First Visit Forms- Print legibly

Name _____**Date** _____

Address _____

City _____ _____**State** _____ **Zip** _____

Home Ph _____ **Cell Ph** _____

Date of Birth _____**Occupation** _____

Email address _____ **Who Referred you**_____

Please print and complete all the enclosed disclosures and forms and bring them with you to the first visit.

If you cannot print them, you can come an hour early and complete them in my office before your appointment, if I know you need to do that.

Frequently Asked Questions

What is Functional Medicine?

Please go to my website and read the detailed description. If you need to talk to me prior to the visit, schedule a time to talk.

1 Do you accept insurance?

I do not accept any insurance. I can provide coded bills for you to submit for reimbursement. Payment is due at the appointment.

2 Do you accept HSA (Health Savings Account) or FSA (Flexible Spending Account).

I do accept HSA and FSA.

3 How long are the appointments?

The first appointment is 60-90 minutes, and follow up appointments range from 30 to 90 minutes.

4 How can I pay for your services?

I accept credit cards, debit cards (Mastercard, Visa, Discover) personal checks, and cash. I charge a surcharge to use a credit card of 3%. Debit cards do not have a surcharge if you use a pin # when I use the debit card or they also incur a charge of 3%. I can also accept Zelle

5 How do I prepare for my first appointment?

Go to First Visit Forms, download and print the forms, complete them and bring them with you along with any recent lab tests.

6 Will I need laboratory tests?

Usually lab tests will be needed. Functional Medicine exceeds the scope of main stream health care. Some blood, saliva, urine or stool testing is usually needed. What tests are needed are part of the first visit diagnostic work.

7 What are your hours?

I work Monday through Saturday from 10 am to 6 pm, by appointment. I can make exceptions for people who cannot meet during normal hours.

8 Do you work via telemedicine on a computer or the phone?

There are some visits that can be done via computer or phone.

9 Can I have a consult before my first visit to determine if you can help me?

I can consult prior to a first meeting for a brief talk (5 to 10 minutes), to answer a few questions. If you need a 30 minute consult there is a charge of $75 due at the time of the consult.

10 What do you charge for your visits?

The first visit is $195. Follow-up visits are $195 for 90 minutes, $135 for an hour, $75 for 30 minutes. Usually follow up visits are 30-60 minutes. Reviewing initial lab tests requires 60 minutes. If you buy a package of 6 or more visits, the cost per visit is reduced.

11 Do you offer acupuncture treatments?

I do offer acupuncture for conditions that I think will respond to acupuncture.

12 Can you prescribe medication?

I am a licensed Nurse Practitioner, and I can prescribe medication. I consider what is best for each patient, based on their health history, examination, and lab tests. Supplements, lifestyle changes, herbs, homeopathy, and medication are all considered case by case.

Patient Name _____Date _____

Arbitration Agreement: Integrative Medicine of Northern Virginia, LLC

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

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration , will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouses(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, supervising physicians, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within 30 days and a third arbitrator (neutral arbitrator) P 1 of 3

shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party of such party's own benefit. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed, pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount, payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic loses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to

pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy. I acknowledge this agreement is posted on www.imednova.com

This Arbitration Agreement applies to any patients of Integrative Medicine of Northern Virginia ,LLC and any of it's employees, health care providers, Physicians, Nurse Practitioners, administrative staff, Supervising Physicians, Nurse Practitioners, as well as Stuart Saltzman, NP, Lic Ac and George Weston, MD.

The patient understands they have agreed to arbitration as their sole means to take any action whatsoever.

_____Patient Signature _____ Date

_____Guardian Signature _____ Date

Questionnaires

1. **Please answer all the questions carefully, as best you can.**

2. **The answers are not a diagnosis.**

3. **The answers are indications of imbalance or dysfunction.**

4. **The questions are organized in functional categories, and provide insight into your day to day experience.**

5. **These questionnaires are used in conjunction with lab test to understand the cause of your symptoms. Often the cause is not obvious. Treating the cause of the symptoms is the goal of functional medicine, while we reduce the discomfort of the symptoms.**

6. **Lab tests do not show all the causes, and they are helpful. Accurate thorough diagnostic information is needed to provide effective treatment.**

7. **These Questions are from Western Medical, Chinese Medical and Homeopathic phenomena.**

Questionnaire

Please indicate the correct number that matches the <u>frequency</u> of the following experience and symptoms.

0=never 1=few times per month 2 =few times per week 3=most of the time
There are a few yes or no answers where appropriate -

<u>Category 1</u>

_____ **Feeling your bowels do not empty completely**
_____ **Low abdominal pain relieved by passing stool or gas**
_____ **Alternating diarrhea and constipation**
_____ **Diarrhea**
_____ **Constipation**
_____ **Hard, dry or small stool**
_____ **Coated or fuzzy tongue**
_____ **Pass large amounts of foul smelling gas**
_____ **Use laxatives**

<u>Category 2</u>

_____ **Aches and Pains throughout the body**
_____ **Swelling**
_____ **Bloating and/or distention after eating**
_____ **Undigested food in stools**
_____ **Fullness after eating that lasts 2-4 hours**
_____ **Tenderness left side under rib cage**
_____ **Eating food high in fiber causes constipation**
_____ **Undigested stools, foul smelling stools, poorly formed stools**
_____ **Excessive belching and burping**
_____ **Gas immediately following a meal**
_____ **Offensive breath**
_____ **Bad taste in mouth**
_____ **Difficulty digesting fruit and vegetables**
_____ **Stomach pain, burning or aching in stomach**
_____ **Use antacids**
_____ **Feel hungry an hour or two after eating**
_____ **Heartburn when bending over or lying down**
_____ **Heartburn relieved by food, milk, or carbonated beverages**

Category 3

_____ **Nausea or vomiting**
_____ **Bitter metallic taste in mouth**
_____ **Unexplained itchy skin**
_____ **Yellowish cast to eyes**
_____ **Clay colored stools**
_____ **Reddened skin on palms of hands**
_____ **Pain under right rib cage**
_____ **Pain between shoulder**
_____ **Stools float in the toilet**

_____**Yes** _____**No** **Cannot digest or tolerate fatty foods**

_____ **Yes** ____**No** **Burpy fishy aftertaste after taking fish oil**

Category 4

_____ **Acne breakouts**
_____ **Yellow cast to face, eyes, mouth**
_____ **Body swelling for no reasons**

_____ **Intolerance to smells**
_____ **Intolerance to the scent of detergents, shampoo, chemicals**
_____ **Skin outbreaks**
_____ **Excessive foul smelling sweat**
_____ **Itchy anus**
_____ **Pain upper right rib cage**
_____ **Floaters in eyes**
_____ **Intolerance to perfume**
Yes_____No____ Intolerance to any scents
Yes_____No_____Rashes from time to time

Yes ____ No ____ headaches

Yes_____No ____ Hemorrhoids

Category 5

_____ **Crave sweets during the day**
_____ **Irritable if meals are missed**
_____ **Depend on coffee to keep going during the day**
_____ **Depend on coffee to get started in the morning**
_____ **Get light headed if meals are missed**
_____ **Eating relieves fatigue**
_____ **Feel shaky or have the jitters**
_____ **Agitated, easily upset**
_____ **Poor memory, forgetful**
_____ **Blurred vision**
_____ **I skip breakfast**

Category 6

_____ **Fatigue or sleepy after meals**
_____ **Eating sweets does not relieve craving for sweets**
_____ **Must have sweets after meals**
_____ **Frequent urination**
_____ **Increased thirst**
_____ **Difficulty losing weight**
_____ **Increased appetite**

Yes_____ No_____ Waist girth greater to or equal to hips

Yes _____ No _____ Gain weight easily

Category 7

_____ **Cannot stay asleep (wake up 3am to 4 am often)**
_____ **Crave Salt/Salty foods**
_____ **Afternoon fatigue**
_____ **Wake up tired**
_____ **Light hurts eyes**
_____ **Dizzy when standing up quickly**
_____ **Afternoon headaches**
_____ **Weak Nails**
_____ **Shallow / light sleep**
_____ **Cannot fall asleep**

_____ **Go to sleep after midnight**
_____ **Cannot wake up in the morning**

<u>Category 8</u>

_____ **Tired /fatigued**
_____ **Cannot get out of bed in the morning**
_____ **Feel cold easily or I have cold hands or cold feet**
_____ **Constipated**
_____ **Require excessive amounts of sleep to function**
_____ **Feel depressed, lack motivation**
_____ **Morning headaches that wear off as the day progresses**
_____ **Mental sluggishness**
Yes _____No _____Hair loss or thinning (head, genitals, eyebrow
Yes_____ No_____ Dry skin/Dry Hair
Yes_____ No_____ Gain weight easily
Yes_____ No_____ Cannot lose weight even w diet and exercise
Yes _____No ____ Cannot get pregnant

Yes ____ No ____ lateral eyebrows are thinning

<u>Category 9</u>

_____ **Heart palpations**
_____ **Inward trembling**
_____ **Increased pulse even at rest**
_____ **Nervous/anxious**
_____ **Night sweats**
_____ **Difficulty gaining weight**
_____ **Excess heat in face, head or chest**

<u>Category 10 Menopausal or Post Menopausal or Perimenopause</u>

_____ **Hot flashes**
_____ **Night sweats**
_____ **Mental fogginess**
_____ **Mood swings**
_____ **Facial Hair growth**
_____ **Acne**
_____ **Vaginal itching, dryness, pain**
_____ **Disinterest in sex**
Yes_____ No____ Shrinking breasts

Yes_____ No____ Memory declining
Yes ____ No ____ Weight gain since menopause that cannot be lost
Yes _____ No ____ Painful Intercourse since menopause

Yes _____ No ____ Urinary tract Infections or Candida infections

Category 11 Menstruating Women (including perimenopause)

Yes ____ No _____ Pain or cramping before bleeding starts with menses
Yes_____ No _____ Pain or cramping during menses
Yes_____ No _____ Pain or cramping after bleeding stops
Yes_____ No _____ Heavy bleeding during menses or clots with menses
Yes _____ No _____ Scanty bleeding during menses
Yes _____No _____ Headaches with menses
Yes_____ No _____ Menses cycle less than 26 days
Yes_____ No _____ Menses cycle more than 30 days
Yes_____ No _____ Breast pain during menstrual cycle
Yes _____ No_____ I use an IUD
Yes _____ No _____ I take Birth Control Pills

Category 12 Men only Yes or No answers

_____ Spells of mental fatigue
_____ Inability to concentrate
_____ Episodes of depression
_____ Muscle soreness
_____ Decreased interest in sex
_____ Decreased fullness of erections
_____ Difficulty maintaining erections
_____ Decreased physical stamina
_____ Increased fat accumulation in abdomen

Category 13 SD Answer 0 to 3

_____ **You feel overwhelmed**
_____ **You have feelings of inner rage**
_____ **You feel sad of down for no reason**
_____ **You feel like you are not enjoying life**
_____ **You feel dependent on others**
_____ **You feel like you are losing interest in life**
_____ **You do not have any fun**

Category 14 DD Answer 0 to 3

_____ **You feel anger or aggression while under stress**
_____ **You prefer to isolate your self from others**
_____ **You have an inability to finish tasks**
_____ **You are easily distracted form tasks**
_____ **You feel un-motivated**
_____ **You feel unable to handle stress**
_____ **You Have difficulty focusing**

Category 15 GD Answer 0 to 3

_____ **You worry about things that you did not worry about before**
_____ **You have feelings of guilt about every day decisions**
_____ **You have feelings of inner tension or anxiety**
_____ **You find it difficult to relax and turn your mind off**
_____ **You have feelings of dread or impending doom**

Category 16 AD Answer 0 to 3

_____ **Your memory has decreased**
_____ **You have memory Lapses**
_____ **Your comprehension has decreased**
_____ **You have difficulty calculating numbers**
_____ **You are experiencing slower mental responses**

Category 18 **Answer 0 to 3**

_____ **Headaches/Migraines**
_____ **Neck Pain**
_____ **Shoulder/Arm Pain**
_____ **Back Pain**
_____ **Hip Pain**
_____ **Knee Pain**
_____ **Wrist Pain/Ankle**
_____ **Numb/tingling arms or legs**
_____ **Sinus Stuffy**
_____ **Runny Nose**
_____ **Ear Ringing**
_____ **Skin Problems**

Category 19 **Changes in my life in the last year**

Yes ____ No ____ **I moved**
Yes_____No_____ **I lost a pet**
Yes_____No_____ **I lost a loved one**
Yes_____No_____ **I got divorced or separated**
Yes_____No____ **I got married or engaged**
Yes_____No____ **I started a new job or business**
Yes_____No____ **I had surgery**
Yes_____No____ **I was seriously injured**
Yes ____ No ____ **I traveled outside the United States**

Category 20 **I received the following vaccines in the last 12 month**

Covid **Yes_____No_____** **Tetanus** **Yes _____ No _____**
Flu **Yes_____No_____** **RSV _____** **Yes _____No _____**
Shingles **Yes____ No_____** **Hepatiitis** **Yes _____ No _____**
Pneumonia **Yes_____No_____** **Yellow Fever yes ____ No _____**

Other _____

Category 21

I currently have cancer **Yes _____ N0 _____**

Describe if Yes _____ Current treatment _____

I previously had cancer **Yes _____ No _____**

Describe if Yes _____ Treatment _____

Misc info

_____

_____

_____

Category 22 I have been diagnosed with any of the following

A fibrillation of my heart **Yes ____ No ____ Medication _____**

Heart Murmur **Yes _____ No ____ Medication _____**

High Blood Pressure **Yes _____ No _____Medication _____**

Coronary Artery Disease **Yes _____ No _____ Medication _____**

Blood clotting or DVT **Yes _____ No _____Medication_____**

Blocked arteries **Yes _____ No _____ Medication _____**

Lupus **Yes _____ No _____ Medication _____**

Rheumatoid Arthritis **Yes _____ No _____ Medication _____**

Multiple Sclerosis **Yes _____ No _____ Medication _____**

Sjorgrens Disease **Yes _____ No _____ Medication_____**

Psoriasis **Yes _____ No _____ Medication_____**

Hashimoto's Disease **Yes _____ No ____ Medication_____**

Graves Disease **Yes _____ No ____ Medication _____**

Health History

Surgery	Date	Purpose

Childbirth	Date	Is child still alive
Miscarriages	**Date**	

Injury	Date	Status -Healed or Not

Medication	Dose	Purpose
Allergies	**What are you allergic to?**	**How long**

Diseases Diagnosed (Example Diabetes)	When was it diagnosed	Is it under control

Exams or screening	Date approximate	Any adverse findings
Dentist		
Eye Doctor		
Pap smear		
Mammogram		
X Ray		
MRI		
Ultra Sound		
Ear doctor		
Cardiologist		
Rheumatologist		
Ear Nose and Throat Dr		
Oncologist		
GYN		
Other		
Other		

I have fully disclosed all the information requested accurately.

Signature _____**Date** _____

Check the box that applies to you	YES	NO
I smoke or vape tobacco		
I consume alcohol daily		
I consume fried food at least 1 time a week		
I consume cheese or milk at least 1x times a week		
I am currently in therapy		
I lead a high stress life		
I have been sexually abused		
I have been physically abused		
I have been verbally abused		
I am a relationship right now that is abusive		
I use recreational drugs		
I use medication to sleep		
I use medication to ease depression		
I use medication to ease anxiety		
I am willing to make changes in my life to improve my health		

HIPPA Disclosure

Integrative Medicine of Northern Virginia

11870 Sunrise Valley Dr, Suite 100, Reston Va 20191

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to you past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you jn the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your insurance or providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to other consultants, but only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you, This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits,
processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Office, Stuart Saltzman 11870 Sunrise Valley Dr, Suite 100, Reston Va 20191

- **Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you, We may charge a reasonable, cost based fee for copies.**

- **Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.**

Your Rights

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one account in any 12month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of this Notice. You have the right to a copy of this Notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Stuart Saltzman.

We will not retaliate against you for filing a complaint.

For Health Care Operations. We may use disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy Of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required bv Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted bv HIPPA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situation. The types of uses and disclosures that may be made without your authorization are those that are:

Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)

Required by Court Order

If it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use disclosure your information to family members that are directly involved in your treatment with your written permission.

With Authorization. uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Patient Name

_____

DOB _____

I HEREBY ACKNOWLEDGE THAT I RECEIVED, AND HAVE BEEN GIVEN AN

OPPORTUNITY TO READ A COPY OF INTEGRATIVE MEDICINE OF NORTHERN VIRGINIA PRIVACY PRACTICES. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS

REGARDING THENOTICE OR MY PRIVACY RIGHTS, I CAN CONTACT THE

PRIVACY OFFICER AT: 11870 Sunrise Valley Dr, Suite 100, Reston Va 20191

I further acknowledge this disclosure is posted on www.imednova.com

_____

Signature of Patient

_____

Signature of Parent, Guardian or Personal Representative if needed

_____Date

Informed Consent

Print Name _____ Date_____

I hereby request and consent to be treated at Integrative Medicine of Northern Virginia, LLC for Nutritional counseling, and/or herbal treatment, and or homeopathic treatment, and/or acupuncture, and/or primary care, or weight loss and other health conditions, within the scope of practice of: Stuart Saltzman, Nurse Practitioner and licensed acupuncturist, as well as by his associates , and associated physicians or supervising physicians

I understand the methods of treatment may include but are not limited to: Acupuncture, Electrical stimulation, Herbal Medicine, Nutritional counseling, laboratory tests, Homeopathy and lifestyle coaching, use of hormones and other nutritional products, and the prescription of medication.

I have been informed that the above treatments are generally safe. The side effects of acupuncture include but are not limited to: bruising, numbness, tingling, fainting, diarrhea, constipation, and fatigue. The side effects of herbs or medication are considered before prescribing them to you.

Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infections is another risk, although the clinic uses sterile disposable needles and maintains a safe clean environment. Herbs and nutritional supplements are considered safe, although some may be toxic in large doses. Some herbs and supplements are inappropriate during pregnancy. Some possible side effects of herbs and supplements are hereby mentioned but are not limited to: nausea, gas, stomachache, vomiting, headache, rashes, diarrhea, constipation, hives, and tingling of the tongue.

I agree to immediately notify the staff of Integrative Medicine of Northern Virginia, LLC if I experience any side effects, so by voluntarily signing below, I show I have read and understood the herein contained disclosure . I understand results are not guaranteed and I have been told about the risks and benefits of treatment by the staff at Integrative Medicine of Northern Virginia, LLC . I further understand my patient records and lab reports will be kept confidential and will not be released without my consent. By voluntarily signing this consent I agree that I have been given the opportunity to ask questions, and I have access to the staff at Integrative Medicine of Northern Virginia, LLC in the future, and during the course of treatment, and after treatment, to P 1 of 2

discuss my condition and the results of my treatments.. I intend this consent form to cover the entire course of treatments for my present condition and for any future conditions for which I seek treatment.

I further affirm, that I have been advised by the staff at Integrative Medicine of Northern that I can be advised how to manage my treatment appropriately. I do not expect the staff at Integrative Medicine of Northern Virginia, LLC to anticipate any and all risks and complications of treatment and I will rely of the staff to exercise good judgment based on the facts then known and disclosed by me . I understand that my compliance with recommendations is a requirement for optimal results as well as full disclosure of all known diseases and injury and health history and any use of medication or supplements not prescribed by anyone at Integrative Medicine of Northern Virginia, LLC

I acknowledge that advise, treatments, tests and diagnosis, and prescriptions may not be FDA approved.

I also acknowledge that clinical time, tests, treatments, supplements, medication may not be covered by my insurance policy(s). I understand I may have to pay out of pocked, with no reimbursement whatsoever.

_____Signature_____Date

What are your top five health concerns

1._____

2._____

3._____

4_____

5._____