Dr. Vera Singleton

Consent for Naturopathic Medical Treatment

Patient Name: _____ Date of Birth: _____

I voluntarily consent to outpatient care with Dr. Singleton, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of medications and supplements prescribed by the doctor.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including their designees as is necessary in the medical staff's judgment.

I understand that not ALL of the treatment suggestions provided are accepted by the United States FDA and therefore should not be taken as such. The following therapies may be utilized during my course of treatment with Dr. Singleton:

- **Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation of vitamins,
- minerals, intravenous administration of vitamins, amino acids and other therapeutic substances.
- **Botanical medicine:** botanical formulations may be prescribed as teas,
- alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- **Homeopathic medicine:** dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- **Lifestyle counseling and hygiene:** diet therapy, fasting, elimination diets, promotion of wellness including recommendations for exercise, sleep, stress reductions and balancing of work and social activities.
- **Hydrotherapy**: application of a contrast of hot and cold water directly applied to the body

Dr. Singleton has discussed and explained to my satisfaction the basic procedures of the above therapies and the risks and benefits of the care I will receive and I have been given the opportunity to ask questions about the treatment plan and procedures. I recognize certain potential risks of the procedures I am receiving, as they were described to me and as described more generally below:

POTENTIAL RISKS: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, finger prick for diagnostic testing, and possible prescription drug interaction with prescribed natural supplements or products.

ALTERNATIVES –It has been recommended to me that I maintain a relationship with a primary care physician and/or a specialist to obtain information about all of the conventional medicine treatment alternatives available to me.

I understand that this consent form will be valid and remain in effect as long as I receive medical care with Dr. Vera Singleton

This form has been explained to me and I fully understand this *Consent To Treatment* and agree to its contents.

Signature of Patient: _____ Print Name _____

If the patient is a minor or is unable to consent, complete the following:

_____ _____

Signature of Closest Relative or Legal Guardian Print Name

Relationship: _____

Dr. Vera Singleton
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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical 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 California law, and not by a lawsuit or resort to court process except as California 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 before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Duly Authorized Representative Signature (Date)

By _____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Patient's Representative's Signature (if applicable)(Date)

_____
Print Name and Relationship to Patient

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.

Dr. Vera Singleton

New Patient Intake Form

Name _____ Today's Date _____

Date of birth _____ Age _____
Gender: ☐Male ☐Female
Address _____ City _____
Zip code _____
Phone: Home _____ Work _____ Other _____
May we leave messages relating to your visit? ☐ Yes ☐ No

Email _____

☐ I would like to receive updates, newsletters and articles from Dr. Singleton

We strive to maintain and safeguard your personal information. Only qualified medical professionals will have access to your medical record and will be used for medical purposes only according to HIPAA regulations.

Please provide the following as proof of your identity
Driver's License # or SSN#_____

Emergency contact person
Name: _____ Relationship: _____
Phone: _____ Alternate number: _____

How did you hear about Dr. Vera Singleton?

_____

Insurance information

Primary Insurance Company Name:_____
Type of Insurance (please circle all that apply):
HMO PPO HSA FSA Medicare Other_____

Dr. Vera Singleton service is a fee for service. It is the patient's responsibility to inquire about insurance reimbursement and to know the limits of coverage in regards to Naturopathic doctors and coverage.

What is your chief health concern today?_____

_____

If you have been previously diagnosed with a condition by a physician or specialist, describe it below.
1)
2)
3)

List All Surgeries, Accidents or Hospitalizations, including date occurred:

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:

_____

_____

_____

Allergies

List all known Allergies (food, drugs, environment) and describe your reaction if any: _____

_____

Imaging studies: Describe When & Why You Have Had Each of the Following:

X-Rays:	_____	MRI/Cat Scans:	_____	Ultrasounds:	_____
TB Test	_____	Dexa/NTX:	_____	Mammogram	_____
DRE/PSA	_____	Last Dental Visit:	_____	Last Eye Exa n:	_____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles:	D I N	Chicken Pox:	D I N	Hemophilus (Hib):	D I N
Rubella:	D I N	Tetanus:	D I N	Whooping Cough:	D I N
Mumps:	D I N	Hepatitis B:	D I N		

Any vaccination reactions: _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day & number of years:____

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes/Past: _____

Soda Pop: Y N P Ounces per day if Yes/Past: _____

Other Fluids Ounces per day _____

Alcohol: Y N P How often & how much if Yes/Past: _____

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P Any Drug Treatment:

Recreational Drugs: Y N P Any Drug Addictions: Y N P

Exercise

How often do you exercise? _____ What type of exercise? _____

For how long? _____

Hobbies: _____

Sleep

How long per night? _____ If you wake up frequently, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

Good Energy:Y N P

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? _____

If you have fatigue, does it affect your performance during the day? Y N

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life

Enjoy job: Y N P Hours worked per week: _____ Highest Level of Education: _____

Active spiritual practice: Y N P

Marital Status: _____

Children:_____

Quality of significant relationship: _____

History of sexual, mental/emotional, physical abuse: Y N P

Weight/Body Image/Diet

Current weight:_____ Ideal Weight:_____

History of Eating Disorders: Y N P

Are there any foods you crave?

Are there any foods you have removed from your diet?

Family History

HAS ANYONE IN YOUR IMMEDIATE FAMILY (PARENTS AND/OR GRANDPARENTS) BEEN DIAGNOSED WITH THE FOLLOWING: (PLEASE CHECK)

__ HIGH BLOOD PRESSURE	RELATIONSHIP_____
__ HIGH CHOLESTEROL	RELATIONSHIP _____
__ HEART DISEASE	RELATIONSHIP _____
__ DIABETES	RELATIONSHIP _____
__ THYROID DISEASE	RELATIONSHIP _____
__ BREAST CANCER	RELATIONSHIP _____
__ COLON CANCER	RELATIONSHIP _____
__ DEPRESSION/ANXIETY	RELATIONSHIP _____
__ AUTO –IMMUNE	RELATIONSHIP _____
__ OSTEOPOROSIS/ BONE LOSS	RELATIONSHIP _____
__ INSOMINA	RELATIONSHIP _____
__ ASTHMA/ECZEMA/DERMATITIS	RELATIONSHIP _____
__ OTHER _____	RELATIONSHIP _____

TAKE SOME TIME TO REFLECT AND ANSWER THE FOLLOWING QUESTIONS.
PLEASE USE THE BACK IF NECESSASARY.

1. How have your health issues affected your life and lifestyle negatively?

2. What reasons might you have to maintain your life/lifestyle as is?

3. What do you have to loose by continuing with your current habits?

4. What possibilities would exist-if you could have anything you wanted?

CHECKLIST: Review of Systems

Please circle or highlight if any symptoms apply to you. Indicate **P** if in the past.

General
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head
□ Headache
□ Head injury
□ Neck Pain

Ears
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks
□ Glaucoma
□ Cataracts

Nose
□ Stuffiness
□ Discharge
□ Itching
□ Hay fever
□ Nosebleeds
□ Loss of sense of smell

Throat
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Non-healing sores

Neck
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts
□ Lumps
□ Pain
□ Discharge
□ Self-exams
□ Breast-feeding

Respiratory
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Swelling
□ Water retention

Gastrointestinal
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin
Frequency of Bowel movements_____

Urinary
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Vascular
□ Calf pain with walking
□ Leg cramping

Musculoskeletal
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic
□ Ease of bruising
□ Ease of bleeding

Endocrine
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite
□ Low Libido/sex drive
□ Difficulty with Erections/Orgasm

Psychiatric
□ Nervousness
□ Stress
□ Depression
□ Anxiety
□ Memory loss