INTEGRATIVE MEDICINE
Orange County™

Patient Packet

Patient Name: _____ Date of Birth: _____

Address: _____ Apt. No.:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____
Leave voicemails at: _____

E-mail: _____ Employer: _____

Occupation: _____ Referred By: _____

SSN: _____ Driver's License: _____

Sex: M F Marital Status: Single Married Separated Divorced

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Responsible Party (if different from above):

Responsible Party's Name: _____ Date of Birth: _____

Address: _____ Apt. No.:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Please be advised that SMS text appointment reminder is not a confidential transmission.
Please inform us if you would like to opt out of SMS text appointment reminders. Opt out _____

There is a 72-hour cancellation policy at the clinic. If you are unable to make your appointment, please notify the clinic at least 72 hours in advance to ensure you are not charged a $299 NO SHOW fee.

I authorize and consent to examination and treatment as deemed medically necessary to the above named patient by Dr. Mae Kinaly, M.D. and staff. I authorize the release of medical information necessary to process this claim. I authorize the payment of medical and/or surgical benefits to physician of supplier. I acknowledge that I am responsible for payment of all charges in full.

Signed: _____ **Date**: _____

22 Odyssey #215 . Irvine . CA 92618 **949 . 398 . 7444**

Daily Lifestyle Procedures

Name: _____

What time do your normally wake-up?

What time do you normally fall asleep?

Do you have trouble falling asleep or waking up through the night?

How frequently do you exercise?

Do you consume alcohol? If yes, how often?

Do you smoke? If yes, how often?

Average breakfast: Time of breakfast: _____

Average lunch: Time of lunch: _____

Average dinner: Time of dinner: _____

Snacks throughout the day? Time(s) of snacks: _____

Water intake (ounces daily): Juice intake (ounces daily):

Soda intake (ounces daily): Coffee intake (ounces daily):

Initials _____

22 Odyssey #215 . Irvine . CA 92618 **949 . 398 . 7444**

Medication/Supplement/Allergy List

Name: _____

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Supplement		
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Allergies:

1: 2:

3: 4:

5:

Pharmacy Name/Phone Number:

Initials _____

Medical & Family History

Name: _____

Patient Medical History:

Diabetes	Yes	No	Convulsions	Yes	No
Hypertension (high blood pressure)	Yes	No	Acute Infection	Yes	No
Cancer	Yes	No	Venereal Disease	Yes	No
Stroke	Yes	No	Hereditary Defects	Yes	No
Heart Trouble	Yes	No	Tuberculosis	Yes	No
Heart Attack (Myocardial Infraction)	Yes	No	Hepatitis	Yes	No
Arthritis/Gout	Yes	No	Peptic Ulcer Disease	Yes	No

Last Menstrual Period Date: _____ Frequency of Menstrual Cycle: _____

Previous Surgeries/Dates: _____

Hospitalizations/Serious Injuries/Dates: _____

_____

Patient Social History:

Marital Status: single married separated divorced widowed

Use of Alcohol: never rarely moderate daily

Use of Tobacco/Cigarettes: never previously, but quit Date quit: _____

_____ Length of use (current/previous) _____ packs a day

Use of Illegal Drugs: never ____ Type/frequency _____ Date last used _____

Use of Diet Drugs: never ____ Type/frequency _____ Date last used _____

Excessive exposure at home, or at work, to hazardous waste and/or materials: no yes type: _____

Family Medical History:

Family Member:	Age	Disease	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Initials _____

Constitutional Symptoms		
Good General Health	No	Yes
Recent Weight Change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes
Eyes		
Eye Disease or Injury	No	Yes
Wear Glasses/Contacts	No	Yes
Blurred/Double Vision	No	Yes
Glaucoma	No	Yes
Ears/Nose/Mouth/Throat		
Hearing Loss of Ringing	No	Yes
Earaches or Drainage	No	Yes
Chronic Sinus Problems	No	Yes
Nose Bleeds	No	Yes
Mouth Bleeds	No	Yes
Bleeding Gums	No	Yes
Bad Breath or Bad Taste	No	Yes
Sore Throat or Voice Change	No	Yes
Swollen Glands in Neck	No	Yes
Cardiovascular		
Heart Trouble	No	Yes
Chest Pain or Angina Pectoris	No	Yes
Palpitation	No	Yes
Shortness of Breath (when lying or walking)	No	Yes
Swelling of Feet, Ankles, or Hands	No	Yes
Respiratory		
Chronic or Frequent Coughs	No	Yes
Spitting up Blood	No	Yes
Shortness of Breath	No	Yes
Asthma or Wheezing	No	Yes
Gastrointestinal		
Loss of Appetite	No	Yes
Change in Bowel Movements	No	Yes
Nausea and/or Vomiting	No	Yes
Painful Bowel Movements/Constipation	No	Yes
Rectal Bleeding or Blood in Stool	No	Yes
Abdominal Pain or Heartburn	No	Yes
Peptic Ulcer (Stomach or Duodenal)	No	Yes
Genitourinary		
Frequent Urination	No	Yes
Burning or Painful Urination	No	Yes
Blood in Urine	No	Yes
Change in Force of Strain when Urinating	No	Yes
Incontinence or Dribbling	No	Yes
Kidney Stones	No	Yes
Sexual Difficulty	No	Yes
Male - Testicular Pain	No	Yes
Female - Pain with Periods	No	Yes
Female - Irregular Periods	No	Yes
Female - Vaginal Discharge	No	Yes
Female - # Pregnancies_____		
Female - # Miscarriages _____		
Female - Date of last pap smear		

Musculoskeletal		
Joint Pain	No	Yes
Joint Stiffness or Swelling	No	Yes
Weakness of Muscles or Joints	No	Yes
Muscle Pain or Cramps	No	Yes
Back Pain	No	Yes
Cold Extremities	No	Yes
Difficulty Walking	No	Yes
Integumentary (Skin, Breast)		
Rash or Itching	No	Yes
Change in Skin Color	No	Yes
Change in Hair or Nails	No	Yes
Varicose Veins	No	Yes
Breast Pain	No	Yes
Breast Lump	No	Yes
Breast Discharge	No	Yes
Neurological		
Frequent/Recurring Headaches	No	Yes
Lightheadedness or Dizziness	No	Yes
Convulsions or Seizures	No	Yes
Numbness or Tingling Sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head Injury	No	Yes
Psychiatric		
Memory Loss or Confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Endocrine	No	Yes
Glandular or Hormonal Problem	No	Yes
Thyroid Disease	No	Yes
Diabetes	No	Yes
Excessive Thirst or Urination	No	Yes
Heat or Cold Intolerance	No	Yes
Dry Skin	No	Yes
Change in Hat or Glove Size	No	Yes
Hematologic/Lymphatic		
Slow to Heal After Cuts	No	Yes
Bleeding or Bruising Tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past Transfusions	No	Yes
Enlarged Glands	No	Yes
Allergic/Immunologic		
Allergies/Reactions to:	No	Yes
Penicillin	No	Yes
Sulfa	No	Yes
Morphine, Demerol, Narcotics	No	Yes
Novocain, Anesthetics	No	Yes
Aspirin	No	Yes
Tetanus Antitoxin	No	Yes
Iodine, Antiseptics	No	Yes
Other Drugs/Medications	_____	

Initials _____

Procedure/Vaccination List

Name: _____

Procedure	Date	Facility
Full Blood Test		
EKG		
Chest X-Ray		
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Other		

Vaccine	Date	Facility
Flu Vaccine		
Pneumonia Vaccine		
Shingles Vaccine		
Tetanus Vaccine		
H1N1 Vaccine		
Other		

Initials _____

INTEGRATIVE MEDICINE
Orange County™

PAYMENT POLICY

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of Integrative Medicine Orange County, you are responsible for the total charges incurred for each visit. Charges for services are to be paid at the time of services being rendered.

We accept all Major Credit Cards, personal checks and cash as forms of payment. There will be a **$50.00** charge for all returned checks. We are an **out-of-network provider** for all insurance providers; including but not limited to Medicare, Medi-Cal, HMOs, EPOs, PPOs and other private insurance providers & co-operatives.

Patient will be given an Insurance Claim Form reflecting the services rendered after each visit and is the patient's responsibility to submit the claim to their insurance provider for reimbursement. If the claim is denied or payment is not made, it is the patient's responsibility to contact their insurance provider to resolve the issue.

Please remember that the patient has the primary relationship with their insurance provider and are responsible for the total amount due at the time of the visit.

All follow-up appointments are confirmed one day in advance and appointments not cancelled within **at least 24-hours notice** will be charged a **$99.00 no-show fee**. All new patient appointments are confirmed one day in advance and appointments not cancelled within **at least 72-hours notice** will be charged a **$299.00 no-show fee**. This charge is directly payable by you and cannot be submitted to your insurance.

Phone consultations payment is required at the time of the scheduled appointment. Payment for all supplements & treatments is due at the time of service or purchase. Insurance providers may not cover these services. You have the right to refuse any service recommended by our staff.

If you fail to pay for services or products on the date received, Integrative Medicine Orange County will charge the credit card on file, unless alternative payment arrangements are made within 24 hours after the date of service or receipt of products.

By signing below, I acknowledge that I have read, understand and agree to the above stated policies of Integrative Medicine Orange County:

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to Patient: _____

INTEGRATIVE MEDICINE
Orange County™

CREDIT CARD POLICY

It is a policy of Integrative Medicine Orange County for all patients to have a credit card on file.

For expediting the payment process, you may authorize Integrative Medicine Orange County to use the credit card listed below for future appointments, treatment or supplement payments.

If you fail to pay for services or products on the date received, Integrative Medicine Orange County will charge the credit card on file, unless alternative payment arrangements are made within 24 hours after the date of service or receipt of products.

********Please Print Clearly ********

Patient's Name

_____

Cardholder's Name As It appears On The Card:

_____

Cardholder's Relationship to Patient:

_____

Credit Card: **VISA** **MC** **AMEX** **OTHER** _____

Credit Card Number: _____

Exp. Date: _____ **CVV (3-4 digit code)**: _____

Address (number) Affiliated With Card _____ **Zip Code** _____

Cardholder's Signature & Authorization To Use For Patient:

_____ **Date:** _____

INTEGRATIVE MEDICINE
Orange County™

Acknowledgement of Privacy Notice

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Mae Kinaly, MD, Integrative Medicine Orange County. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.drkinaly.com and in our office. You may request a copy of the Notice of Privacy.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Restoring Your Healthy Balance
www.myintegrativedoc.com
22 Odyssey #215 **.** Irvine **.** CA 92618
(949) 398 7444

INTEGRATIVE MEDICINE
Orange County™

CONSENT TO USE ELECTRONIC COMMUNICATIONS

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using electronic communications. However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.

- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.

- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.

- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.

- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.

- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.

- Electronic communications maybe disclosed in accordance with a duty to report or a court order.

- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing. If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.

- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

- While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.

- If your electronic communication requires or invites a response from the Physician and you have not received a

response with in a reasonable time period, It is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.

- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations. You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.

- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.

- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

- You agree to inform the Physician of any types of information you do not want sent via electronic communication by notifying the Physician in writing.

- The Physician is not responsible for information loss due to technical failures associated with your software or Internet service provider.

INSTRUCTIONS FOR ELECTRONIC COMMUNICATION

- Reasonably limit or avoid using an employer's or other third party's computer.

- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate electronically.

- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.

- Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.

- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.

- Withdraw consent only by email or written communication to the Physician.

- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on electronic communication. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.

INTEGRATIVE MEDICINE
Orange County™

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of electronic communication more fully described in this consent form. I understand and accept the risks outlined in this consent form, associated with the use of electronic communications with the Physician and the Physician's staff. I consent to the conditions and will follow the instructions outlined above, as well as any other conditions that the Physician may impose on electronic communications with patients.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk.

I acknowledge that either the Physician or I may, at any time, withdraw the option of communicating electronically upon providing written notice.

I HAVE REVIEWED AND UNDERSTAND ALL THE RISKS, CONDITIONS, AND INSTRUCTIONS DESCRIBED IN THIS CONSENT FORM.

Patient/Guardian email address:

_____

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (Relation to patient): _____

INTEGRATIVE MEDICINE
Orange County™

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I hereby consent to engage in telemedicine as part of my treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine may also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

By signing this form, I understand and agree to the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine that identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time
- I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform IMOC of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Kinaly and IMOC, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if Dr. Kinaly believes I would be better served by another form of treatment (e.g. face-to-face services) I may be referred to another medical

facility or doctor who can provide such services in my area. I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of IMOC, my condition may not be improve, and in some cases may even get worse.

- I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
- Finally, I understand that if I engage in telemedicine I will be required to pay in advance, via credit card. By signing this agreement I agree to provide my credit card information and to have the agreed upon charges charged to the provided card.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

_____ _____

PATIENT/REPRESENTATIVE SIGNATURE DATE

_____

PATIENT NAME (PRINTED)

_____

REPRESENTATIVE'S RELATION TO PATIENT