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 Sacramento at the SE corner of Howe Avenue and Northrup. Our office in the rear of the building on the south side, Suite 370. 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.

800 Howe Avenue, Ste 370 Sacramento CA 95825 916.803.7040 tel 916.852-7041 fax
www.centerforlivinghealth.com patientinfo@centerforlivinghealth.com

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 Telemedicine 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 and I agree to pay for all services in full at time of visit. I agree to accept the fee charged for missed appointments and services charged for unpaid bills 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_____

Please let our staff know if you would like a copy of this form for your records.

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 ☐ Other _____

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 _____

Please let our staff know if you would like a copy of this form for your records

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?

- ☐ Breath-holding spells
- ☐ Chicken pox
- ☐ Colic or esophageal reflux
- ☐ Dehydration
- ☐ Ear Infections ☐ many ☐ rarely ☐ none
- ☐ Encephalitis
- ☐ Head injuries (*describe*_____)

Check all that apply

- ☐ 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 mother)

- ☐ 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**_____