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OC Integrative Medicine

Rajsree Nambudripad, MD
Roy Nambudripad, MD

Welcome! We are honored to be part of your journey to health.

Instructions for New Patient

1. Before your first visit, please read the following instructions, print, and sign.
2. Please complete the "New Patient History Forms" to the best of your ability, or please come 45 minutes early to your appointment to fill them out in our office.
3. Please read and sign the "Consent forms." If you have any questions, please call our office. We are also happy to answer all questions at your initial appointment.
4. If you are interested in hormone evaluation and treatment, please also complete the appropriate Female or Male Hormone forms and consent.
5. If you have all your forms filled out, please arrive 15 minutes prior to your scheduled appointment time.
6. Your first visit with us will be a complete medical evaluation, so please bring copies of your medical records including any recent lab tests, imaging studies, and doctors notes. We will review your history in detail, perform a physical exam, and determine if further lab tests are needed.
7. If you are interested in NAET, please read "Say Goodbye to Illness" or "Say Goodbye to Your Allergies" by Devi Nambudripad, DC, LAc, PhD, to get a background on this technique. This is available on Amazon.com or on the NAET website. We also encourage you to view the videos and research articles available on our website. Please make sure you get a copy of the NAET Guidebook, free of charge, from our office on your first visit. Please review this in detail before you begin treatments on your second visit.
8. If you are considered to be a good candidate for NAET, these treatments will begin on the second visit.
9. For pediatric patients with autism or ADHD, we request 2 adults accompany them to the first visit, so that one adult can provide a detailed history while the other adult is able to look after the child.
10. Because we have many patients with strong sensitivities to smells, we ask that you do not wear any perfume, cologne or strong fragrances.
11. Because we treat many patients with food allergies, we ask that you consume food and beverages prior to your appointment. Water bottles are fine.
12. If you are menstruating, please let the physician know, so that we can adjust your treatment accordingly.

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13. Please come on time for all visits as others have appointments after you, and we would like to give you the proper attention and time as needed.
14. If you need to cancel your appointment, please do so 48 hours in advance by leaving us a message or emailing us, otherwise you will be charged a cancellation fee as stated in our "Office Policy and Financial Contract."
15. Our office does not bill insurance. Payment is collected prior to each visit and refunds are not given after services are provided.
16. Please bring your insurance card with you, as we may order bloodwork or other tests through your insurance.

I have read and understand the above instructions.

Signature of patient or guardian _____Date_____

Printed name of patient_____

Witness Signature (office staff)_____Date_____

Rajsree Nambudripad, MD
Roy Nambudripad, MD

Office Policy and Financial Contract

- Payment for all visits must be made at the time of service. We accept cash, check, or credit card payment.

- This office does not bill insurance companies directly. If you have a PPO insurance, you can request a superbill from us, which you can mail to your insurance company for possible partial reimbursement.

- This office will not enter into a dispute with an insurance company over reimbursement for a superbill. Drs. Nambudripad will not negotiate coverage for labs tests, prescribed medications, or imaging tests with insurance companies.

- This office does not bill Medicare. We do not provide superbills to patients with Medicare as their primary insurance.

- We do not treat personal injury cases, workman's compensation, or auto accidents, etc.

- No refunds are given after services are provided.

- Supplements and test kits purchased at our office are final sale and cannot be returned for a refund.

- Cancellation Policy: We request 48 hour notice to cancel or reschedule an appointment. Missed appointments, or late cancellations are charged $40 for weekday appointments or the full office visit charge for Saturday appointments. For Saturday appointments, payment is taken at the time of booking and is non-refundable within 48 hours of your appointment.

I have read the office policies as above and will comply with the above statements.

Patient Name_____

Patient Signature_____Date_____

Rajsree Nambudripad, MD
Roy Nambudripad, MD

Consent to Treatment

I _____ hereby consent, authorize and request Drs. Rajsree and Roy Nambudripad to administer the treatment deemed advisable and necessary to my (my ward's) condition in accordance with his/her expertise. I agree to hold him/her free and harmless from any claims, suits for damages or complications, which may result from such treatment.

Patient or Guardian Signature_____Date_____
Print Name _____

Signature of Witness (office staff) _____Date_____
Print Name _____

Consent to Communicate with your Primary Care Physician

My primary care physician is _____,
located in _____.
Their office number is _____.

I give my consent to Drs. Rajsree and Roy Nambudripad to communicate with my primary care physician, listed above, regarding my medical care.

Patient or Guardian Signature:_____Date_____
Print name_____

Rajsree Nambudripad, MD
Roy Nambudripad, MD

Consent to Use Email or Voicemail for Confidential Medical Information

Patient Name: _____
Parent Name (if patient is a child):_____

Our office would like to maintain good communication with you regarding your appointments, lab results, or other updates. Please let us know your email and phone number by which we can best contact you and leave confidential messages pertaining to your medical care**.**

Email Address:_____

I hereby give Drs. Nambudripad, as above, and office staff permission to use the above email address to communicate lab results, office appointments, and other confidential medical information pertaining to my health, or the health of my child/parent/significant other who is the patient. I understand that electronic communication may not always be 100% secure, and therefore the physicians and staff cannot guarantee the security and confidentiality of email communications.

Patient or Guardian Signature _____Date_____

Phone Number: _____
Alternate Number: _____

I hereby give Drs. Nambudripad, as above, and office staff permission to leave voice messages at this number to communicate lab results, office appointments, and other confidential medical information pertaining to my health, or the health of my child/parent/significant other who is the patient.

Patient or Guardian Signature _____Date_____

Rajsree Nambudripad, MD
Roy Nambudripad, MD

Acknowledgement of Privacy Notice

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from insurance companies for diagnostic tests, medications, etc. (or if requested to process a superbill)
- The day-to-day healthcare operations of your practice

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for OC Integrative Medicine, available to read in full on our website at oc-integrative-medicine.com. We are also happy to provide you with a hard copy of our privacy practices.

If you would like the doctors to allow communication of your health-related information with a family member or friend, please indicate those persons below:

Name of person:_____ Relationship_____
Name of person:_____ Relationship_____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name_____ Date_____
Signature_____
Relationship to Patient:_____

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If you have Medicare, please read and sign below. Our doctors have opted out of Medicare.

Medicare Opt Out Contract

Drs. Rajsree and Roy Nambudripad, whose office is OC Integrative Medicine, at 1440 N. Harbor Blvd. Suite 105, Fullerton, CA 92835, have both opted out of Medicare as of January 3, 2012, and November 15, 2011, respectively.

By executing this contract, the Medicare beneficiary acknowledges and agrees as follows with respect to all items or services provided by the physicians above:

1. That Medicare Beneficiary will not submit a claim, or request Physicians to submit a claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.

2. That Medicare Beneficiary agrees to accept full responsibility for payment in full at the time of service, in accordance with Physicians' current fee schedule, whether Medicare Beneficiary is reimbursed through private insurance or otherwise, for payment for all such items or services.

3. Medicare Beneficiary understands that NO reimbursement can or will be provided by Medicare for such items or services provided by Physicians.

4. That Physicians are not limited by Medicare in the amount that he or she may charge Medicare Beneficiary for the items or services provided, and that Medicare Beneficiary will pay physician's charges in full at time of service.

5. That Medigap plans do not make payment, and other Medicare supplemental insurance plans may choose not to make payment, for items or services furnished by Physicians.

6. That Medicare Beneficiary has the right to have the items or services sought from Physicians to be provided by other physicians or practitioners whose items or services would be covered by Medicare.

7. That Medicare Beneficiary is not in an emergency or urgent health care situation.

8. That Medicare Beneficiary agrees to reimburse Physicians for any costs, collection fees, and reasonable attorney's fees that result from violation of this Agreement by Medicare Beneficiary.

9. That Medicare Beneficiary acknowledges a copy of this agreement has been made available to him or her.

10. That Medicare Beneficiary signs this Private Contract voluntarily and upon full understanding of its terms.

By signing below, I agree to the Medicare-Opt Out contract as above and will not submit any claims to Medicare for treatment or care received by Drs. Rajsree and Roy Nambudripad.

Patient Name_____Signature_____Date_____
Rajsree Nambudripad, MD Signature_____Date_____
Roy Nambudripad, MD Signature_____Date_____

Rajsree Nambudripad, MD
Roy Nambudripad, MD

For patients pursuing NAET treatments in our office, please read and sign:

NAET Safety and Disclosure Form

I,_____, certify that Drs. Nambudripad (as listed above) do not claim to diagnose or cure any illnesses or diseases with NAET® (Nambudripad's Allergy Elimination Techniques).

I understand that NAET® is not a medical diagnostic procedure and therefore does not diagnose a disease. Rather, NAET® gives the practitioner an indication as to the substance(s) to which the patient may have a sensitivity (or energy imbalance). The premise behind NAET® is to balance the energy of the individual patient toward a substance(s) using a combination of techniques from allopathy, chiropathy, acupuncture, nutritional science, and applied kinesiology. The goal of NAET® is to balance the patient's energy toward an item or emotion to reduce the symptoms the patient experiences when in contact with that item. I understand that while some patients see improvement in symptoms after a few treatments, most require about 15 treatments to see improvement in symptoms.

Drs. Nambudripad (as listed above), may recommend blood allergy testing to determine if you have true medical allergies toward foods or environmental items. Compliance with these tests is important for patient safety and to better direct your treatments. I understand that if I have a real medical allergy based on symptoms (or determined from blood testing), NAET® can by tried to lessen the severity of possible allergic reactions (based on preliminary research findings), but the number and duration of treatments will be determined by Drs. Nambudripad (as listed above) and individual success varies. I am aware not to expose myself (or my dependent) to any such allergens unless directed by Drs. Nambudripad (as listed above). For patients with a history of anaphylaxis, NAET® can be tried to improve symptoms of anaphylaxis. However, complete avoidance of the allergen is still recommended and the patient must carry an Epipen at all times unless directed by Drs. Nambudripad (as listed above), or other qualified physician. Success of NAET® for treatment of true medical allergies and anaphylaxis has been seen in many patients, but I understand that research is ongoing, and that individual treatment courses and success varies. I can access the research studies for my own review on the following websites: "naet.com" or "oc-integrative-medicine.com"

I understand that I am (or my dependent is) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. If I (or my dependent) experience any type of allergic reaction or serious symptom during the course of NAET® treatments, I must seek immediate medical attention at the nearest emergency room, or by

calling 911. Drs. Nambudripad (as listed above) can be contacted after hours by email for non-urgent issues only.

I understand that for 25 hours my NAET® treatment, I am (or my dependent is) to avoid touching, breathing and coming within a specified distance of the treated item, as instructed by Drs. Nambudripad (as listed above). If I have accidental exposure to the treated item, I am aware that the treatment may fail and have to be repeated on a subsequent visit for an additional charge. If I have an allergic reaction or any other serious reaction due to the exposure, I must seek immediate medical attention at the nearest emergency room, or by calling 911.

I understand that I (or my dependent) must return to the office at my earliest convenience to determine if the NAET® treatment was successful. I fully understand that I (or my dependent) may still experience a reaction to the substance(s) of unknown severity if I (or my dependent) did not successfully pass the NAET® treatment as determined on the follow-up visit. If I (or my dependent) did not pass the treatment, I (or my dependent) may need to repeat the procedure (more office visits at my cost) until I (or my dependent) clear them satisfactorily. I may need more than one treatment for certain items, depending on the severity of the allergy or sensitivity.

I give permission to OC Integrative Medicine to use my (my dependent's) medical record for research purposes, without disclosing my real name or address. I also give permission to have photographs taken of my (or my dependent's) diseased body part (e.g. in case of skin rash, etc) to use in research or patient education purpose without disclosing my real name or address.

I have read or have had read to me the above statements. I have had the opportunity to ask questions about its content and all my questions were answered. By signing below I express full understanding of its content and will abide by the recommended safety guidelines.

Patient or Guardian Signature_____Date_____

Print Name_____

Witness Signature (office staff)_____Date_____

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Rajsree Nambudripad, MD

For patients pursuing hormone replacement therapy, please read and sign.

Consent for Hormone Replacement Therapy

I request and consent to the administration of hormones (either bio-identical or synthetic) and supplements as prescribed by Dr. Rajsree Nambudripad.

The potential benefits of hormone replacement therapy have been explained to me, and I voluntarily choose to pursue hormone replacement therapy. However, because each individual responds differently to hormones, I understand that no guarantees or assurances can be made with respect to the benefit of hormone supplementation. I understand that adjustments in the dose or type of hormone prescribed may be needed before the desired benefits are achieved. I understand that bio-identical hormone replacement therapy (BHRT) is a new specialty and there are no guarantees with respect to treatment prescribed.

I understand that I will be in charge of taking or administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration. I understand that the initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests or ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physicians any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I take full financial responsibility for lab testing and pharmacy charges. While insurance may help with these charges, I understand that I am ultimately responsible for the cost of these tests and hormone treatments.

I understand that if I have a genetic predisposition, hormone supplementation could potentially increase my risk of cancer, heart disease, stroke or blood clots. If I have personal or family history of any type of cancer, I understand that I may be at increased risk of developing cancer, as well as recurrence of my previous cancer whether I use hormone replacement or not. I understand that research on bio-identical hormones is ongoing. Thus, I understand bio-identical hormone replacement could increase my risk of cancer if I am predisposed.

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I understand that I need to continue regular visits with my primary care physician and obtain appropriate cancer screening exams as advised.

I release Dr. Rajsree Nambudripad M.D. and her employees from any liability should any adverse outcomes of hormone replacement occur. I have been encouraged to ask any questions regarding hormone replacement therapy. My questions have been answered to my satisfaction.

I have read and understand all of the above informed consent. I fully understand the potential benefits and risks of hormone replacement and bio-identical hormone replacement therapy. I hereby request and consent to treatment using hormone supplementation therapy.

Patient Signature_____Date_____

Physician Signature_____Date_____

Witness Signature (office staff)_____Date_____