) Reasonable continuity of care and to know in advance the time and location of appointment as well as the physician or other medical provider providing the care.
12) Be advised if center/personal physician or other medical provider proposed to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects.

13) Be informed by his/her physician or a delegate of his/her physician of his/her continuing health care requirements following his/her discharge from the center.
14) Examine and receive an explanation of his/her bill regardless of source of payment.
15) Know which center rules and policies apply to his/her conduct as a patient.
16) Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17) Designate visitors of his/her choosing. If the patient has decision-making capacity, whether or not the visitor is related by blood or marriage, unless;
    (A) No visitors are allowed;
    (B) The facility reasonably determines that the presence of a particular visitor to the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility;
    (C) The patient has indicated to the health facility staff that he/she no longer wants this person to visit.
18) Have the patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the center policy on visitation. At a minimum, the center shall include any person living in the household.
19) This section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.
20) Confidentiality, privacy, security, complaint resolution (refer to Grievance Procedure), spiritual care and communication. If communication restrictions are necessary for patient care and safety, the Center personnel will document and explain these restrictions to each patient and family member/caretaker.
21) Be protected from abuse and neglect.
22) Access protective services.
23) Complain about their care and treatment without fear of retribution or denial of care.
24) Timely complaint resolution (refer to Grievance Procedure).
25) Be involved in all aspects of their care including:
    (A) Refusing care and treatment
    (B) Resolving problems with care decisions
26) Be informed of unanticipated outcomes as thoroughly as possible.
27) Family input in care decisions, in compliance with existing legal directives of the patient or existing court-issued legal orders.
28) The right to be informed that Cameron Chesnut, MD has an ownership interest in this center.

Concerns regarding ÔPTIM Clinic/Chesnut MD may be addressed to the Administrator at (509) 456-5949 or to:

Washington State Department of Health
HSQA Complaint Intake
P.O. Box 47857
Olympia, WA 98504-7857
Phone: (360) 236-4700
Toll Free: (800) 633-6828
Fax: (360) 236-2626
Email: mailto:HSQAComplaintIntake@doh.wa.gov

Accreditation Association for Ambulatory Health Care, Inc.
5250 Orchard Road, Suite 200
Skokie, Illinois 60077
(847) 853-6060

Center for Medicare and Medicaid Services (CMS)
Office of the Medicare Beneficiary Ombudsman:
http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html
Medicare Help and Support: 1-800-MEDICARE (1-800-633-4227)

*I have read and understand ÔPTIM Clinic/Chesnut MD Notice of Privacy Practices & Patient Rights:

_____

Name Printed Date

_____

Signature Date