Rosh Health Center
info@roshhealth.com
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Patient Registration

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____/_____/_____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Primary language: _____ How did you hear about us: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Primary Care Physician (PCP)

Primary Care Physician Name: _____ Phone: _____

Patients Seeking Adjunctive Cancer Care

Oncologist Name: _____ Phone: _____

Most Recent Appt Date: _____/_____/_____ Last Bloodwork Date: _____/_____/_____

Guarantor Information (Financially Responsible Person)

Last Name: _____ First Name: _____ Middle Name: _____

Guarantor Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____

I certify to the best of my knowledge the information provided above is true and correct. I understand that I am the guarantor and responsible for full payment for the services that I will be receiving at this clinic.

_____ _____/_____/_____ _____

Signature of Patient or Legal Guardian **Date of Signing** **Indicate Relationship if Legal Guardian**

_____

Signer Name if Legal Guardian (Please Print)

Patient Name: _____ DOB: _____/_____/_____ Date of Visit: _____/_____/_____

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Patient Registration

Personal Health History

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____/_____/_____ Most Recent Physical Exam: _____

Purpose of today's visit: _____

_____

Estimate General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any allergies?

☐ Aspirin ☐ Ibuprofen ☐ Acetaminophen ☐ Codeine ☐ Penicillin ☐ Erythromycin

☐ Tetracycline ☐ Sulfa ☐ Local Anesthetic ☐ Fluoride ☐ Metals ☐ Latex

☐ Supplements ☐ Herbs ☐ Foods ☐ Other _____

Past Health History

Medical Conditions: Do you currently have or have history of any medical conditions?

_____

_____

List recent surgeries, hospitalization (provide date):

_____

List all current drugs, herbs, and supplements that you are taking:

Patient Name: _____ DOB: _____/_____/_____ Date of Visit: _____/_____/_____

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Do you have any family history of health conditions?

Family Member	Age	Health Condition

Social History

Alcohol intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking history: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Review of Systems: Please check boxes if you have experienced in the last six months any of these problems

Constitutional	☐ Fatigue ☐ Fever ☐ Chills ☐ Night sweats ☐ Weight gain ☐ Weight loss ☐ Exercise intolerance
Eyes	☐ Pain in or around the eyes ☐ Floaters ☐ Blurred vision ☐ Dry eyes ☐ Vision change ☐ Seeing double ☐ Discharge from the eyes
Ears	☐ Ear pain ☐ Ringing in the ears ☐ Loss of hearing
Nose	☐ Nasal congestion ☐ Nasal discharge ☐ Frequent nosebleeds ☐ Sinus pain ☐ Postnasal drip
Mouth/Throat	☐ Sore throat ☐ Bleeding gums ☐ Mouth sores ☐ Hoarseness ☐ Toothache ☐ Snoring
Cardiovascular	☐ Chest pain ☐ Palpitations ☐ Elevated blood pressure ☐ Heart murmurs ☐ Edema ☐ Bluish or purple discoloration ☐ Difficulty breathing when lying down ☐ Difficulty breathing during exertion ☐ Leg pain with exercise ☐ Varicose veins

Patient Name: _____ DOB: _____/_____/_____ Date of Visit: _____/_____/_____

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Respiration	☐ Cough ☐ Abnormal sputum ☐ Wheezing ☐ Shortness of breath ☐ Coughing up blood
Gastrointestinal	☐ Abdominal pain ☐ Nausea ☐ Vomiting blood ☐ Difficulty swallowing ☐ Belching ☐ Indigestion ☐ Bloating ☐ Flatus ☐ Diarrhea ☐ Constipation ☐ Hemorrhoids ☐ Blood in bowel movement
Genitourinary	☐ Difficulty urinating ☐ Pain during urination ☐ Bladder pain ☐ Pain in the flank ☐ Blood in urine ☐ Increased urinary frequency ☐ Urinary loss of control
Musculoskeletal	☐ Joint pain ☐ Back pain ☐ Muscle aches ☐ Cramps ☐ Soft tissue/joint stiffness ☐ Soft tissue/joint swelling
Integumentary	☐ Abnormal mole ☐ Rash ☐ Dry skin ☐ Itching ☐ Nail changes ☐ Jaundice ☐ Change in color of the skin ☐ Wounds
Neurologic	☐ Weakness ☐ Numbness ☐ Tremor ☐ Dizziness ☐ Frequent or severe headaches ☐ Loss of consciousness ☐ Seizures
Psychiatric	☐ Depression ☐ Anxiety ☐ Sleep disturbances ☐ Mood changes ☐ Hallucinations ☐ Suicidal thoughts
Endocrine	☐ Increased urinary frequency ☐ Increased hunger/appetite ☐ Increased thirst ☐ Hair changes ☐ Heat/cold intolerance ☐ Lump in the throat
Hematologic/Lymphatic	☐ Swollen glands ☐ Easy bruising ☐ Excessive bleeding ☐ Delayed healing ☐ Recurrent infections

Reset

Patient Name: _____ DOB: _____/_____/_____ Date of Visit: _____/_____/_____

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Informed Consent for Telehealth

Please read each paragraph and initial the bottom of first page and sign and date the second page.

Patient Name: _____ DOB: _____ Date: _____

At Rosh Health Center, patients will have the opportunity to connect with the clinic staff and seek telemedicine (TM) care through video conferencing, email, and fax. The process of handling protected health information (PHI) when participating in telemedicine at our center is explained in this document.

1. **Risks:** Telemedicine appointments can be delayed due to technical equipment failure. Our-center takes every measure to securely handle protected health information (PHI). In very rare event, there are possibilities of a security breach allowing unauthorized access to my confidential medical information. As we connect with our patients through email, the email could be sent to the wrong address. At Rosh Health Center, we take all measures to protect telemedicine PHI as we would protect any other PHI at our clinic. We try our best and use all of our resources to protect every TM communication. There are no guarantees that your data will be completely protected. You may also be required to schedule a face-to-face appointment at our center or with your local primary care physician if the naturopathic doctor or I feel that an in-person visit is necessary for any reason.
2. **Benefits:** Telemedicine provides the opportunity to seek healthcare from the comfort of your home. It is a convenient method of accessing healthcare, especially where there is long-distance travel.
3. **Nature of Telemedicine Communication:** With telemedicine communication, you can consult with your naturopathic doctor or staff members with all the available electronic communication such as video calling, phone calls, emails, fax, etc. The main goal of this communication is to analyze past medical history and previous medical records in order to diagnose, treat, or educate.
4. **Medical Information and Records:** Your TM medical information will not be shared with anyone. All laws that are associated with doctor-patient confidentiality apply to TM consultations. Patient's records and disclosed information will be kept confidential and will not be shared with anyone without your written consent.
5. **Confidentiality:** State and federal law apply to privacy and confidentiality of information used and discussed for TM consultation.
6. **Rights:** You have the right to withdraw your consent to a TM consultation without affecting your right to future healthcare at our center.
7. **Insurance Reimbursement:** We do not bill insurance. All fees are due at the time of service and may be paid through PayPal.
8. **Cancellations:** During last-minute cancellations, our healthcare providers become unavailable to provide service to other clients. We require a 48-hour notice of cancellation. If you must cancel or change your appointment, please contact us at 1(619) 354-7996 or e-mail info@roshhealth.com 48 hours in advance. If you decide not to keep your session without giving appropriate notice, you will be charged the full fee of the appointment.
9. **Out-of-State Patients:** The TM consultation with your naturopathic doctor at Rosh Health Center is not intended to replace your primary care provider. You must continue to seek healthcare from your local primary care physician. By consenting to this arrangement, you are consenting to keep working with your local primary care physician and recognizing that the naturopathic doctor at Rosh Health Center is filling in as auxiliary healthcare provider.

Initial_____

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My healthcare provider or staff has reviewed the information in this documentation. I have had the chance to pose questions about this document and my questions have been answered. With this knowledge, I voluntarily consent to the telemedicine consultation realizing that no guarantees have been given to me by Rosh Health Center or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

_____	_____/ _____/ _____	_____
Signature of Patient or Legal Guardian	**Date of Signing**	**Indicate Relationship if Legal Guardian**

_____

Signer Name if Legal Guardian (Please Print)

REFUSAL: I refuse to participate in a telemedicine consultation as described above.

Signature: _____ Date: _____/ _____/ _____

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Notice of Privacy Practices Acknowledgement Form

Patient Name: _____DOB: _____/ _____/ _____

The Health Insurance Portability and Accountability Act (HIPAA) requires healthcare providers to provide a Notice of Privacy Practices. This notice provides individuals with information about how their protected health information may be used and disclosed.

Visit https://roshhealth.com/notice-of-privacy-practices/ to view Rosh Health Center's Notice of Privacy Practices.

_____ _____/_____/_____ _____

Signature of Patient or Legal Guardian **Date of Signing** **Indicate Relationship if Legal Guardian**

_____

Signer Name if Legal Guardian (Please Print)

OFFICE USE ONLY

Staff Member's initials: _____

☐ I have offered the patient or legal guardian the Notice of Private Practices. The patient **RECEIVED** a hard copy or digital version of the notice.

☐ I have offered the patient or legal guardian the Notice of Private Practices. The patient **REJECTED** to receive a copy of the notice.

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Patient Informed Consent

Please read each paragraph and initial the bottom of first page and sign and date the second page.

Patient Name: _____

DOB: _____ **Telephone:** _____

Address: _____ **City** _____ **State**_____ **Zip** _____

I hereby request and consent to receive naturopathic medical care by the California licensed naturopathic doctor and/or other licensed naturopathic doctors at Rosh Health Center who now or in the future may treat me while working at or associated with or serving as back-up, whether signatories to this form or not.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. To properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

I hereby authorize the physicians and medical personnel of Rosh Health Center to perform with my approval and consent the following procedures for my diagnosis and treatment:

Initial_____

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I recognize the potential risks and benefits of these procedures as described below:

- **Physical Exam:** E.g., general, musculoskeletal, cardiovascular, gynecological, abdominal, respiratory, neurological, urological.
- **Medicinal use of Nutrition:** Therapeutic nutrition, nutritional supplementation.
- **Botanical Medicine:** Botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.
- **Homeopathic Medicine:** The use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle Counseling and Hygiene:** Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- **Psychological Counseling**
- **Hydrotherapies:** E.g., contrast treatments and wet sheet wrap.
- **Soft tissue manipulation:** Massage, neuro-muscular technique, muscle energy stretching, visceral manipulation.
- **Contraception and hormone replacement therapies**
- **Intravenous, Intramuscular and Subcutaneous injections:** Nutritional supplementation, therapeutic nutrition, pain management, joint care
- **Oral chelation therapy**

Potential Risks: Allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes, aggravation of present conditions, injuries such as pain, discomfort, discoloration, and pneumothorax from injections, venipuncture, and other procedures. Soft tissue or bony injury from physical manipulation.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, and prevention of disease and its progression.

Allergies Notice: I have informed the healthcare providers at Rosh Health Center of any known or suspected allergies to drugs, supplements, herbs, food, latex, or any other allergies not mentioned in this list. I acknowledge that not informing my healthcare providers at this clinic about the history of allergies can potentially lead to an allergic reaction with prescribed remedies resulting in mild to severe (anaphylaxis) reaction.

Notice to Cancer Patients: Cancer patients are required to be under an oncologist care before seeking adjunctive care at our clinic where we will focus on symptom management and improving quality of life.

Notice to Women: All female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

Notice to all patients: Your primary care physician's care is not replaced by naturopathic primary care services. To help improve your health and wellness, naturopathic primary care services should be used as an adjunctive care service.

I do not expect the doctors in Rosh Health Center to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with my healthcare provider to my satisfaction:

1) my suspected diagnosis or condition
2) the nature, purpose and potential benefit of the proposed care
3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
4) the probability or likelihood of success
5) reasonable available alternatives to the proposed treatment / procedure
6) the possible consequences if treatment or advice is not followed and/or nothing is done.

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by Rosh Health Center or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

_____	_____/ _____/ _____	_____
Signature of Patient or Legal Guardian	**Date of Signing**	**Indicate Relationship if Legal Guardian**

_____

Signer Name if Legal Guardian (Please Print)

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Patient Cancellation and No-Show Policy

Patient Name: _____ DOB: _____/ _____/ _____

Welcome to Rosh Health Center. Our healthcare providers are here to help you through your journey of health and wellness.

Our center focuses on providing high quality care. Therefore, showing up to your appointment on time is important for you, your doctor, and to others who are in need of our services. There are specific policies that our center adheres to in regard to cancellations, late arrivals, and no-show.

No-show/Late Arrival

- Patients that arrive 20 minutes late are subjected to the providers' discretion. It is up to the provider if the patient can be seen for their appointment or if the appointment will be abbreviated.
- Patients that cannot be seen by their provider after 20 minutes will be considered as no-show. They will be charged the full fee of the appointment.

Cancellation

- During last-minute cancellations, our healthcare providers become unavailable to provide service to other clients. We require a 48-hour notice of cancellation.
- If you must cancel or change your appointment, please contact us at 1(619) 354-7996 or e-mail info@roshhealth.com 48 hours in advance.
- If you decide not to keep your session without giving appropriate notice, you will be charged the full fee of the appointment.

I have read, understand and agree to Rosh Health Center's patient cancellation and no-show policy. I have been given the opportunity to ask questions about its content, and by voluntarily signing below I agree to this patient cancellation and no-show policy.

_____ _____/ _____/ _____

Signature of Patient or Legal Guardian **Date of Signing**

_____

Signer Name if Legal Guardian (Please Print)

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Patient Financial Agreement

Patient Name: _____ DOB: _____/ _____/ _____

Thank you for joining Rosh Health Center. We offer integrative healthcare and help patients through their journey to health and wellness. Rosh Health Center adheres to this Written Financial Policy and the following is our clinic's financial arrangements:

Patient Payment

- I have discussed payment options and agreed upon payment with the undersigned provider.
- I understand that I am responsible for full payment for the services that I will be receiving at this clinic.
- It is this clinic's policy to receive payments before the completion of treatment.
- I agree to pay for my treatment and services fees.

Insurance

- I acknowledge that Rosh Health Center does not accept health insurance.
- I understand that payment of a proposed service in full is expected at each visit before the service is rendered.

Credit and Collection

- I acknowledge that if any balance on my account is not paid 30 days after receiving a final notice stating that I have to pay my account in full, then the unpaid balance will be sent to a collection agency.

I have read, understand, and agree with Rosh Health Center's patient financial agreement policy. I understand that I am financially responsible for all healthcare treatments and services. I have been given the opportunity to ask questions about its content, and by voluntarily signing below I agree to this financial agreement policy.

_____ _____/ _____/ _____

Signature of Patient or Legal Guardian **Date of Signing**

_____

Signer Name if Legal Guardian (Please Print)

Reset