

Patient Registration

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 (PCF	9)			
Primary Care Physician Nam	e:	Pho	one:	
Patients Seeking Adjunctive	Cancer Care			
Oncologist Name:		Phone:		
Most Recent Appt Date:		Last Bloo	dwork Date:/	/
Guarantor Information (Fin				
Last Name:	First Name:		Middle Name:	
Guarantor Address:		City:	State:	Zip:
Date of Birth:/				
I certify to the best of my ki that I am the guarantor and clinic.	•	•		
Signature of Patient or Legal	Guardian Date of Si	gning /	Indicate Relatio	nship if Legal Guardia
Signer Name if Legal Guardi	an (Please Print)			

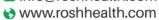


Patient Registration

Last Name: F	irst Name:	Middle Name	e:
Date of Birth:/	Most Recent Ph	nysical Exam:	
Purpose of today's visit:			
Estimate General Health:			
Any allergies?			
□ Aspirin □ Ibuprofen □ Aceta	minophen 🗆 Codeine	□ <mark>Pe</mark> nicillin □ Eryth	nromycin
☐ Tetracycline ☐ Sulfa ☐ Local	Anesthetic 🗆 Fluoride	e □ Metals □ Latex	
□ Supplements □ Herbs □ Foo	ods 🗆 Other		
Past Health History			
Medical Conditions: Do you curi	rently have or have his	story of any medical	conditions?
List recent surgeries, hospitaliza	ation (provide date):		
List all current drugs, herbs, and		•	
	l		
Patient Name:	DOB:	[Date of Visit://_

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Do you have any family history of health conditions?

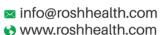
Family Member	Age Health Condition
_	
Social History	
·	
Alcohol intake:	□ None □ Occasional □ Moderate □ Heavy
Smoking history:	□ None □ Occasional □ Moderate □ Heavy
Review of Systems: Ple	ease check boxes if you have experienced in the last six months any of these problems
Constitutional	☐ Fatigue ☐ 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	\square Cough \square Abnormal sputum \square Wheezing \square Shortness of breath \square Coughing up blood
Gastrointestinal	\square Abdominal pain \square Nausea \square Vomiting blood \square Difficulty swallowing \square Belching \square Indigestion \square Bloating \square Flatus \square Diarrhea \square Constipation \square Hemorrhoids \square 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	\square Joint pain \square Back pain \square Muscle aches \square Cramps \square Soft tissue/joint stiffness \square 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
Patient Name:	DOB:/ Date of Visit:/





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:	

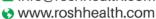
At Rosh Health Center, patients will have the opportunity to connect with the clinic staff and seek telemedicine (TM) care through video conferencing, email, and fax. The process of handling protected health information (PHI) when participating in telemedicine at our center is explained in this document.

- 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		

Rosh Health Center





Signature:



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) |

Date:

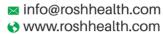






Notice of Privacy Practices Acknowledgement Form

Patient Name:	DOB://
The Health Insurance Portability and Accountability Ao Notice of Privacy Practices. This notice provides individualth information may be used and disclosed.	
Visit https://roshhealth.com/notice-of-privacy-practices/ Practices.	to view Rosh Health Center's Notice of Privacy
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 RECEIVED a hard copy or digital version of the notice that the patient of the notice is a second of the notice is	
☐ I have offered the patient or legal guardian the Notice REJECTED to receive a copy of the notice.	e of Private Practices. The patient





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 other licensed naturopathic doctors at R associated with or serving as back-up, v	Rosh Health Center who	now or in the future m			
I understand that the methods of treatment include but are not limited to nutritional hydrotherapy, intramuscular injections,	l couns <mark>eling, western h</mark>				
I have had the opportunity to discuss we procedures. I am aware that all existing level of risk. Within the general health from minor to fatal.	methods of diagnosis a	and treatment, including	g naturopathic healthcare, pose some		
The herbs, homeopathic medicines and that have been recommended, are considered important that you follow the nutritional supplements because they make the prepared and the teas consumed accordance unpleasant smell or taste. I understand immediately notify the doctor if I become	idered safe when taken e prescribed recommen hay be toxic when taken ing to the instructions p that some herbs and sup	as instructed in the practical dations when taking her in large doses. I under provided orally and in woplements may be inappet.	ctice of naturopathic medicine. It is rbs, homeopathic medicines and stand that herbs may need to be writing. The herbs may be an		
I will immediately inform the doctor if similar condition), allergic reactions (hi unanticipated or unpleasant effects assounderstand that while this document de To properly treat your medical condition In any event, if an emergency medical of 1.	ives, rashes, tingling of ociated with treatment of scribes the most common, the doctor must be c	the tongue, headache of or the herbs or other sup on risks of treatment, of ontacted promptly if an	r similar condition), or any plements prescribed by the doctor. I ther side effects and risks may occur. adverse reaction or condition occurs		
I have read, or have had read to me, the about its content, and by voluntarily sig cover the entire course of treatment for treatment.	gning below I agree to t	he above-named proced	lures. I intend this consent form to		
I hereby authorize the physicians and me the following procedures for my diagno		sh Health Center to per	form with my approval and consent		
<u>Initial</u>					

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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.

Center or any of its personnel regarding cure or discontinue participation at any time.	improvement of my condition. I und	erstand that I am free to withdraw my consent and
Signature of Patient or Legal Guardian	Date of Signing	Indicate Relationship if Legal Guardian

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been given to me by Rosh Health

Signer Name if Legal Guardian (Please Print)

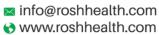
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Patient Cancellation and No-Show Policy

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)





Patient Financial Agreement

Patient Name:	DOB:	/	
Thank you for joining Rosh Health Center. Whealth and wellness. Rosh Health Center adherinancial arrangements:	9		
Patient Payment			
 I have discussed payment options and I understand that I am responsible for It is this clinic's policy to receive pay I agree to pay for my treatment and see 	full payment for the services that ments before the completion of tr	I will be rec	
Insurance			
 I acknowledge that Rosh Health Cent I understand that payment of a propos 	_		ore the service is rendered.
Credit and Collection			
 I acknowledge that if any balance on have to pay my account in full, then to 			
I have read, understand, and agree with Rethat I am financially responsible for all heat ask questions about its content, and by vol	althcare treatments and services	s. I <mark>ha</mark> ve bee	en given the opportunity t
Signature of Patient or Legal Guardian	Date of Signing	_/ g	/
Signer Name if Legal Guardian (Please Pr	int)		