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 $85-$170 depending of type of appointment.

Tele-Health Consults
Dr. Allen will do telephone, video 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.

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. Invoices may be emailed and paid online through your bank for phone/email consultation, or Newborn home visits.

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 $85-270 depending of type of appointment. **Initial**_____
6. Patient agrees to pay $40.00 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, Video and Email consultations are available for established patients at the same rate as office visit fee. Formal letters are $85-$255 **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)_____

Patient Consent to Use of Telemedicine

By signing this form, I understand the following:

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and 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 have read and understand the information provided above regarding telemedicine. I hereby authorize Center for Living Health practitioners to use telemedicine in the course of my diagnosis and treatment when I request it.

Signature of Patient (or parent if under 18):_____ Date: _____

If authorized signer, relationship to patient: _____

Notice of Privacy Practices

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_____ **Cell Phone #**_____ ☐Allow SMS text Reminder

Name _____ ☐ Female ☐ Male

First MI Last

MailingAddress_____City_____State_____Zip_____

Date of Birth: _____ Age____ Phone: _____ ☐ Home ☐ Work ☐ Cell

Occupation _____ Employer _____

Marital Status ☐ Single ☐ Married/long term relationship ☐ Separated ☐ Divorced ☐ Widowed

Are any other family members patients of Center for Living Health? ☐ Yes ☐ No

If yes Names_____

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 Liability: 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.

Signature_____ Date _____

Patient History Form

Name: _____ Date_____

Reason for Visit _____
_____
_____

Please list the top five health concerns for your visit:
1._____
2._____
3._____
4._____
5._____

Have you been seen by any other health care professional for these issues? ☐ Yes ☐ No
(If yes please explain)_____
_____

What lab work (blood, urine, parasite, other) was most recently done?_____
Please list any operations/hospitalizations and the year they took place_____
_____

List any physical trauma (broken bones, stitches, accidents) that you have experienced
_____
_____

Please list any emotional trauma, stress or life changes that you have experienced
_____
_____

Please list all the medications you are taking, either over the counter or prescription:
_____
_____

Please list any vitamins, herbal, homeopathics, anthroposophical remedies or supplements you are currently taking:
_____

Please list any known allergies to food, drugs, environment or animals _____
_____
_____

Have you 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 you live? ☐ Yes ☐ No

Please check any of these you have or had in the past: (Please check all that apply)

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Broken/fractured bones
- ☐ Bronchitis
- ☐ Cancer

- Chronic Fatigue Syndrome
- Crohn's Disease or Ulcerative Colitis
- Diabetes
- Emphysema
- Epilepsy, convulsions, or seizures
- Gallstones
- Gout
- Heart attack/Angina
- Other (describe) _____

- Heart failure
- Hepatitis
- High blood fats (cholesterol, triglycerides)
- High blood pressure (hypertension)
- Irritable bowel
- Kidney stones
- Mononucleosis
- Pneumonia
- Rheumatic fever
- Sinusitis
- Sleep apnea
- Stroke
- Thyroid disease
- headaches/head injuries

Please check any of these symptoms occurs presently or in the last 6 months:

GENERAL

- Cold hands & feet
- Cold intolerance
- Daytime sleepiness
- Difficulty falling asleep
- Early waking
- Fatigue
- Fever
- Flushing
- Heat intolerance
- Night waking
- Nightmares
- No dream recall

HEAD/EYES/EARS

- Conjunctivitis
- Distorted sense of smell
- Distorted taste
- Ear fullness
- Ear noises
- Ear pain
- Ear ringing/buzzing
- Eye crusting
- Eye pain
- Headache
- Hearing loss
- Hearing problems
- Lid margin redness
- Migraine
- Sensitivity to loud noises
- Vision problems

EMOTIONAL/NERVES

- Agoraphobia
- Anxiety
- Auditory hallucinations
- Black-out
- Depression
- Difficulty:
- Concentrating
- With balance
- With thinking
- With judgment
- With speech
- With memory
- Dizziness (spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic attacks
- Paranoia
- Seizures
- Suicidal thoughts
- Tingling
- Tremor/trembling
- Visual hallucinations

MUSCULOSKELETAL

- Back muscle spasm
- Calf cramps
- Chest tightness
- Foot cramps
- Joint deformity
- Joint pain
- Joint redness
- Joint stiffness
- Muscle pain
- Muscle spasms
- Muscle stiffness
- Muscle twitches:
- Around eyes
- Arms or legs
- Muscle weakness
- Neck muscle spasm
- Tendonitis
- Tension headache
- TMJ problems

SKIN PROBLEMS

- Acne on back
- Acne on chest
- Acne on face
- Acne on shoulders
- Athlete's foot
- Bumps on back of upper arms
- Cellulite
- Dark circles under eyes
- Ears get red
- Easy bruising

DIGESTIVE

- Bad teeth
- Bleeding gums
- Bloating
- Burping
- Canker sores
- Cold sores
- Constipation
- Cracking at corner of lips
- Diarrhea
- Difficulty swallowing
- Dry mouth
- Heartburn
- Hemorrhoids
- Liver disease/jaundice (yellow eyes or skin)
- Lower abdominal pain
- Nausea
- Periodontal disease
- Reflux
- Sore tongue
- Strong stool odor
- Undigested food in stools
- Upper abdominal pain
- Vomiting

Are you on a special diet? ☐ Yes ☐ No

If yes, what kind: ☐ ovo-lacto ☐ vegetarian ☐ diabetic ☐ vegan ☐ dairy restricted ☐ blood type diet

☐ other (describe):_____

Is there anything special about your diet that we should know? ☐ Yes ☐ No If yes, please explain:_____

_____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? ☐ Yes ☐ No

If yes, are these symptoms associated with any particular food or supplement(s)? ☐ Yes ☐ No

If yes, please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_____

_____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ☐ Yes ☐ No

What food nurtures you? _____

What food make you feel worse? _____

Please check below which most accurately describes information about your bowel movements:

Frequency_____

Color_____

Blood ☐ Yes ☐ No

Mucus ☐ Yes ☐ No

CONSISTENCY

- ☐ Soft and well formed
- ☐ Often float
- ☐ Large, Difficult to pass
- ☐ Diarrhea
- ☐ Thin, long or narrow
- ☐ Small and hard
- ☐ Loose but not watery
- ☐ Alternating between hard and loose/watery

Intestinal gas: ☐ Daily ☐ Present with pain ☐ Occasionally ☐ Foul smelling ☐ Excessive ☐ Little odor

Have you ever used alcohol? ☐ Yes ☐ No

If yes, how often do you now drink alcohol?

☐ No longer drinking alcohol ☐ Average 1-3 drinks per week ☐ Average 4-6 drinks per week

☐ Average 7-10 drinks per week ☐ Average >10 drinks per week

Have you ever had a problem with alcohol? ☐ Yes ☐ No If yes, when_____.

Have you ever used recreational drugs? ☐ Yes ☐ No
Are you exposed to second hand smoke regularly? ☐ Yes ☐ No
Have you ever used tobacco? ☐ Yes ☐ No
If yes: number of years as a nicotine user ____ ☐ Amount per day ____ ☐ Year quit _____
If yes, what type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Do you have mercury amalgam fillings? ☐ Yes ☐ No
Do you have any artificial joints or implants? ☐ Yes ☐ No Describe
_____

Do you feel worse at certain times of the year? ☐ Yes ☐ No If yes, when? ☐ spring ☐ fall ☐ summer ☐ winter
Have you ever had psychotherapy or counseling? ☐ Yes ☐ No If yes: ☐ Currently ☐ Previously, from _____ to _____.
Describe _____

Are you currently ☐ single ☐ married or in a long term relationship ☐ divorced ☐ separated ☐ widowed
Comments_____

Do you have children? ☐ Yes ☐ No
If yes, how many and what are their ages? _____
Please briefly describe your experience parenting (challenges, emotions, beliefs, etc...)
_____
_____

Hobbies and leisure activities: _____
_____

Do you exercise regularly? ☐ Yes ☐ No
If so, how many times a week? _____ ☐ When you exercise, how long is each session?_____
What type of exercise is it?
☐ jogging/walking ☐ tennis ☐ basketball /sports ☐ swimming ☐ home aerobics ☐ yoga ☐ other _____

Please say something about your spiritual life: _____
_____

BIRTH HISTORY/CHILDHOOD
Please do your best to answer the following questions:

What type of delivery did you have? ☐ vaginal ☐ C-section ☐ forceps ☐ full term ☐ preemie (how early) _____

Check all that your mother experienced during pregnancy: ☐ Cigarette smoking ☐ Lived with a smoker ☐ Drank Alcohol ☐ Recreational drugs ☐ Prescription Drugs ☐ Physical abuse ☐ Emotional abuse
Were you breastfed? ☐ Yes ☐ No Until what age _____
Did you feel safe growing up? ☐ Yes ☐ No
Have you been involved in abusive relationships in your life? ☐ Yes ☐ No
Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships? ☐ Yes ☐ No

Please briefly describe your childhood:
_____

FOR WOMEN ONLY
Have you ever been pregnant? ☐ Yes ☐ No If yes, how many times _____
Number of miscarriages ____ ☐ Number of abortions ____ ☐ Number of preemies _____
Number of term births ____ ☐ Birth weight of largest baby ____ ☐ Smallest baby _____
Did you develop toxemia (high blood pressure)? ☐ Yes ☐ No
Have you had other problems with pregnancy? ☐ Yes ☐ No
If so, please comment: _____
_____
Age at first period _____
In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability(PMS)?
☐ Yes ☐ No ☐ Not applicable
Please describe your cycle (regular, irregular, PMS, cramping, heavy/low flow, etc...) _____
_____
Date of last Pap Smear _____ ☐ Normal ☐ Abnormal
Date of last Mammogram_____ ☐ Normal ☐ Abnormal
Have you ever used birth control pills? ☐ Yes ☐ No If yes, when _____
Are you taking the pill now? ☐ Yes ☐ No
Did taking the pill agree with you? ☐ Yes ☐ No ☐ Not applicable
Do you currently use contraception? ☐ Yes ☐ No
If yes, what type of contraception do you use? _____
Are you in menopause? ☐ Yes ☐ No If yes, age at last period_____
Do you take any hormone supplements ☐ Yes ☐ No
If yes, ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin
☐ Progesterone ☐ Provera ☐ Other (specify) _____
How long have you been on hormone replacement therapy (if applicable)? _____