Welcome to the Center for Living Health as a new patient of Michael Allen, MD.

The Center for Living Health was founded by husband and wife team Michael Allen MD and Linda Lazar Allen CAMT. Together they created a heart centered practice that consciously strives to bring balance, strength and optimal health to the whole person by integrating conventional and holistic medicine and therapies. We look forward supporting you in a more balanced approach to health.

Enclosed is our new patient packet. This packet contains notices and agreements that need to be read and signed **before** your first appointment. It can take awhile to fill out the forms completely; and we have found that a detailed patient history is one of the most effective ways of discovering the root cause of troublesome symptoms.

Please be sure to complete this form ahead of time and bring it to your visit.

Please read through our cancellation policies and be aware of your commitment as a patient of our practice. Missed appointments are costly and take away valuable appointment time from others.

We are located in Gold River just east of Sacramento at 11344 Coloma Road (off of Sunrise Blvd near Hwy 50), in the Regents Park Office Complex. Our office is in building 400 in the rear center portion of the complex, Suite 445 on the lower level. You may want to plan on arriving early to account for difficulty finding the office, traffic, and filling out any additional registration forms (see our website for complete directions).

Our team of providers and support staff at The Center for Living Health are committed to providing you with the highest level of personalized integrative care and working together with you as partners in your health and healing.

Again, welcome to the Center for Living Health.
We look forward to seeing at your upcoming appointment.

Office Practices and Policies

Patient Hours
We schedule Patient visits Mondays, Tuesdays, Wednesdays and Fridays from 9:30-5pm.

Cancelling Appointments/Missed Appointments

- **New Patient Consultations** changes must be made **7 business days** in advance.
- **Established patients** changes must be **at least 48 business hours prio**r to your scheduled appointment.
- Charges are $70-$140 depending of type of appointment.

Telephone and Email Consults
Dr. Allen will do telephone and email consults for established patients. These are billed in 15 minute increments at the same rate as office visits.

Formal Letters
Simple formal letters from Dr. Allen are $70 and complex letters are $140-$210

Billing
Payment for office visits or phone consultations is **due at the time of service** and can be in the form of cash, credit card or check. If possible we prefer checks over credit cards to help keep our costs down. Phone/email consultation invoices may be emailed and paid online through your bank.

PPO Insurance
Remember we are an out of Network provider, which means we do not participate with any insurance company. All patients must pay at time of service for their care. We will provide you with a Superbill form to submit to your insurance company. Please refer to our web site for ideas on lowering costs with insurance. We are not responsible for any claims that are unpaid or rejected.

Our practice model allows us to provide you quality, personalized care without interference from insurers, including:

- longer, unrushed visits allow us to focus on your unique needs, offer customized treatments and go over all questions you may have
- Allows us to offer more treatment options including alternative and homeopathic medicine and supplements along with conventional medicine.

Website and Facebook:
Complete information about our practice and all relevant patient forms are on our website: www.centerforlivinghealth.com.
Also please follow Center for Living Health on **Facebook for office updates and information**.

Office Policies and Patient Consent

Patients must read through and initial ALL policies to be accepted as a new patient. Thank you.

1. Michael Allen, MD is out of network provider who does not accept insurance. The entire fee for service is due at the time of each visit. No call backs, lab results, forms, etc.. will be provided until any outstanding fee's are paid. **Initial___________**

2. Patient is aware that the medical work as practiced by Michael Allen, MD may extend beyond conventional medical treatment. It is with this information that I request the services as provided and prescribed by Michael Allen, MD. **Initial____________**

3. We recommend our patients maintain a primary care physician for vaccinations, after hours call, emergency, and hospital admissions. **Initial____________**

4. Office hours are Monday-Wednesday and Friday 9:30am-5pm. Please note we are not available for calls or visits outside of normal business hours. We are not open on Thursdays, weekends or holidays. **Initial___________**

5. Patient agrees to pay all late cancellation and missed appointment fee's. New Patient Consultations please make changes 7 business days in advance. Established patients please make changes at least 48 business hours prior to your scheduled appointment. Charges are $70-$140 depending of type of appointment. **Initial______**

6. Patient agrees to pay $35.00 fee for returned checks. **Initial _________**

7. Refills need to be written by the doctor during your office visit, not by phone or fax. We will make exceptions for some patients with a 48 hour notice. **Initial____________**

8. Patient understands that Phone and Email consultations are available for established patients at the same rate as office visit fee. Formal letters are $70-$210 **Initial _________**

9. I understand that all emails become part of the patient chart. **Initial______**

10. I understand, and agree to pay Unpaid Balance Fee's as follows: 1) 10% unpaid balance fee applied to all balances 30 days past due. A second 10% fee will be applied to all balances 60 days overdue . 2) Unpaid balances past due 90 days will be sent to collections and a 50% collection fee will be applied to your account. **Initial______**

I have read this entire form and fully understand it and agree to abide by its terms. I waive now and forever, my right of exemption under the laws of California. I have read the policies above of Center for Living Health and do agree to be bound by its terms. I understand that Insurance may not pay for these services <u>and I agree to pay for all services in full at time of visit.</u> I agree to <u>accept the fee charged for missed appointments and services charged for unpaid bills</u> should such be necessary.

Patient Signature______________________________ Date__________________________

Print Name____ Relationship to Patient (if other than patient)________________________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contain a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent (Notice available in office or on our web site). Patient Understands and Agrees That By Signing This Form: .

- Patient consents to CFLH's use and disclosure of protected health information about you for treatment, payment & health care operations (TPO)
- Patient consents Center for Living Health staff to call, text, email and leave messages on voice mail that assist the practice in carrying out TPO such as appointment reminders, statements and calls pertaining to my care, using the address or numbers I provide.
- Practice may take a picture of patient to be placed in medical record

My signature below indicates I have reviewed the CFLH Notice of Practice of Privacy (on website or available in our office) and fully understand its terms, including my responsibilities and assumed risks. I herby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.

Responsible Party Signature_________________________________ Date____________________________

Appointment Confirmation Best Contact:

Email Address___________________________________ **Phone #**____________________

Child's Name ____ ☐ Female ☐ Male
First *MI* *Last*

MailingAddress____City__________________________State________Zip_________

Date of Birth: ___________________ Age____ School Grade______ School ____

Parent Name __________________________________ Occupation ________________________________

Parent E-mail______________________________________Parent Phone: __________________________ ☐ Home ☐ Work ☐ Cell

Parent Name __________________________________ Occupation ________________________________

Parent E-mail______________________________________Parent Phone: __________________________ ☐ Home ☐ Work ☐ Cell

Parent's are ☐ Married ☐ Separated ☐ Divorced ☐ Living Together ☐ Deceased - how old was child when parent died ______

Are parent's listed the Biological parents of the child? ☐ Yes ☐ No

Siblings *(Names and Date of Birth)* ____

____

Parent/Legal Guardian Address (if different than child) ☐ Mother ☐ Father

Address____City__________________________State________Zip_________

Please list one person not living with you to contact in case of emergency:

Name: ______________________________Relationship ___________________Phone Number ______________________

Address____City__________________________State________Zip_________

Who may we thank for referring you? ____

How did you hear of our practice?____

Waiver of Liablity: I authorize the release of medical information to my referring doctor and all providers at the Center for Living Health. I understand that all fees are due at time of service, and The Center for Living Health is not responsible for any claims unpaid or rejected. I am aware that I need a primary care physician for emergency care.

Parent/Legal Guardian's Signature____ Date __________________________

Pediatric Patient History

Name: ______________________________ **Date** ______________________________

Child's present physical health ______________________________

____

Child's present emotional health/disposition ______________________________

____

Please list the top five health concerns of the child:

1.______________________________

2.______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Has the child been seen by any other health care professional for these issues? ☐ Yes ☐ No

(If yes please explain)______________________________

____

What lab work (blood, urine, parasite, other) has the child most recently done?______________________________

Please list any operations/hospitalizations and the year they took place______________________________

____

Please list any ER visits ______________________________

Has child taken Antibiotics in the past? ☐ Yes ☐ No

(If yes, for what and how many times) ______________________________

List any physical trauma (broken bones, stitches, accidents) that have take place and age of child at the time

____

____

Please list any emotional trauma, stress or life changes that the child has experienced

____

____

Please list all the medications the child is taking, either over the counter or prescription:

____

____

Please list any vitamins, herbal, homeopathics, anthroposophical remedies or supplements the child is currently taking:

____

Are there any known medical allergies? (medications, latex, etc..)______________________________

Please list known allergies to food, environments, or animals____

____

____

Has the child ever lived:

- Near a Refinery, high voltage power lines, or other highly polluted area
- in a house with lead based paint
- In a house with new paint, cabinets or carpet that seemed to affect child
- In a household that had mold in walls
- In a house with smokers

Are pesticides, herbicides or toxic cleaners used in the house where child lives? Yes No
With whom does the child live? Please describe child's daily living arrangements:

____

____

Describe relationship with siblings ____

____

Vaccination History:
Child has had vaccines? Yes No If yes, Write how many and list any reactions:

MMR ___________________________________
Hep ____________________________________
Polio___________________________________
Pneumococcal ___________________________
Hepatitis A ______________________________
Meningococcal ___________________________
Other __________________________________

DTaP ____
Hib ____
Chicken Pox ___________________________________
Influenze ______________________________________
Rotavirus ______________________________________
HPV ____

Has your child had or ever been treated for any of the following? **Check all that apply**

- Breath-holding spells
- Chicken pox
- Colic or esophageal reflux
- Dehydration
- Ear Infections many rarely none
- Encephalitis
- Head injuries (*describe*___________________________)
- Headaches
- Meningitis
- Passing out (syncope)
- Strep Infections
- Seizures with fever w/o fever

Family Medical History

Check if your child or family members (parents, siblings, grandparents, aunts, uncles) and label which family member has had any of the following: (example: ☐ Allergies <u>mother</u>)

☐ Asthma/Wheezing
☐ Allergies
☐ Anemia
☐ Anxiety
☐ Bruise easily
☐ Sensory Integration Dysfunction
☐ Constipation
☐ Colic
☐ Heart Disease
☐ Alcohol Addiction
☐ Mental Illness
☐ Seizures
☐ Eczema
☐ Psoriasis
☐ High Blood Pressure
☐ Alzheimers
☐ High cholesterol
☐ Frequent ear infections
☐ Heart murmur
☐ Frequent antibiotic use
☐ Heart attack at < age 50
☐ Frequent Steroid use
☐ High blood pressure
☐ Pneumonia
☐ Croup
☐ Tuberculosis
☐ High blood lead levels
☐ Arthritis

☐ Hay fever / allergies
☐ Thyroid problems
☐ Headaches
☐ Diabetes
☐ Head injuries
☐ Kidney / bladder problems
☐ Attention Deficit Disorder
☐ Sexually transmitted disease
☐ Learning problems
☐ Problems with bones
☐ Hyperactivity
☐ Problems with muscles
☐ Developmental delay
☐ Emotional disorders
☐ Autism
☐ Depression
☐ Hearing problems
☐ Bipolar disorder
☐ Dental problems
☐ Skin problems / eczema
☐ Alcohol / substance abuse
☐ Problems with digestion
☐ Suicide
☐ Gastric Reflux disease
☐ Other Illnesses:________________________
☐ Cancer: Type:_______________
☐ Other: ______________________________

Birth History
Lbs____ Weeks______ Health of baby at birth ____
APGARS (If known) _________________

Mother's Pregnancy
Mother's age at delivery _____ Number of Pregnancies____________ Number of Live Births________
Where is child in birth order *(if other siblings)*___________________________
Medications during Pregnancy ☐ None ☐ Prenatal Vitamins ☐ Other - Please name______________________
☐ Uncomplicated ☐ Early Labor ☐ Nausea and Vomiting ☐ Bleeding ☐ Diabetes ☐ Thyroid Problems ☐ Pre-eclampsia
Please describe Mother's Pregnancy (planned, problems, high risk, stressful, emotions, concerns, expectations)
____
____
What type of delivery did the mother have? ☐ vaginal ☐ C-section ☐ forceps length of labor_________________________

Difficulties related to birth:____
____

Was the child conceived ☐ Naturally ☐ Aid of In Vitro Reproduction Technology. If yes, What kind _______________________

Check all that the mother experienced during pregnancy: ☐ Cigarette smoking ☐ Lived with a smoker ☐ Drank Alcohol
☐ Recreational drugs ☐ Prescription Drugs ☐ Physical abuse ☐ Emotional abuse

Post Natal Complications
☐ None ☐ Jaundice ☐ Respiratory ☐ Cardiac ☐ Infections ☐ Gastrointestinal ☐ Hospitalized How long? ___________________
☐ Cradle cap ☐ Eczema ☐ Colic ☐ Constipation ☐ Tight neck muscles (Torticollis) ☐ Flattening of the skull

Has child had regression of speech? ☐ Yes ☐ No Difficulty comforting? ☐ Yes ☐ No Difficulty nursing? ☐ Yes ☐ No
Was child breastfed ☐ Yes ☐ No If yes, until what age?_______________________
When was child put on formula?____________ What kind?____
When was the child put on solid food?____________ How did child do initially on solid food?_____________________________

Developmental History
How old was child when: Social Smile ______ Tracking ________ Rolled over_________ Sat ________ Crawled_______
Walked _________ Talked ________ Toilet trained_________ Slept through night__________
Does child bedwet ☐ Yes ☐ No (if yes, is there history of any bedwetters in family)_____________________________________

HOME AND FAMILY

How much screen time (TV, computer,phone, etc) does the child have each **week**?____

Average **Daily** Hrs ____ Average **Weekend** Hrs ____

Does the child engage in physical exercise? ☐ Yes ☐ No If yes, what kind?____

____

Does the child participate in any after school activities?____

Child's special interests or talents____

____

What are your child's gifts? (what comes easily to them)

____

____

What are your child's challenges? (things that are difficult)

____

____

What does your child want to be when he/she is older?

____

Does child have any pets? ☐ Yes ☐ No (If yes, what kind?)____

Is your child on a special or restricted diet? (dairy-free, paleo, etc.) ____________________________________

____

Describe child's typical diet (favorite foods, snacks, meals)

Breakfast ____

Lunch ____

Snack ____

Dinner ____

How much water does child drink on daily basis? ___________

Does child drink soft drinks/soda? ☐ Yes ☐ No if yes, how much ________________

BEHAVIOR

Is there a history of :

☐ biting ☐ hitting ☐ head banging ☐ aggressiveness ☐ odd fascinations ☐ bed wetting ☐ stuttering

☐ teeth grinding at night ☐ teeth grinding in day ☐ pulling own hair

How does child interact with other children? ____

SLEEP

Child's bedtime ______Time child awakens_______

Describe how child awakens (dreamy, cheery, crabby, etc.)____

Sleep Pattern normal difficulty falling asleep frequent waking nightmares night terrors other_________

Does your child snore while sleeping? No Yes

Does your child have pauses or stop breathing while sleeping? No Yes

OTHER

Describe any habits of child (thumbsucking, chewing/twisting hair, nail biting, etc)____

Excessive fears /activities that makes child anxious: □ water being alone dark night terrors thunder strangers

Please describe____

Does child have any sensitivity to sound touch smells lights other (please describe)________________________

Abnormal movements none excessive turning hand flapping tics

SIGNATURE_______________________________________RELATIONSHIP TO PATIENT____