Thank you for selecting The BioMed Center for your medical and dental healthcare. We promise that your experiences here will be comfortable, relaxed and enjoyable in all ways to the best of our ability.

Patient Information **Date** ____________________

First Name ________________________________ MI ______ Last Name _________________________________

By what name do you prefer us to call you? _________________________

Street Address _____________________________________ Town _________________ State ____ Zip __________

Mailing Address (if different) __________________________ Town _________________ State ____ Zip __________

Home Phone (____) _____________ Work Phone (_____) _____________ Cell Phone (_____) _____________

E-mail _________________________________ DOB ____________________ SSN __________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Student

Live with ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Occupation __________________________________ Hours per wk ___________________ Retired in ___________

Employer ____________________________________Work address _______________________________________

Emergency Contact Name _____________________________ Relationship __________________________________

Day Phone (___) _____________ Cell (___) _____________

Blood type (if known) ____________________

For my future appointments:

Please Contact_____________________________________Tel_________________________________ Ext________

Appointment reminder preferences (please check all that apply): ☐ Home ☐ Office ☐ Cell Phone

May we leave messages on your answering machine or voice mail? ☐ Yes ☐ No

My preferred appointment times are:

☐ Early Morning ☐ Late in the day ☐ Other_______________________________________

Has any other family member already been a patient at the clinic? _________________________________

How did you hear about our Center? ____

Whom may we thank for referring you to our practice? ____

If you found us through an online search, what were you looking for? ______________________________

____ ____

SIGNATURE DRIVER'S LICENSE NUMBER (needed for check payments only)

MEDICAL HISTORY

Patient Name____Birth Date_______________________Date___________________

Name of Physician; and his/her Specialty ____

Physician Phone #______________________Town______________________Date of most recent physical exam ________________

What is your estimate of your general health? O Excellent O Good O Fair O Poor

Question	Y	N	If yes, please explain:
1. Are you under a physician's care now?	Y	N	
2. Have you ever been hospitalized or had a major operation?	Y	N	
3. Have you ever had a serious head or neck injury?	Y	N	
4. Are you currently taking any medications, herbal supplements, or non-prescription medications?	Y	N	
5. Do you take, or have you taken, Phen-Fen or Redux?	Y	N	
6. Have you ever taken bisphosphonates such as Fosamax, Boniva or Actonel for osteoporosis?	Y	N	
7. Are you on a special diet?	Y	N	
8. Have you lost or gained more than 10 pounds in the last year?	Y	N	
9. Do you use any form of tobacco?	Y	N	
10. Do you use controlled substances?	Y	N	

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs Other: ______________________________

Women: Are you

Pregnant or trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Drug Addiction	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Easily Winded	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Eating Disorder	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Sleep Apnea/Snoring	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Spina Bifida	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stomach/Intestinal Disease	Yes	No
Bruise Easily	Yes	No	Gastric Reflux	Yes	No	Low Blood Pressure	Yes	No	Stroke	Yes	No
Cancer	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Swelling of Limbs	Yes	No
Chemotherapy	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Thyroid Disease	Yes	No
Chest Pains	Yes	No	Hay Fever	Yes	No	Organ Transplantation	Yes	No	Tonsillitis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Congenital Heart Disorder	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Convulsions	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cortisone Medicine	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness or condition not listed above? Yes No (If yes, please explain)

Other comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

Signature of Patient, Parent, or Guardian **Date**

Medical History Form

(PLEASE FILL OUT BOTH SIDES OF EACH PAGE)

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this center?

- What do you know about our approach?

2) What three expectations do you have from this visit to our center?

- What long term expectations do you have from working with our center?

- What expectations do you have of me personally as your physician?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)
0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

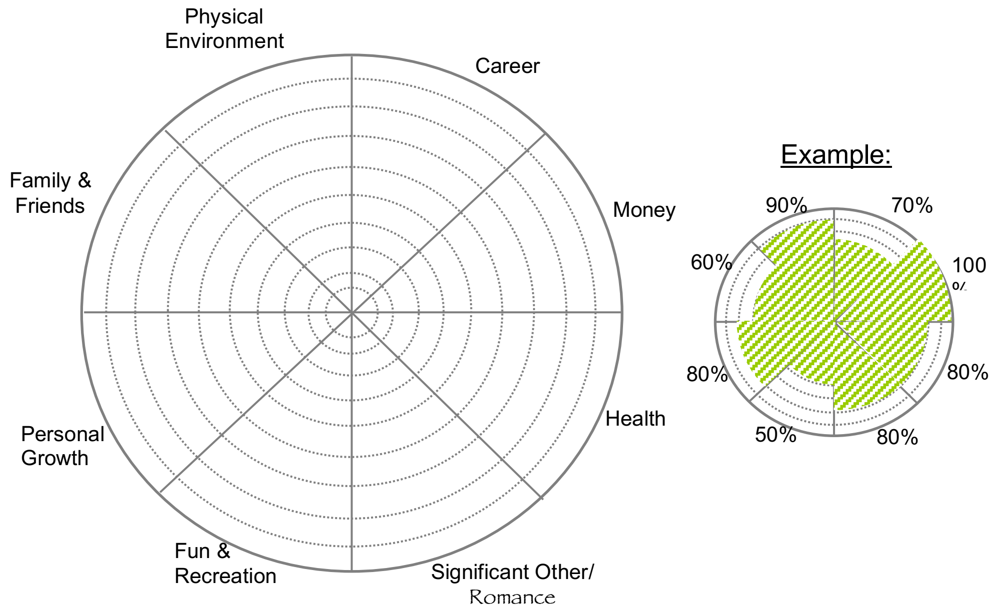
6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Are you currently receiving healthcare? Y N

If yes, where and from whom:____

____

If no, when and where did you last receive medical or health care? ____________________

____

____

What was the reason? ____

What are your most important health problems? List as many as you can in order of importance:

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

Do you have any known contagious diseases at this time? Y N

If yes, what? ____________________

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hayfever/Hives			

Any other relevant family history? ____________________

____

What is your heritage: German _______ Nordic________ Celtic ________ Other ________

Childhood Illnesses

Please circle whether you had any of these as a child:

Scarlet fever	Diphtheria	Rheumatic fever
Mumps	Measles	German measles

Hospitalization, Surgery, Imaging

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

__________________year: ________ __________________ year: ________

__________________year: ________ __________________ year: ________

__________________year: ________ __________________ year: ________

Allergies

Are you hypersensitive or allergic to:

Any drugs? ____________________

Any foods? ____________________

Any environmentals or chemicals? ____________________

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking?

1)____________________ 5) ____________________

2)____________________ 6) ____________________

3)____________________ 7) ____________________

4)____________________ 8) ____________________

General

Height: ______________Weight:______________ lbs. Weight 1 year ago: ____________lbs.

Maximum Weight : ______________ When:____________________

When during the day is your energy the best? ______________ worst? ______________

Typical Food Intake

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

To drink: ______________________________

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now	**N=**Never had	**P=**Significant problem in the past

Habits

Main interests and hobbies?______________________________

Do you exercise? Y N

If yes, what kind?____________________ How often? __________

Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	how many hours? _______	
Any major traumas?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	how many hours? _______	
Been treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? __________		Drink black/green tea?	Y N P
How many packs per day? __________		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what?____________________

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to immunizations?	Y N P	Reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

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

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

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

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	" " " lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? ______________	
Gall Bladder disease?	Y N P	Is this a change?______________	
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

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

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Y=a condition you <u>have now</u>   **N**=Never had   **P**=<u>Significant</u> problem in the past

Male Reproduction

Hernias? Y N P
Testicular pain? Y N P
Venereal disease? Y N P
Are you sexually active? Y N P
Sexual orientation: ____________________
Impotence? Y N P
Premature ejaculation? Y N P
Birth control? Type? __________________

Testicular masses? Y N P
Prostate disease? Y N P
Discharge or sores? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Condyloma? Y N P
Herpes? Y N P
Syphilis? Y N P

Female Reproduction / Breasts

Age of first menses? __________________
Age of last menses? (if menopausal) ______
Length of cycle? ____________ days
Duration of menses? ____________ days
Painful menses? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
If yes, what are your symptoms?
____
____
Endometriosis? Y N P
Ovarian cysts? Y N P
Difficulty conceiving? Y N P
Cervical Dysplasia? Y N P
Sexual difficulties? Y N P
Gonorrhea? Y N P
Herpes? Y N P
Are you sexually active? Y N P
Do you do breast self exams? Y N P
Breast pain/tenderness? Y N P

Date of last annual exam/ PAP ________
Are cycles regular? Y N P
Bleeding between cycles? Y N P
Pain during intercourse? Y N P
Clotting? Y N P
Discharge? Y N P
Birth control? Y N P
What type? ______________________
Number of pregnancies: ____________
Number of live births: ______________
Number of miscarriages: ___________
Number of abortions: _____________
Menopausal symptoms? Y N P
Abnormal PAP? Y N P
Chlamydia? Y N P
Condyloma? Y N P
Syphilis? Y N P
Sexual orientation: _______________
Breast lumps? Y N P
Nipple discharge? Y N P

Dental History

When was your last dental visit? ______________ months/years

Dentist Name: ____________________________ Phone Number: _(____)_______________

Is he/she a biological or holistic dentist? ❑ Yes ❑ No

Have you ever had a panorex x-ray (full mouth and jaw)? ❑ Yes ❑ No
Do you have any gum (periodontal) issues? ❑ Yes ❑ No ❑ Past
Do you have any silver fillings? ❑ Yes ❑ No ❑ Past *** If so, how many? __________
Have you had any silver fillings removed? ❑ Yes ❑ No

Do you have any caps (crowns)? ❑ Yes ❑ No ❑ Past
Do you have any root canals? ❑ Yes ❑ No ❑ Past *** If so, how many? __________
Do you have any dental implants? ❑ Yes ❑ No ❑ Past *** If so, how many? __________
Have you had orthodoctics (braces) ❑ Yes ❑ No

You have made it to the last page!

Thank you for your time and effort. Our team looks forward to providing you with the best possible care.

Is there anything else you would like to add or comment on?

DENTAL HISTORY

Patient Name____Nickname________________DOB _____________

On a scale of 1 to 10 (with 10 being completely healthy), where do you rate your current level of oral health? _________

Previous Dentist_____________________________________How long have you been a patient there?_______months/years

Date of most recent dental exam__________________Date of most recent x-rays __________________

Date of most recent treatment (other than a cleaning) __________________

I routinely see my dentist every: D 3 months D 4 months D 6 months D 12 months D Not routinely

My main dental concern is ____

	Yes	No
PERSONAL HISTORY		
1. Are you fearful of dental treatment? If so, how fearful? (on a scale of 1 (least) to 10 (most) _________________	D	D
2. Have you had an unfavorable dental experience?	D	D
3. Have you ever had complications from past dental treatment?	D	D
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	D	D
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	D	D
6. Have you had any teeth removed?	D	D
	D	D
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	D	D
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	D	D
9. Have you ever noticed an unpleasant taste or odor in your mouth?	D	D
10. Is there anyone with a history of periodontal disease in your family?	D	D
11. Have you ever experienced gum recession?	D	D
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	D	D
13. Have you experienced a burning sensation in your mouth?	D	D
	D	D
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	D	D
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	D	D
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	D	D
17. Are any teeth sensitive to hot, cold, biting, sweets, or brushing any part of your mouth?	D	D
18. Do you have grooves or notches on your teeth near the gum line?	D	D
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	D	D
20. Do you frequently get food caught between any teeth?	D	D
	D	D
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	D	D
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	D	D
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	D	D
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	D	D
25. Are your teeth crowding or developing spaces between?	D	D
26. Do you have more than one bite and squeeze to make your teeth fit together?	D	D
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	D	D
28. Do you clench your teeth in the daytime or make them sore?	D	D
29. Do you have any problems with sleep or wake up with an awareness of your teeth?	D	D
30. Do you currently wear or have you ever worn a bite appliance?	D	D
	D	D
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change?	D	D
32. Have you ever whitened (bleached) your teeth?	D	D
33. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	D	D
34. Have you been disappointed with the appearance of previous dental work?	D	D

In the past, what may have been a difficulty in pursuing your dental treatment:

□ Cost □ Fear □ Lack of Time □ Lack of Importance □ All

____

Patient/Parent/Guardian Signature Date

Information About Medical and Dental Appointments

The time we spend with you while you're at the Center is most important - for you, your oral health and your overall health. Each patient receives a unique appointment reserved for them alone. When you schedule your appointment, any supplies or materials needed are ordered, and we make special arrangements to be ready for your visit. Except for unforeseen or emergency care needed for another patient, you can expect us to be prompt. We thank you in advance for offering us the same courtesy.

Late Arrival
If you arrive late to your dental appointment there may not be time to complete all your scheduled dental care. You and your dentist or hygienist may decide to alter your planned treatment, or you may be asked to reschedule to another date or time.

Missed Appointments
Because our time is reserved specifically for you, we ask that you kindly give us a notice of at least 24 business-hours if you will be unable to keep your appointment. If your appointment is on Monday, please notify us by the Thursday before. This courtesy makes it possible to offer your reserved time to another patient who may want to be seen sooner.

Repeated cancellations or missed appointments will result in loss of future appointment privileges.
There is a charge of $200 per hour for not showing up for scheduled appointments.

I have read, understand and agree to these terms for missed or late appointments:

____

Patient or Responsible Party Signature *Date*

____

Printed Name of Patient or Responsible Party

Credit card appointment reservation form

Please note: The card you provide below <u>will only be charged</u> on the day of your scheduled appointment if cancellation is <u>not done</u> within the requested 24-hour notice period.

(Circle One) M/C – Visa – Disc – Amex Credit Card # ___________________________________

Expiration Date________________________________ CSV Security Code (3 or 4 digits) ____________________

Cardholder Name ____

Cardholder Signature _____________________________________ Date ________________

Patient/Client Rights and Responsibilities

As an informed client or patient, it's important to know what you can expect from your health care practitioner and support team. As important, understanding your role and responsibilities in support of their efforts to provide you with quality health care will contribute to a successful and collaborative practitioner-patient relationship.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care but are simply intended as a guide.

The Biomed Center is committed to respecting the individual rights of all persons who come to our center for care.

As a patient/client, you have the following rights:

- You shall be offered considerate and respectful care.
- You have the right to ask questions and be given understandable, plain language, explanations about your treatments.
- You have the right to refuse any treatment by The Biomed Center as permitted by law.
- You have the right of privacy and confidentiality and that right shall extend to all records related to your treatment except as otherwise provided by law.
- The Biomed Center shall respond in a reasonable manner to a request for your health information to be provided to other health care providers.
- You have the right to obtain the name of any individual responsible for services or treatment related to your care.
- You have the right to receive reasonable notice of changes in services or charges.
- You have the right to examine and receive an explanation of your bill for services, regardless of the source of payment for your bill.
- You shall be offered treatment without discrimination as to race, ethnicity, gender, religion, or sexual orientation.
- You have the right to express complaints or concerns *at any time*.
- You may assert any of these rights without fear of retaliation.

As patient/client, you have the following responsibilities:

- You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
- You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.

- You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your treatment or plan.
- You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
- You have the responsibility for consequences resulting from declining treatment.
- You have the responsibility to keep your scheduled appointments.
- You have the responsibility to follow recommendations for self-care at home.
- You have the responsibility to fulfill your financial obligations for health care received.

The Biomed Center is licensed by the Rhode Island Department of Health and operates under the supervision of a licensed physician and a licensed dentist.

While some treatments will be provided by licensed health care professionals, such as a Physician, Dentist, Doctor of Naturopathy, Chiropractor, or Registered Nurse, many treatments and therapies offered at The Biomed Center also may be performed legally and safely by unlicensed health care practitioners. ***The State of Rhode Island has not adopted any educational and training standards for unlicensed health care practitioners. Under Rhode Island law, an unlicensed health care practitioner may not provide a medical diagnosis***.

I, _______________________________________, acknowledge that I have read and understand the rights and information summarized above.

____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices:
You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name: ____

Parent/Legal Guardian Name: ____

Signature:____**Date:** __________________

Relationship to Patient: ____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ▫ Individual refused to sign
- ▫ Communication barriers prohibited obtaining the acknowledgement
- ▫ Other (please specify) ____