INTEGRATIVE HEALTHCARE SOLUTIONS

NEW PATIENT INFORMATION PACKET

In this packet you'll find:

- New Patient Health History Forms
- Office Policies
- Consent forms

Thank you for considering including Integrative Healthcare Solutions in your wellness journey.

Our mission is to help you heal and resolve your chronic health struggles. We follow a systems-oriented approach, and take time with each patient; we will work together in an effort to get to the root of your health issue(s). We dedicate up to 1.5 hours for each patient's initial evaluation and up to 45 minutes for each patient's follow-up appointments. Additionally, we prepare for appointments by reviewing the patient's history and lab results. In light of these things, we require 72 hours' notice to cancel or reschedule your appointment.

All patients are required to have a signed credit card authorization form (included in this packet) on file before scheduling appointments. Patients who cancel with less than 72 hours' notice are responsible for paying for the time reserved for them in full and we will charge the credit card on file. We do make allowances in case of true emergencies.

A $200 deposit is required for the initial exam (only). The deposit will go towards the full cost ($395) of the new patient exam. If you provide less than 72 hours' notice of cancellation for your initial exam, you will forfeit your $200 deposit to cover the time set aside for, and the time the doctors spent preparing for your exam. Rescheduling your initial exam will require a new $200 deposit.

ON CALL DOCTOR CANCELLATION NOTICE (Dr. Lauren Caffery, DC ONLY): Please be advised that Dr. Lauren Caffery, DC has limited office hours (Monday mornings only) and is **on call** with the hospital during that time. While incredibly rare, your appointment is subject to being canceled at the last minute or cut short, if she gets called into the hospital. You will not be charged for an appointment that is canceled (in its entirety). For appointments that are cut short, they will be rescheduled and finished at a later date.

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I fully understand and agree to the above cancellation policy and on call doctor cancellation notice, and am ready to begin my wellness journey.

_____
Print Name

_____ Date_____
Patient Signature

If the patient is a minor (under 18 years of age) or unable to give consent, consent must be granted by their authorized parent, custodian, or legal guardian.

I_____, the parent/legal guardian of _____, do understand the above informed consent in full.

_____ Date_____ Parent/Legal Guardian Signature

CHILDHOOD DEVELOPMENTAL HISTORY

PATIENT INFORMATION

Today's Date (Month/Day/Year): _____/_____/_____ Date of Birth (Month/Day/Year): _____/_____/_____ Age:_____

Name: _____Gender: M☐ F☐

Address: _____

City: _____ State:_____ Zip:_____

Phone: (_____) _____ Cell: (_____) _____ Email: _____

Name of Parent or Guardian: _____

Who referred you to our office? _____

Please list this child's 5 major health concerns in order of importance:

1._____
2._____
3._____
4._____
5.

MEDICATIONS AND SUPPLEMENTS

Is this child currently taking any medications (prescribed or over the counter), if so please list them.

Medication	Duration on medication	Did it help?
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		

Supplement	Duration on medication	Did it help?
1._____		
2._____		
3._____		
4._____		
5._____		
6._____		

Doctor's Notes:_____

_____

_____

_____

Does this child have any known allergies, if so please list them? *(if more than 6, please tell us!)*

1. _____. 3. _____. 5. _____.
2. _____. 4. _____. 6. _____.

Has this child had any accidents, hospitalizations, infections, injuries, or illnesses since birth?

☐ No. ☐ Yes. Explain:_____

_____

_____

What is the main problem that led to the child being brought here?

☐ Child has no problems	☐ Problems thinking clearly	☐ Refusal to go to School	☐ Neglect by Parents
☐ Depression	☐ Arguments with Parents	☐ Behavior Problems at Home	☐ Bed-Wetting
☐ Anxiety	☐ Adjustment to Parents Divorce	☐ Health Problems	☐ Stealing
☐ Suicidal Thoughts	☐ Academic Problems	☐ Physical Abuse	☐ Fears
☐ Suicidal Actions	☐ Behavior Problems in School	☐ Sexual Abuse	☐ Other: _____

Have you sought treatment for this problem? If yes, what was the outcome?

☐No ☐Yes. Explain:_____

_____

How severe is this problem?

☐ Does not apply ☐ Mild ☐ Moderate ☐ Severe

How long has the child had this problem?

☐ Does not apply	☐ For the past several days	☐ For the past year	☐ For the past several years
☐ For the past several years	☐ For past several months	☐ For the past two years	☐ Other: _____

Which of the following has this problem affected?

☐ Does not apply	☐ The child's relationships with family members	☐ The child's behavior
☐ None		☐ Other: _____
☐ The child's academia performance	☐ The child's physical health	
☐ The child's relationship with peers	☐ The child's emotional health	

What is the child's status in school?

☐ Has not started school	☐ Part-time, regular classes	☐ Expelled from school
☐ Full-time, regular classes	☐ Part-time, special education classes	☐ Being Tutored at Home
☐ Full-time, special education classes	☐ Suspended from school	☐ Other: _____

What grade is the child in now (or when school starts again in the fall)?

☐ Not in school, will not be in school	☐ Preschool	☐ First	☐ Third	☐ Fifth	☐ Seventh
	☐ Kindergarten	☐ Second	☐ Fourth	☐ Sixth	☐ Other: _____

Who does the child live with?

☐ Natural parents	☐ Shared living arrangements with both parents (divorce)	☐ Foster parents
☐ Natural Mother		☐ Lives in an orphanage
☐ Natural Father	☐ Relatives	☐ Lives in an agency
☐ Natural Mother and Stepfather	☐ Friends	☐ Other_____
☐ Natural Father and Stepmother	☐ Adoptive Parents	

Doctor's Notes:_____

_____

_____

_____

Where does the child live?

☐ House ☐ Trailer ☐ Boarding School ☐ Institution
☐ Apartment ☐ Condo ☐ Agency housing ☐ Other _____

How many children are in the child's family including the child?

☐ Only child ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ More than 10

How old was the child's natural father at the time of the child's birth?

☐ Do not know ☐ 15-19 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50 or older

How old was the child's natural mother at the time of the child's birth?

☐ Do not know ☐ 15-19 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50 or older

Was the pregnancy planned?

☐ Do not know ☐ Yes ☐ No

What was the mother's attitude while pregnant with the child?

☐ Do not know ☐ Ambivalent ☐ Angry ☐ Worried ☐ Moody
☐ Accepting ☐ Happy ☐ Depressed ☐ Fearful ☐ Other:_____

What level of stress would you say the mother experienced during her pregnancy?

☐ Do not know ☐ Mild ☐ Moderate ☐ Severe

Did the mother have any illnesses during her pregnancy?

☐ No ☐ Yes. Explain:_____

What was the child's physical condition immediately after birth?

☐ Do not know ☐ Problems with heart ☐ Jaundice ☐ Other: _____
☐ Normal, no unusual problems ☐ Problems with bones ☐ Had blood transfusion _____
☐ Low birth weight ☐ Had seizures _____
☐ Injured at birth ☐ Problems with digestion ☐ Fever Place in intensive care
☐ Difficult breathing ☐ Infection ☐ Placed in incubator

Did the child receive all required vaccinations ("shots")?

☐ No Vaccinations ☐ All required shots ☐ Only some selected vaccinations. Explain:_____

Approximately how much did the child weigh when born?

☐ Do not know ☐ 1 pound ☐ 2 pounds ☐ 3 pounds ☐ 4 pounds ☐ 5 pounds ☐ 6 pounds
☐ 7 pounds ☐ 8 pounds ☐ 9 pounds ☐ 10 pounds ☐ 10 + pounds

How many days did the child spend in the hospital after birth?

☐ Do not know ☐ More than 5 days ☐ More than 20 days
☐ 5 days or less ☐ More than 10 days ☐ More than 30 days

Who was the child's primary caretaker before age 2?

☐ Natural Parents ☐ Adoptive Parents ☐ Natural Father ☐ Grandmother ☐ Orphanage
☐ Natural Mother ☐ Natural Mother and Stepmother ☐ Grandfather ☐ Agency
☐ Natural Father and Stepfather ☐ Grandparents ☐ Foster Parents ☐ Other:_____

Doctor's Notes:_____

_____

_____

_____

How was the child fed before age 2?

☐ Do not know ☐ Bottle ☐ Breast ☐ Bottle and Breast

Describe the child's temperament before age 2?

☐ Do not know	☐ Withdrawn	☐ Affectionate	☐ Hypersensitive	☐ Fearful	☐ Other:_____
☐ Calm	☐ Happy	☐ Crying	☐ Angry	☐ Cranky	_____
☐ Active	☐ Unhappy	☐ Difficult	☐ Regular	☐ Curious	_____
☐ Sociable	☐ Sleepy	☐ Irritable	☐ Irregular	☐ Playful	_____

When did the child develop the ability to sit?

☐ Do not know ☐ 6 months ☐ 1 to 1 ½ years ☐ Other:_____
☐ Before 6 months ☐ 6 months to 1 year ☐ 1 ½ to 2 years

When did the child develop the ability to crawl?

☐ Do not know ☐ 6 months ☐ 1 to 1 ½ years ☐ Other:_____
☐ Before 6 months ☐ 6 months to 1 year ☐ 1 ½ to 2 years

When did the child learn to walk?

☐ Do not know ☐ Before 1 year ☐ 1 to 1 ½ years ☐ 1 ½ to 2 years ☐ After 2 years ☐ Other: _____

When did the child learn to talk?

☐ Do not know ☐ Before 1 year ☐ 1 to 1 ½ years ☐ 1 ½ to 2 years ☐ After 2 years ☐ Other: _____

When did toilet training begin?

☐ Do not know ☐ 2 years 2 ½ years ☐ After 4 years
☐ Before 1 year ☐ 3 years 3 ½ years ☐ Other:_____
☐ 1 year 1 ½ years ☐ 4 years

Were there problems in toilet training?

☐ No ☐ Mild ☐ Moderate ☐ Severe problems ☐ Do not know

Has the child suffered any major illnesses or conditions?

☐ Asthma	☐ Ear infections	☐ Tonsil infections	☐ Scabies	☐ Insect bites
☐ Allergies	☐ Fetal alcohol syndrome	☐ Hernias	☐ Hip dysplasia	☐ Measles, Mumps,
☐ Eczema, psoriasis, seborrhea, dermatitis	☐ Heart/Vascular disorders	☐ Chicken pox	☐ Jaundice	☐ Scoliosis
	☐ Kidney disorders	☐ Hypothyroid	☐ Colic	☐ Rickets
☐ Hives (urticaria)	☐ Tumors/cancer	☐ Hydrocephalus	☐ Strabismus	☐ Other:_____
☐ Muscular dystrophy	☐ Cerebral Palsy	☐ Tetanus	☐ Diphtheria	

Has anyone in the child's biological family suffered any major illnesses or conditions?

Mother:_____
Father:_____
Siblings:_____
Maternal Grandparents:_____
Paternal Grandparents:_____

Doctor's Notes:_____

Has the child suffered any physical traumas (falls, car accidents, sports injuries, etc)?

☐ No ☐ Yes. Explain:_____

Who was the child's primary caretaker from ages 2-5?

☐ Natural Parents
☐ Natural Mother Natural Father
☐ Adoptive Parents
☐ Natural Mother and Stepfather
☐ Natural Father and Stepmother
☐ Grandparents
☐ Grandmother Grandfather Foster Parents
☐ Orphanage
☐ Agency
☐ Other:_____
_____

Describe the child's motor development (running, jumping, throwing, etc) from ages 2-5.

☐ Do not know
☐ Advanced in comparison to other children
☐ Average in comparison to other children
☐ Slow in comparison to other children
☐ Other: _____
_____

Describe the child's language development (talking in sentences, vocabulary, etc) from ages 2-5.

☐ Do not know
☐ Advanced in comparison to other children
☐ Average in comparison to other children
Slow in comparison to other children
☐ Other:_____
_____

Describe the child's social development (development of friendships, relationships with peers, relationships with adults, etc.) from ages 2 – 5.

☐ Do not know
☐ Advanced in comparison to other children
☐ Average in comparison to other children
☐ Slow in comparison to other children
☐ Other: _____

Describe the child's mental development (counting, knowledge of alphabet, doing puzzles, understanding concepts, etc.) from ages 2 – 5.

☐ Do not know
☐ Advanced in comparison to other children
☐ Average in comparison to other children
☐ Slow in comparison to other children
☐ Other: _____

Describe the child's temperament from ages 2 – 5.

☐ Do not know ☐ Withdrawn ☐ Sleepy ☐ Irritable ☐ Irregular ☐ Playful
☐ Calm ☐ Happy ☐ Affectionate ☐ Hypersensitive ☐ Fearful ☐ Other:_____
☐ Active ☐ Unhappy ☐ Crying ☐ Angry ☐ Cranky _____
☐ Sociable ☐ Alert ☐ Difficult ☐ Regular ☐ Curious

Describe the child's current subject strengths in school.

☐ Does not apply ☐ Art ☐ Music ☐ Reading ☐ Math ☐ Spelling ☐ English ☐ Science
☐ None ☐ History ☐ Social Studies ☐ Other: _____

Describe the child's current subject weaknesses in school.

☐ Does not apply ☐ Art ☐ Music ☐ Reading ☐ Math ☐ Spelling ☐ English ☐ Science
☐ None ☐ History ☐ Social Studies ☐ Other: _____

Describe the child's current skill strengths in school.

☐ Does not apply ☐ Handwriting ☐ Understanding concepts ☐ Reading comprehension
☐ None ☐ Memorizing ☐ Pleasing the teacher ☐ Spelling
☐ Concentration ☐ Playing attention in class ☐ Behaving correctly ☐ Working hard
☐ Organization ☐ Getting assignments done on time ☐ Taking tests ☐ Intelligence
☐ Test preparation ☐ Being careful and checking work ☐ Reading speed ☐ Other: _____
☐ Paper and Reports ☐ Vocabulary and expression _____

Doctor's Notes:_____

_____

_____

_____

Thank you for carefully answering each question!

INTEGRATIVE HEALTHCARE SOLUTIONS

Patient: Blue ink,
Doctor: Red ink

Does the child currently have problems with attention and concentration in the classroom?

- ☐ Does not apply
- ☐ No
- ☐ Daydreaming
- ☐ Not getting assignments done
- ☐ Material disorganized or messy
- ☐ Forgets teacher's instructions
- ☐ Acts without deliberation
- ☐ Difficulty sitting still
- ☐ Difficulty being quiet
- ☐ Other: _____

Describe the child's current skill weaknesses in school.

- ☐ Does not apply
- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Test preparation
- ☐ Paper and Reports
- ☐ Memorizing
- ☐ Playing attention in class
- ☐ Getting assignments done on time
- ☐ Being careful and checking work
- ☐ Vocabulary and expression
- ☐ Understanding concepts
- ☐ Pleasing the teacher
- ☐ Behaving correctly
- ☐ Taking tests
- ☐ Reading speed
- ☐ Reading comprehension
- ☐ Spelling
- ☐ Working hard
- ☐ Intelligence
- ☐ Other: _____

Does the child currently have behavior problems in the classroom?

- ☐ Does not apply
- ☐ No
- ☐ Required to sit near teacher
- ☐ Required to sit in an isolated area
- ☐ Often reprimanded
- ☐ Has been sent to the principal's office
- ☐ Talks out of turn
- ☐ Can't wait until turn
- ☐ Other:_____

How is the child described by current teacher(s)?

- ☐ Does not apply
- ☐ None of the following
- ☐ Fidgety
- ☐ Has problem remaining seated
- ☐ Distractible
- ☐ Doesn't wait turn in games
- ☐ Answers questions before completed
- ☐ Fails to finish assignments
- ☐ Has problem maintaining attention
- ☐ Switches from one unfinished task to another
- ☐ Has problem playing quietly
- ☐ Talks excessively
- ☐ Interrupts
- ☐ Doesn't listen
- ☐ Frequently loses objects
- ☐ Fails to consider safety
- ☐ Other:_____

Which of the following are true?

- ☐ Do not know
- ☐ None
- ☐ Child has had regular medical checkups
- ☐ Child has had regular hearing tests
- ☐ Child has had regular vision tests
- ☐ Child has had regular dental checkups

Which of the following are true?

- ☐ None
- ☐ Child wears glasses
- ☐ Child wears a hearing aid
- ☐ Child wears an orthopedic brace
- ☐ Child wears orthopedic/corrective shoes
- ☐ Child uses crutches for walking
- ☐ Other: _____

What problems does the child have with sleep?

- ☐ None Trouble getting to sleep
- ☐ Waking up a lot at night
- ☐ Not getting enough sleep
- ☐ Sleeping too much
- ☐ Restlessness in bed
- ☐ Waking up too early in the morning
- ☐ Sleeping enough, but still tired
- ☐ Falling asleep in school
- ☐ Refusing to go to bed at night
- ☐ Refusing to get up in the morning
- ☐ Sleepwalking
- ☐ Nightmares or Night Tremors
- ☐ Other:_____

What problems does the child have with eating?

- ☐ None
- ☐ Refuse to eat balanced diet
- ☐ Eating too many snacks
- ☐ Finicky about food
- ☐ Has a poor appetite
- ☐ Overeats
- ☐ Other: _____

Doctor's Notes:_____

_____

_____

_____

Today's Date:

Doctor's Initials:_____

Does the child have problems with wetting or soiling?

☐ No ☐ Frequently wets bed ☐ Occasionally wets pants ☐ Occasionally soils pants
☐ Occasionally wets bed ☐ Frequently soils bed ☐ Frequently wets pants ☐ Other: _____

What kinds of discipline do the child's parents (or caretakers) use?

☐ Does not apply ☐ None ☐ Lectures ☐ Punishment ☐ Loss of allowance
☐ Do not know ☐ Yelling ☐ Physical ☐ Grounding ☐ Withdrawal of privileges

How strict are the child's parents (or caretakers)?

☐ Does not apply ☐ Very strict ☐ Average ☐ Very permissive
☐ Do not know ☐ Strict ☐ Permissive

Has the child ever been abused by a current or previous member of the household?

☐ Does not apply ☐ No ☐ Yes, emotionally ☐ Yes, sexually
☐ Do not know ☐ Yes, physically ☐ Yes, verbally ☐ Yes, neglected

Which of the following describes the child now?

☐ Has many close friends ☐ Has several close friends ☐ Has few close friends ☐ Has no close friend

Any comments or other concerns you wish to express?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

It's important to us to communicate with other health care providers that may also be treating you. Please provide us with the information of any other health care providers that you are a patient of so that we can send them a report of your care here at Integrative Healthcare Solutions.

Primary Care Physician

Doctor's name: _____
Practice name: _____
Office number: _____ **Fax number:** _____

Doctor's Notes:_____
_____
_____
_____

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name: _____Age: _____ Sex: _____ Date:_____

* Please circle the appropriate number "0 - 3" on all questions below. **0 as the least/never to 3 as the most/always.**

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)
  _____
  _____
- List your child's 4 healthiest foods eaten regularly.
  _____, _____,
  _____, _____
- List your child's 4 unhealthiest foods eaten regularly.
  _____, _____,
  _____, _____
- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?
  _____, _____,
  _____, _____
- List the medication(s) your child is currently prescribed and over the counter.
  _____
  _____
- Do you find it difficult as a parent to have your child on a special diet?
  _____

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? **0 1 2 3**
- Does your child eat dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? **0 1 2 3**

SECTION: B (K53)

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocadoes, flax seeds, olives) *(mark "0" if present, "3" if missing)* **0 1 2 3**
- Does your child eat *fried* foods? **0 1 2 3**

SECTION: C (K34)

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION: D (K16)

- Does your child have stress? **0 1 2 3**
- Does your child **not** have enough sleep and rest? *(mark "3" if not enough)* **0 1 2 3**
- Does your child **not** have regular exercise? *(mark "3" if no exercise)* **0 1 2 3**
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION: E (K16, K51)

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an **inability** to nap or sleep when physically exhausted? *(mark "3" if unable)* **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively when it is inappropriate? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION: F (K51)

- Does your child get excited easily? **0 1 2 3**
- Does your child have anxiousness and panic for minor reasons? **0 1 2 3**
- Does your child feel overwhelmed for minor reasons? **0 1 2 3**
- Does your child find it difficult to relax when she/he is awake? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: G (K50)

- Does your child seem depressed? **0 1 2 3**
- Does your child have mood changes with overcast weather? **0 1 2 3**
- Does your child have symptoms of inner rage? **0 1 2 3**
- Does your child seem uninterested in games or hobbies? **0 1 2 3**
- Does your child have difficulty falling into deep restful sleep? **0 1 2 3**
- Does your child seem uninterested in friendships? **0 1 2 3**
- Does your child have symptoms of unprovoked anger? **0 1 2 3**
- Does your child seem uninterested in eating? **0 1 2 3**

SECTION: H (K49)

- Does your child have difficulty handling stress? **0 1 2 3**
- Does your child have anger and aggression while being challenged? **0 1 2 3**
- Does your child feel tired even after long sleeps? **0 1 2 3**
- Does your child tend to isolate from others? **0 1 2 3**
- Does your child get distracted easily? **0 1 2 3**
- Does your child have constant need and desire for candy and sugar? **0 1 2 3**
- Does your child have disorganized attention? **0 1 2 3**

SECTION: I (K48)

- Does your child have difficulty with visual memory? **0 1 2 3**
- Does your child have difficulty remembering locations? **0 1 2 3**
- Does your child have fatigue or low endurance for learning activities? **0 1 2 3**
- Does your child have difficulty with attention or low attention span or endurance? **0 1 2 3**
- Does your child have slow or difficult speech? **0 1 2 3**
- Does your child have uncoordinated or slow movement? **0 1 2 3**

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only

SMGECNNQ01(0709).INDD

Fees and Office Policies

Fee schedule:

New patient initial visit*	**$395**
Follow-up office visit or phone consultation (up to 45 mins)	**$165**
Re-evaluation office visit or phone consultation two years since the patient's last follow-up* (up to 45 mins)	**$240**

* The cost of labs and nutritional supplements are in addition to the visit(s).

***IF YOU HAVE AN EMERGENCY*:** We recommend you see your primary care doctor or go to the emergency department. We only treat patients with chronic conditions and do not treat acute conditions.

1) PAYMENT IS REQUIRED AT THE TIME SERVICES ARE PROVIDED: We accept cash, checks, and credit/debit cards. We accept Visa, Mastercard, Discover, and American Express.

2) ***CANCELLATION POLICY:*** All patients are required to have a signed credit card authorization form on file before scheduling appointments. We will do our best to honor your time by staying on schedule. Please help us by arriving on time for your appointments. If you arrive late, the time missed is deducted from your appointment. Due to the amount of time spent at patient visits, we require 72 hours' notice to cancel or reschedule your appointment. If you do not notify us at least 72 hours in advance, you are responsible for paying for the time reserved for you in full (we make allowances in case of true emergencies). We will use the credit card we have on file for this charge.

3) OFFICE HOURS AND LOCATION: We are located in Two Echelon Plaza. Our address is 221 Laurel Rd. Ste. 160 Voorhees, NJ 08043. We are available by appointment only.

4) HEALTH INSURANCE: We do not accept health insurance of any kind. We can provide a superbill of one's visit upon request. Lab services may or may not be eligible for insurance coverage, it is the responsibility of the patient to verify lab coverage before having labs drawn. We do offer non-insurance discount lab services for some testing but these can only be utilized before labs are drawn.

5) SCHEDULING & COMMUNICATION FOR ESTABLISHED PATIENTS: We are dedicated to providing all of our patients with personalized care. We enjoy practicing in a small office setting and running many aspects of our practice (with some help from one other). Bear in mind that our holistic model of functional healthcare is labor and time intensive. In order to stay current with the latest information we are constantly traveling, attending seminars, conferences, and webinars. With that being said, if you have a question, we will try our best to answer your question in a prompt fashion. E- mail is the best way to get your questions answered. You can contact Dr. Christopher Caffery, DC at drcaffery@gmail.com and Dr. Lauren Caffery, DC at drlaurencaffery@gmail.com. E- mails will usually be returned by the end of the next business day. This means if you email on Friday, your email will usually be returned by the end of the day Monday. If you do not have e-mail, you can fax questions to (682) 214-3197.

6) DISABILITY: We do not provide disability or impairment assessments and we do not fill out forms for disability ratings or claims. These types of evaluations would need to be sought from an alternate provider.

7) SUPPLEMENTS: You will be able to purchase the recommended supplements at the office, at our website www.drcafferysupplements.com, by phone, or fax. It is generally recommended that one purchase a supply of supplements to last until the next scheduled visit. If you need supplements before your next visit you can do so through the aforementioned channels. Shipping charges apply to orders less than $100, shipping is free with orders above $100. The supplements and their shipping will have to be paid in full with a credit/debit card before they are shipped.

8) RETURN POLICY: There are no refunds for any office visits, phone visits, exams, or lab tests (once utilized). Supplements may be returned within 30 days of purchase if they are unopened. Special order supplement items may not be returned. There is a 15% restocking fee on all returned supplements.

9) I fully understand and agree to the above policies and fees. I request care from Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC.

_____Date_____

Patient Signature

If the Patient is a minor (under 18 years of age) or unable to give their own consent, permission for treatment must be granted by their authorized Parent, Custodian, or

Legal Guardian. I _____, the Parent/Legal Guardian of

_____, age _____, do hereby authorize and request Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC to provide care for my child/legal trustee and I agree to be financially responsible for such care.

_____Date _____

Parent/ Legal Guardian Signature

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SOLUTIONS

Informed Consent for Care

I understand that care from Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC (hereinafter collectively referred to as "the doctors" is not a substitute for conventional medical care with a medical doctor. I also understand that the doctors' involvement with my care is to provide dietary, nutritional supplement, exercise and lifestyle recommendations.

I understand that recommendations by the doctors are not treatment, prevention, or curative of any disease process. I also understand that none of the recommended nutritional supplements have been approved by the FDA.

I understand that there are possible adverse effects from any or all treatments and/or therapies rendered by the doctors. These possible adverse effects include, but are not limited to, aggravation of pre-existing symptoms, flu-like symptoms, allergic reactions, fatigue, and/or gastrointestinal disturbances. I also understand that some of the therapies that the doctors utilize are considered investigational and the long-term effects are not known.

I understand that the doctors cannot anticipate and explain all risks and complications. I also understand that the doctors do not claim any positive outcomes for cases, and there is risk of spending money, time, and energy without guarantee of results.

I have read, or have had read to me, the above consent. By signing below, I voluntarily consent to the treatment plan.

_____

Print Name

_____ Date_____

Patient Signature

If the patient is a minor (under 18 years of age) or unable to give consent, consent must be granted by their authorized parent, custodian, or legal guardian.

I_____, the parent/legal guardian of _____, do understand the above informed consent in full.

_____Date_____

Parent/Legal Guardian Signature

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ACKNOWLEDGEMENT OF NOTICE

I, _____acknowledge that the **Notice of Privacy Practices** (aka Notice) for Integrative Healthcare Solutions has been made available to me. I understand that I have the right to review the Notice prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment and/or the performance of healthcare operations at Integrative Healthcare Solutions.

Integrative Healthcare Solutions reserves the right to change the privacy practices that are described in the Notice. I understand that I may obtain a revised Notice at www.drcafferyintegrativehealth.com, by calling and requesting a copy by mail, or by picking one up at one of the offices.

_____ _____

Signature of Patient or Personal Representative Date

CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number? ☐ Yes ☐ No

May we leave a message for you on your home voicemail? ☐ Yes ☐ No

May we send you an email? ☐ Yes ☐ No

INFORMED CONSENT REGARDING E-MAIL

Integrative Healthcare Solutions provides patients the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail; however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist after the sender, or recipient has deleted his/her history.

b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Integrative Healthcare Solutions that all e-mail messages sent, or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Integrative Healthcare Solutions will use reasonable means to protect the security and confidentiality of e-mail, or internet communications.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following

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conditions:
a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected health information, Integrative Healthcare Solutions physicians and upon written authorization other healthcare providers will have access to e-mail messages contained in protected health information.

INFORMED CONSENT REGARDING E-MAIL continued

b. Integrative Healthcare Solutions may forward e-mail messages within the practice as necessary for diagnosis and treatment. Integrative Healthcare Solutions will not; however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. Integrative Healthcare Solutions will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency. Just a reminder, if you have a medical emergency call 911, we do not treat acute conditions.

d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

f. Integrative Healthcare Solutions cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication, but Integrative Healthcare Solutions is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Integrative Healthcare Solutions of any type of information you do not want to be sent by e-mail.

h. It is the responsibility of the patient to protect their password, or other means of access to e-mail sent, or received from Integrative Healthcare Solutions, to protect confidentiality. Integrative Healthcare Solutions is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis, r treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Integrative Healthcare Solutions.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Print Patient Name:

_____

Patient Signature:

_____Date:_____

Informed Consent for Credit Card Authorization

By my signature, I understand that I must give Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC (hereinafter collectively referred to as "the doctors") at least 72 hours' notice of any cancellation or schedule change or I will be charged for the full new patient fee or office visit fee (whichever visit was scheduled) that will not count for the next scheduled appointment. I hereby authorize the doctors and Integrative Healthcare Solutions to charge my credit card if the aforementioned 72 hours' notice is not given. I understand that no appointment will be made or kept without a valid credit card on file.

In addition, I give Dr. Christopher Caffery, DC, Dr. Lauren Caffery, DC and Integrative Healthcare Solutions authorization to pay for any outstanding office visit balances, cancellation fees, laboratory fees and products.

_____ _____

Patient's Name Printed Today's Date

_____ _____

Patient's or Guardian's Signature Date of Birth (Patient)

_____

Guardian's Name Printed if Patient is under 18 years.

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Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Policies provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the Notice of Privacy Policies may change. If we change our Notice, you may obtain a revised copy by contacting our Privacy Officer, Lauren Caffery, D.C. at (856) 888-1860, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound to our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent Form, we have the right to refuse you as a patient. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information for purposes of requesting your revocation, or you may simply send us a letter in writing.

By signing this consent, you acknowledge that you have received a copy of the "Notice of Privacy Policies".

_____ _____

Patient's Name Printed Today's Date

_____

Patient's or Guardian's Signature

_____

Guardian's Name Printed if Patient is under 18 years.

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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 it carefully.** If you have any questions about this Notice please contact our Privacy Officer.
Our Privacy Officer is: Lauren Caffery, D.C.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out your treatment and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your Protected Health Information (PHI). Your PHI is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

This Notice of Privacy Practices serves as notice for Integrative Healthcare Solutions.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.drcafferyintegrativehealth.com, calling the office and requesting a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information (PHI)

A) Uses and Disclosures of PHI Based Upon Your Implied Consent
By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to support the operation of the practice.

Following are examples of the types of uses and disclosures of your protected health information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

> **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information to another physician or health care provider who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

A) Uses and Disclosures of PHI Based Upon Your Implied Consent (cont.)

Payment: Since we do not participate with any insurance carriers, your protected health information will not be used to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students. We may also call you by name in the reception or treatment areas. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

B) Uses and Disclosures of Protected Health Information That May Be Made with Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

C) Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

D) Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may also use and disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, your location, or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

E) Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any uses or disclosures.

Public Health: We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information includes government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcements purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of crime, (4) suspicion that death has occurred as a result of criminal activity, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interests to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your provider does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent to use and Disclosure of Protected Health Information" form. Complete the form, sign it, and ask the staff to provide you with a photocopy of your request initialed by them. This will serve as your receipt.

You have the right to request confidential communications from us by alternative means or at an alternative location.

We will accommodate reasonable requests. We may also condition this accommodation by asking for you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing using "Request for Confidential Communications of Protected Health Information" available from the Privacy Officer.

You have the right to have your doctor amend your protected health information.

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical records.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected

health information.
This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after January 1, 2008. The right to receive this information is subject to certain exceptions, restrictions, and limits. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. Our Privacy Officer is Lauren Caffery, D.C. You may contact our Privacy Officer at (856) 888-1860 or via our website, which is www.drcafferyintegrativehealth.com for further information about the complaint process.

This notice was published and becomes effective on March 1, 2011.