Today's Date _____ / _____ / _____

PEDIATRIC INTAKE (Birth – 17 Years)

Patient's name _____ Date of first visit _____

Age _____ Date of Birth _____ / _____ / _____ Gender: Female ____ Male ____

Mother's name _____ Father's name _____

If parents are separated or divorced- who has custody of the child and power to make medical decisions?

_____

Address_____ City_____

State _____ Zip _____

Tel (H)_____ (W)_____ (Cell)_____

How did you hear about our center?_____

Health insurance: Company _____

Policy/I.D. No. _____ Group No. _____

Name policy is in _____

Date of birth of policy holder _____

Name of Dr.'s Office/ Hospital/ Clinic where your child's health records are kept? _____

_____

Reason for referral or presenting problems _____

_____

Next of Kin or other to reach in case of an emergency? _____

_____

Relationship _____ Phone _____

Address _____

Please list with whom, other than yourself, we may discuss your child's personal medical information

1) Name _____

   Telephone _____

   Relationship _____

2) Name _____

   Telephone _____

   Relationship _____

In the event that we cannot speak to you directly, do you wish for us to leave messages medical information on your voicemail or message system?

Yes _____ No _____

If yes, what number may we leave medical information?

(H) _____ (W) _____ (Cell) _____

Do you wish to receive newsletters in the form of emails from our office?

Yes _____ No _____

Do you wish to receive text messages about appointment reminders?

Yes _____ No _____

What are your child's most important health problems? List them in order of importance:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

MEDICATONS	Now	Past		Now	Past
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Antihistamine	____	____
Decongestant	____	____	Ibuprofen	____	____

Any other medications and dosages_____

_____

Please list any medications, over the counter medications, vitamins or supplements that your child is currently taking

1.) _____ 6.)_____
2.) _____ 7.)_____
3.) _____ 8.)_____
4.) _____ 9.)_____
5.) _____ 10.)_____

ALLERGIES

Is your child allergic or sensitive to any of the following

Any foods? _____

Any drugs? _____

Any environmental? _____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx. no _____

_____ Measles _____ Pneumonia _____ Ear infections, no. _____

_____Mumps _____Frequent colds _____ Rheumatic fever _____

_____Rubella _____Other (explain) _____

Has your child had any of the following tests? (When, where, and results?)

Electroenceohalogram_____

Psychological evaluation _____

Hearing _____

Speech/Language_____

Injuries/ Surgeries/ Hospitalizations (please list) _____

_____

_____

IMMUNIZATIONS

_____ Measles _____Polio _____MMR _____Small Pox

_____Mumps _____DPT _____Tetanus _____Influenza

Others (list) _____

Any adverse reactions ? Y / N

What? _____

FAMILY HISTORY

_____ Heart disease _____Diabetes _____Birth defects Hypertension _____

_____ Arthritis _____Tuberculosis _____ Cancer Allergies _____

_____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?

Mother age at child birth? _____

Mothers health during pregnancy ? _____

_____ Bleeding _____ Physical or emotional trauma _____ Nausea

_____ Cigarettes, alcohol, drug consumption _____ Medications

_____ Hypertension (pre eclampsia) _____ Thyroid problems _____ Diabetes

BIRTH HISTORY (children birth to 5 y/o)

Term: Full_____ Premature _____ Late _____ Weight at birth _____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____Birth injuries _____Blue baby _____ Cerebral palsy

_____ Seizures _____ Jaundice _____Colic _____ Fever

_____ Rashes _____ Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breast fed? Y / N To what age? _____

Formula? milk / soy To what age? _____

Age began solids _____ Which foods? _____

Sitting _____ Crawling _____

Walking _____ Talking _____

Review of Systems mark **Y** if current, **P** for past symptoms, **N** for none)

MENTAL/ EMOTIONAL

Treated for emotional problems	Y P N	Depression	Y P N
Mood swings	Y P N	Anxiety or nervousness	Y P N
Unusual Swings	Y P N	Irritability	Y P N

MENTAL/ EMOTIONAL (con't)

Poor concentration	Y P N	Memory problems	Y P N
Hyperactivity	Y P N	Introvert/Extrovert	Y P N
Motion sickness	Y P N	Cries easily	Y P N

ENDOCRINE

Hypothyroid	Y P N	Heat or cold intolerance	Y P N
Low blood sugars	Y P N	Diabetes	Y P N
Excessive thirst	Y P N	Excessive hunger	Y P N
Fatigue	Y P N		

NEUROLOGIC

Seizures	Y P N	Muscles weakness	Y P N
Loss f memory	Y P N	Easily stressed	Y P N
Loss of memory	Y P N	Vertigo or dizziness	Y P N
Loss of balance	Y P N		

SKIN

Rashes	Y P N	Eczema	Y P N
Acne, Boils	Y P N	Itching	Y P N
Color Change	Y P N	Perpetual Hair Loss	Y P N
Lumps	Y P N	Night Sweats	Y P N

HEAD

Headaches	Y P N	Head Injury	Y P N

EYES

Impaired vision	Y P N	Glasses or contacts	Y P N
Blurriness	Y P N	Tearing or dryness	Y P N

Color blindness?	Y P N		

EARS

Impaired Hearing	Y P N	Ringing	Y P N
Earaches	Y P N		

NOSE AND SINUSES

Frequent colds	Y P N	Nose Bleeds	Y P N
Stuffiness	Y P N	Hayfever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH AND THROAT

Frequent sore throat	Y P N	Copious saliva	Y P N
Teeth grinding	Y P N	Sore tongue/lips	Y P N
Gum problems	Y P N	Hoarseness	Y P N
Dental Cavities	Y P N	Jaw Clicks	Y PN

RESPIRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N
Pneumonia	Y P N	Pleurisy	Y P N
Shortness of breath	Y P N	Tuberculosis	Y P N

HEART

Heart disease	Y P N	Murmurs	Y P N
High/Low Blood Pressure	Y P N	Fainting	Y P N

GASTROINTESTINAL

Trouble swallowing	Y P N	Heartburn	Y P N
Change in thirst	Y P N	Change in appetite	Y P N

Nausea	Y P N	Vomiting	Y P N
Vomiting blood	Y P N	Bowel Movements	____ # per day
Blood in Stool- Is this a change _____		Constipation	Y P N
Pain or cramps	Y P N	Diarrhea	Y P N
Belching or passing gas	Y P N	Gall bladder	Y P N
Black Stools	Y P N	Ulcer	Y P N
Jaundice (yellow skin)	Y P N	Hemorrhoids	Y P N
Liver Disease	Y PN		

URINARY

Pain on urination	Y P N	Increased frequency	Y P N
Bed wetting	Y P N	Inability to hold urine	Y P N
Frequent infections	Y P N		

BOY'S HEALTH

Hernias	Y P N	Testicular masses	Y P N
Testicular pain	Y P N	Prostate disease	Y P N
Venereal disease	Y P N	Discharge or sores	Y P N
Are you sexually active	Y N	Chlamydia	Y P N
Sexual orientation _____		Gonorrhea	Y P N
Birth control? Type? _____		Herpes/Syphilis	Y P N

GIRLS's HEALTH

Age of first menses _____		Age of last menses?	_____
Are cycles regular	Y N	Length of cycle	_____ days
Bleeding between cycles	Y P N	Duration of menses	_____ days
Pain during intercourse	Y P N	Painful menses	Y P N
Clotting	Y P N	Heavy or excessive flow	Y P N
Discharge ?	Y P N		

P M S? if yes, symptoms? _____

Birth control?	Y P N	What type?_____ Number of years?_____	
Number of pregnancies ?	____	Numbers of miscarriages ?	_____
Number of live births ?	____	Number of Abortions ?	_____

GIRL'S HEALTH (cont.)

Endometriosis	Y P N	Ovarian Cyst	Y P N
Difficulty conceiving	Y P N	Menopause Symptoms	Y P N
Cervical Dysplasia	Y P N	Abnormal PAP	Y P N
Sexual difficulties	Y P N	Chlamydia	Y P N
Gonorrhea	Y P N	Condyloma	Y P N
Herpes	Y P N	Syphilis	Y P N
Are you sexually active?	Y N	Sexual orientation?	_____
Do you do breast self-exam?	Y P N	Breast lumps?	Y P N
Breast pain/ tenderness	Y P N	Nipple discharge?	Y P N

MUSCULOSKELETAL

Joint pain or stiffness	Y P N	Arthritis	Y P N
Broken bones	Y P N	Weakness	Y P N
Muscle spasm or cramps	Y P N	Sciatica	Y P N

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising	Y P N	Anemia	Y P N
Deep leg pain	Y P N	Cold hands/ feet	Y P N

DIET

Please describe your child's typical daily diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

Is your child on any special diet?

Gluten Free? Y N Wheat Free? Y N Vegan? Y N Yeast Free? Y N

Dairy /Lactose Free? Y N Vegetarian? Y N Other? _____

Exercise

What form _____

How often _____

Is there any additional information that you feel is pertinent to better understand your child's health?

_____

_____

Dear parent (s),

Moringa Natural Health Center (MNHC)is honored to be a part of your child(ren)'s care. We as naturopathic physicians have a focus on preventative care for the entire family, and pediatric care as an integral part of that focus. In order to provide the best care for your child(ren), we would like to have all parents and guardians who have rights to make medical choices on your child(ren)'s behalf sign an informed consent to treatment. This will insure that all caregivers are aware of and may take part in the care provided by **MNHC**.

By signing the informed consent, you are giving any advanced permission to the doctors or staff at the **MNHC** to perform any testing or treatment on your chid(ren); you are acknowledging that they are under our care. All testing and treatments will be discussed with the caregivers at each visit as indicated.

Please list below any caregivers that have rights to make medical decisions on your child(ren)'s behalf along with their relationship to your chil(ren). Established care and treatment cannot continue until the informed consent forms are signed by parent/guardian legally involved in your child(ren)'s healthcare.

Feel free to discuss any questions or concerns with our staff or with your child (ren)'s naturopathic provider during the allotted visit.

Call us at **623.266.0059** to learn more about our yearlong preventative family wellness program to ensure that each of you is taken care of throughout all seasons.

Name of parent/guardian: _____ Date:_____

Relationship to child: _____ Received copy of informed consent Y N

Name of parent/guardian: _____ Date: _____

Relationship to child: _____ Received copy of informed consent Y N

Name of parent/guardian: _____ Date: _____

Relationship to child: _____ Received copy of informed consent Y N

NATUROPATHIC CONSENT TO TREATMENT FORM

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches are used. Diet and Nutritional supplements, Nutritional therapies, homeopathy, traditional Chinese medicine, acupuncture, hydrotherapy, regenerative injection therapies for pain, and lifestyle counseling are the mainstays of naturopathic medicine.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits include increase energy, improve gastrointestinal function, better immunity, and general well-being.

Botanical Medicine is a plant-based medicine using herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boos the body's immune system and prevent diseases.

Homeopathy is a form of medicine based on the Law of Similars, which is the use of tiny, extremely diluted doses of the very same thing that causes symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's inability to heal itself. Homeopathy is a powerful tool and affects healing on a physical and emotional level.

Chinese Medicine includes acupuncture, cupping, guasha, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points of the surface of the body. Sometimes moxa (a compressed herb in the form of a stick) is burned over an acupuncture point to help relieve symptoms. Botanical formulas may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Herbal formulas may include shell, mineral, animal, and plant materials. Dietary advice is based on traditional Chinese medical theory.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.
As Naturopathic Medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. My mission is to help identify any risk factors and make recommendations to help you optimize your physical, mental, and emotional environment. I will take a thorough case history, do a screening physical examination (including breast examination if indicated).

It's known that even least invasive therapies have their complications in certain physiological conditions such as pregnancy and/or lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver, and/or kidney disease. It is very important that you inform us immediately of any disease process that you're suffering from or if you're taking

any medications. If you're pregnant, suspect you're pregnant, or you're breast-feeding, please inform us immediately.

There are some slight health risks to treatment by naturopathic medicine. These include, but are not limited to:

Temporary aggravation of pre-existing symptoms
Allergic reactions to herbs or supplements
Bruising from regenerative injection therapies, IV therapies, acupuncture, intramuscular injection, mesotherapy, and neural therapy.

A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others unless you give your written consent or the law requires it. You may look at your medical record at any time and can request a copy of it by submitting a written request and paying the appropriate fee for copying charges.

I, _____ understand that my Naturopathic Doctor will answer any questions to the best of their ability. I understand that results are not guaranteed. I do not expect my Naturopath to be able to anticipate and explain all risks and complications. I will rely on my Naturopathic Doctor to exercise judgment during the course of the procedure which he/she feels at that time is in my best interests based on the facts when known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (*please list any exceptions above*).

_____

_____

_____

_____

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient's Printed Name: _____Today's Date _____

Patient's or Guardian's Signature: _____

□ I would also like to apply my consent to treat all necessary treatments per discussion with my doctor, Dr. Lena Fernandez _____

Patient's or Guardian's Signature: _____

Notice of Privacy Practices for Protected Health Information (PHI)

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.

Moringa Natural Health Center is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This clinic will not use or disclose your health information except as described in this notice. If you consent, the office is permitted by federal privacy laws to make uses and disclosure of your health information we create and obtain in providing our services to you. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

Examples of uses of your health information for Treatment purpose:

✓A provider or assistant obtains treatment information about you and records it in a health record.

✓During the course of your treatment, the provider determines if he/she will need to consult with another specialist in the area. He/She will obtain your signed authorization before sharing information with such specialist to obtain his/her input.

✓Referral information may be forwarded to Diagnostic Testing Labs for further treatment or testing when the provider will want results of such treatment or testing reported back to him/her.

✓If the provider is a specialist, your health information and progress may be reported back to your primary care provider or referring provider, upon receipt of your written authorization.

Examples of uses of your health information for Payment purposes:

✓All payments are due at the end of services rendered on the day of. We do NOT submit requests for payment to your health insurance company. Upon your request, after the payment for services have been received, we gladly provide you with billing information so you can submit requests for payment to your health insurance company directly.

Examples of uses of your health information for Health Care Options:

✓We obtain services from other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, medical transcription, medical review, legal services, and electronic health record (EHR).

✓We will share health information about you with our laboratory contracts and other business associates to protect the confidentiality of your health information.

Your Health Information Rights:

The health records we maintain are the physical property of the treating provider. The information in it, however, belongs to you. You have the right to:

✓Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted as required by law.

✓Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.

✓Obtain an accounting of disclosure of your health information as required to be maintained by lay, upon request. An accounting will not include internal uses of information for treatment, payment, operation, or disclosure made to you.

✓Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

✓If you want to exercise any of the above rights, please contact our office in writing during normal business hours. We will provide you with assistance on the steps to take for you to exercise your rights.

✓You have the right to review this notice before signing the consent authorizing use and disclosure of your PHI for treatment, payment, and health care operations purpose.

Our Responsibilities:

This office is required to:

✓Maintain the privacy of your health information as required by law.

✓Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.

✓Abide by the terms of this notice.

✓Notify you if we cannot accommodate a requested restriction or request.

✓Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provision in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our notice. You're entitled to receive a revised copy of the notice by calling and requesting a copy of our notice or by visiting our office and picking up a copy.

To Request Information or File a Complaint:

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office at the contact number listed above. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office or by delivering the written complain to our office. You may also file a complaint by mailing it to the above address. We cannot, and will not, require you to waive the right to file a complaint with us as a condition of receiving treatment from our office. Likewise, we cannot, and will not, retaliate against you for filing a complaint with our clinic.

Other Disclosures and Uses:

Notification of Family/Friends: Our office does not disclose PHI or any other information to friends/family members unless you complete and sign an acknowledgment to release PHI to specific listed person(s).

Appointment Reminders and Treatment Information: We may contact you and/or leave a message on your telephone answering machine and/or voice mail to provide you with appointment reminders and/or payments due unless you submit a written request asking not to.

We do not leave lab results, prescription information, and/or recommended treatments on your answering machine and/or voice mail.

Workers Compensation: If you are seeking compensation through Workers Compensation, we will provide you with necessary paperwork to submit claims directly to them. We do not submit claims at our office. However, all payments are due at the end of services rendered on the same day.

Abuse, Neglect, and/or Domestic Violence: We may disclose your health information to public authorities as allowed by law to report abuse, neglect, and/or domestic violence.

Inmates: If you are an inmate of a correctional institution of under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and safety or the health and safety of other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order, for identification of a victim of a crime if certain protective requirements are met, to report a crime in emergencies, and other appropriate situations as permitted by law.

Judicial/Administration Proceeding: We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, discovery request, or other lawful process if certain specific requirement are met. To avert a serious threat to health or safety, we may disclose your PHI consistent with applicable law to prevent or lessen a serious imminent threat to the health and/or safety of a person or the public.

Other Uses: Any other uses and disclosure of your PHI besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Patient's Signature: _____ Today's Date:_____

Patient's Printed Name: _____ Today's Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name: _____Date of Birth:_____

I, _____ request and authorize **Moringa Natural Health Center (MNHC)** to release Protected Health Information (PHI) to the person (s) listed below pertaining to my care. I have the right to cancel this authorization at any time by sending a written request to MNHC.

I understand that cancellation does not apply to PHI already released previous to a revised/new authorization. If any information I have listed on this form changes, I will request and complete a new authorization form.

I understand that MNHC will continue to release PHI to the person(s) listed below until notified of a change.

Moringa Natural Health Care Center is authorized to discuss my care with:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

The Request and Authorization Applies to:

□ All Healthcare Information

□ Appointment Reminders, Treatment, and Billing Information

□ Other:

Patient's Signature: _____ Today's Date: _____

Patient's Printed Name: _____ Today's Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, acknowledge that I have received a copy of **Moringa Natural Health Center (MNHC)** Privacy Practices.

_____

Patient or legally authorized individual signature Date

_____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal Representative, etc.)

Acknowledgement of Non-Insurance Coverage for Services Rendered

I agree, and it has been explained to me, that the following services performed at the **MNHC** are not generally considered and accepted with respect to insurance coverage.

- IV / Injection services and supplies
- Any supplements such as botanicals, homeopathics, nutraceuticals, etc.
- Other supplies such as Kinesio Tape, etc.
- Office visits
- Blood draws in house
- Office Visits
- Prolozone/PRP

I understand that this requires my payment in full for all IV / Injection services, supplies, supplements, prolozone/PRP and I additionally understand that I may not attempt to bill my own insurance company for any of these services.

Patient's Name – Please Print	Date
Patient's Signature	Date
Physician's Name – Please Print	Date
Physician's Signature	Date

Communication Consent Form

E-mail and/or text messaging offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail and/or text messaging is not the same as calling us; there is no person at the other end of the call – just a computer or a cell phone. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail and/or text messaging affords are a benefit to patient care. It will further assist us if you could identify the nature of your request in the subject line of your message. Below are our rules for contacting us using e-mail and/or text messaging. Please check the box after reading each rule.

- ❑ E-mail and/or text messaging are **NOT** appropriate for urgent or emergency cases! Please use your telephone to dial 911 or go to the nearest Emergency Department for immediate care.
- ❑ E-mail and/or text messaging are great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail and/or text messaging also include referral and appointment scheduling requests.
- ❑ E-mails and/or text messages should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- ❑ E-mail and/or text messages are not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, non-clinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- ❑ E-mail and/or text messages may become a part of the medical record when we use it; a copy may be made and added to your electronic health records.
- ❑ E-mail and/or text messages are not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment!
- ❑ E-mails and/or text messages may be forwarded to my staff for handling, if appropriate.
- ❑ If you purchased our monthly single or family membership, then email or text messaging will count as one of your doctor contact and deducted from the membership monthly-allotted calls/visits.

Finally, either one of us can revoke permission to use the e-mail system at any time.

- ❑ I DO want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

Patient Name: _____

Patient Signature: _____

E-mail Address: _____

Date: _____

State of Residence: _____

The information contained in this e-mail or text message is confidential, privileged, or otherwise protected from disclosure. It is intended only for the use of the authorized individual as indicated in the e-mail and/or text message. Any unauthorized disclosure, copying, distribution or taking of any action based on the contents of this material is strictly prohibited. Review by any individual other than the intended recipient does not waive or give up the physician-patient privilege. If you have received this e-mail or text message in error, please delete it immediately.

Welcome to Moringa Natural Health Center! We are very excited to guide you and your family to health and wellness. Thank you for trusting in us. We look forward to helping you reignite your health.

Patient Payment, Appointment Cancellation Policy and Third Party Authorization

The **Moringa Natural Health Center** is a same-day pay office. Therefore, payment is expected at time of service, if you wish to submit the claim to your insurance ask front desk for reimbursement form.

We do offer affordable memberships where you get a chance to work with our doctors without physically being in the office after your initial visit with the doctor. Ask for membership rules and regulations.

Cancellation Policy:
We have a 24-hour cancellation/reschedule policy. If you do not call the clinic within 24 hours prior to your scheduled appointment to cancel or reschedule, you will be charged a $50.00 fee for the appointment.

Third Party Authorization:
Also, in order for **Moringa Natural Health Center (MNHC)** to service your account or to collect any amounts you may owe, that we, or any third-party vendor authorized by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

We, or any third-party vendor authorized by us, may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

By signing below, I understand and agree to the patient payment and cancellation policy. I guarantee payment of all charges incurred as a patient of the Moringa Natural Health Center.

Signed_____Date_____

Printed Name_____

Parent or Guardian (minor)_____Date_____

Medical Record Release Authorization

Authorization for use or disclosure of protected health information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and164).

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Doctor's Name: _____ Fax: _____

I Hereby Authorize and Request to Release My Medical Records To Moringa Natural Health Center. Fax: 623-266-0429

❑ Dr. Lena Fernandez

Please send the following records and information:
❑ Complete medical records ❑ Previous 2 years of records
❑ Dates of service from _____ to _____ ❑ All lab/diagnostic reports
❑ Previous 5 years of records ❑ Current and ongoing medical/protocol updates

Other: Release the Above Information To: _____ ❑ Self:

Phone: _____ Address: _____

FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" AND "X-RAY FILMS" SHALL INCLUDE ALL:
1. Confidential HIV-related information (as defined in A.R.S. Section 36-661).
2. Confidential communicable disease-related information (as defined in A.R.S. Section 36-661).
3. Confidential alcohol or drug abuse-related information (as defined in 42 CFR SECTION 2.1 ET SEQ).
4. Confidential mental health diagnosis/treatment information.
5. Confidential Genetics diagnosis/treatment information.

I have given my consent freely, voluntarily, and without coercion. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original. This authorization does not expire unless otherwise indicated. If you would like this authorizationtoexpire,pleaseindicatethedateofexpiration: _____

_____ _____ _____
Patient or Legally Authorized Representative Signature Relationship Date

Confidentially Notice: This fax may contain privileged material for the sole use of the intended recipient(s). Any review, use, or distribution by any other person (s) is strictly prohibited. If you have received this communication in error, please notify the sender.

Results Request Form

Dr. Lena Fernandez and our team at **Moringa Natural Health Center** take your health care very seriously and strive to provide you with the best information, so that you can in turn make an informed decision about your health care. Your physician has ordered labs or imaging for you, to better understand what may be transpiring within your body.

This information can be invaluable in assisting your physician to make appropriate recommendations for your health. It is the office policy of our clinic that laboratory and imaging results will be released after you have had a visit with your physician to go over the results together. This will ensure that there are no questions with regards to your results and what next steps should be taken as a result of those findings.

We understand and appreciate that you have a legal right to your medical information. We are more then happy to provide you with copies of your results at the time of your follow up at no additional expense.

If you should desire to have a copy of your results WITHOUT a follow up appointment with your physician we will do so with the signing of this document.

If you do not agree to sign this document, then **Moringa Natural Health Center** reserves the right to not release your results directly to you. Legally we have the right to refuse providing you with your results if it is deemed that it could create harm to you. We have encountered a number of instances in which people have taken it upon themselves to search the Internet for the meaning of their results and have then proceeded to attempt to treat themselves resulting in harm to themselves.

If you are going to continue care with another health care provider, we are happy to forward your results to your new provider so that you may have a discussion with them.

Statement:
I understand and assume any and all risk and liability involved in asking for a copy of my medical results WITHOUT having appropriate interpretation and follow up with my physician. I hold harmless my physician and Moringa Natural Health Care Center for any health concerns that may arise in the future as a result of choosing to not follow up with my physician and have proper medical interpretation of said results. Including but not limited to death, cancer diagnosis, medication overdosing or under dosing, heart attack and all other maladies that could arise due to lack of appropriate follow up. I have been given the opportunity to have an appropriate follow up visit with my physician to discuss my results and of my own sound mind and volition I am choosing to not have said follow up.

_____ _____
Patient name or minor guardian Date

_____
Patient signature or minor guardian

_____
Employee Witness

Welcome to Moringa Natural Health Center! We are very excited to guide you and your family to health and wellness. Thank you for trusting in us. We look forward to helping you reignite your health.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1-Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as 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 Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2-All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract, or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below, identified physician, medical group, or association, their partners, associates, corporations, partnerships, employees, agents, clients, and/or providers (therein after collectively referred to as "Physician") to a patient, including any spouse of 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 both the mother and the mother's expected child or children.

Article 3-Procedure and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against the Physician, the amount of damage sought, and the names, addresses and telephone numbers of patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree that arbitration shall be governed pursuant to Arizona revised Statues (ARS) 12-1501-12-1518 and the Federal Arbitration Action (9 U.S.C1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with pro rata share of the neutral arbitrator's fees and expenses.

Article 4-Revocation: This agreement may be revoked by written notice delivered to the Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5-Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from

and the remainder of the Agreement enforced in accordance with Arizona and Federal law.

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

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

Physician or Duty Authorize (Date) Representative Signature	Patient's Signature (Date)
Printed Name of Physician Medical Group, or Association Name	Printed Patient's Name (Date)
Signature of Translation (*if applicable*)	Signature of Patient's Representative (*if applicable)*
Printed Name of Translator (*if applicable*)	Signature of Patient's Representative (*if applicable)*