Ocean Pacific

Integrative Health Center

Dear Patient,

I would like to personally thank you for choosing Ocean Pacific Integrative Health Center for your healthcare needs. As your Naturopathic Doctor, I am here to address your medical concerns, help educate you about natural therapies and ways to improve your overall health, and answer any questions you may have about your current condition. I look forward to meeting you and help supporting you on your path to wellness.

Naturopathic and preventive healthcare are based on treating the whole person. We appreciate your time in carefully and thoroughly completing the intake form for a more complete picture of your physical, mental, emotional and spiritual health.

We look forward supporting you on your path to wellness. Please arrive 15 minutes prior to your appointment time and bring hard copies of your labs, imaging reports and any other medical records if you have them.

Please do not hesitate to call us at 760-944-9300 if you have any questions. We are always here to serve you and to make your experience at our office as pleasant and comfortable as possible.

In good health,

Dr. Abida Zohal Wali, N.D.

41769 Enterprise Circle North, Suite 203
Temecula, CA 92590

Tel: (760)-944-9300
Fax: (888) 419-8560

Website: www.opintegrativecenter.com

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NEW PATIENT INTAKE FORM

Patient Name: _____DOB: _____Date of Service:_____

Age: _____Gender: _____Occupation:_____

If patient is under 18 years of age: Name of parent or Guardian_____

GENERAL PATIENT INFORMATION

Address: _____

City _____State_____Zip_____

Mailing address: (if different from home address): _____
City_____State_____Zip_____

Email Address:_____
Email Correspondence (your email will never be sold, shared or traded)

Would you like to receive a copy of our free newsletter via email? Y or N

Home phone: _____Work phone _____ Cell phone_____

May we leave a confidential voice message at any of the above numbers? ☐ No ☐ Yes
If yes, please specify: ☐ Home ☐ Work ☐ Cell

Are you (please circle): single partnership married separated divorced widowed
Live with (please circle): alone partner parents friends children relatives

Name and ages of Children:_____

Emergency Contact_____

Name:_____Relationship:_____Phone#:_____

List your current health care providers and other specialists that are part of your health care team (includes medical doctors, chiropractors, counselors, massage therapist, physical therapist, acupuncturist):

Name	Profession	Phone Number
Primary Care:		

INSURANCE

Primary Health Insurance:

Type of Insurance (please Check all that apply): ☐ HMO ☐ PPO ☐ HSA ☐ FSA ☐ Other_____

Have you met your deductible ? ☐ Yes ☐ No

Ocean Pacific Integrative Health Center is a fee for service clinic. Patients are responsible for payment in full at the time of service. If you have a PPO plan, we can provide you with a super bill that can then be submitted to the insurance companies for possible reimbursement. It is each patient's responsibility to inquire about insurance reimbursement and to know the limits of coverage in regards to Naturopathic services. Please see our Financial Policy for additional information.

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Patient Name:_____DOB:_____Date of Service:_____

CONTEXT OF CARE
How did you hear about Ocean Pacific Integrative Health Center? _____ What brought you to our clinic? _____ What expectations do you have of me personally as your physician? _____ _____ What is your present level of commitment to addressing your health concerns? Rate from 0-10, 10 being 100% committed: 1 2 3 4 5 6 7 8 9 10 Is there anything else you would like us to know in order to serve you better? _____ _____

Current Health Concerns
What are your most important health concerns? List as many as you can, in order of importance to you. 1._____4._____7._____ 2._____5._____8._____ 3._____6._____9._____

Allergies **List known allergies or sensitivities and describe the reaction (e.g. hives, swelling, short of breath, rash, etc.):**		
Drugs	**Reactions**	**Severity (mild, moderate, or severe)**
Food	**Reaction**	
Environmental	**Reaction**	
Chemical	**Reactions**	
Latex		

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NEW PATIENT INTAKE FORM

Patient Name:_____DOB:_____Date of Service:_____

HEALTH OVERVIEW

Comprehensive health care requires a complete picture of your health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during your visit.

Patient Medical History: (check all that apply) C = current condition within last 6 months P = problem of the past

C	P		C	P		C	P	
☐	☐	ALLERGIES	☐	☐	DRUGS/ALCOHOL USE	☐	☐	PNEUMONIA
☐	☐	ANEMIA	☐	☐	GLAUCOMA	☐	☐	RHEUMATIC HEART DZ
☐	☐	ARTHRITIS	☐	☐	HEART DISEASE	☐	☐	REPRODUCTIVE DISORDER
☐	☐	ASTHMA	☐	☐	HEART MURMUR	☐	☐	SEIZURES/EPILEPSY
☐	☐	CANCER	☐	☐	HIGH BLOOD PRESSURE	☐	☐	SINUS PROBLEMS
☐	☐	CHRONIC INFECTIONS	☐	☐	LIVER DISORDER	☐	☐	SKIN PROBLEMS
☐	☐	DEPRESSION	☐	☐	MENTAL HEALTH CONDITION	☐	☐	STOMACH ULCERS
☐	☐	DIABETES	☐	☐	PARALYSIS	☐	☐	STROKE

☐ OTHER condition not described above: _____

Childhood Illnesses (Check all that apply)

☐ Chicken pox ☐ Mumps/Measles ☐ Rubella ☐ Whooping cough
☐ Diphtheria ☐ Scarlet fever ☐ Asthma ☐ Others:

Immunization history (Check all that apply)

☐ Tetanus ☐ Measles/Mumps/Rubella ☐ Pertussis ☐ Diphtheria ☐ Hepatitis A
☐ Hepatitis B ☐ Polio ☐ Flu shot ☐ Others:

Previous Medical Diagnosis	Diagnosed By	Date of Diagnosis
1.		
2.		
3.		
4.		
Injuries, Trauma or Car Accidents:		

List any injuries, surgeries or hospitalizations you have had:

Type of illness, injury or operation/procedure Date Hospital

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date of Last Physical exam:	Pap Smear: Results? Year	Date of Last Blood Work:	Mammogram: Result? Year

What other medical lab works or diagnostic tests have you had (endoscopy, colonoscopy, MRI, CT scan, x-rays, ECG, etc.)?

_____

(To make your first appointment more productive, please bring copies of your lab results and imaging reports.)

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NEW PATIENT INTAKE FORM

Patient Name:_____DOB:_____Date of Service:_____

HEALTH HABITS

Do you drink alcohol? _____ If yes, what type of alcohol _____and how much/week?

☐ Never ☐ None ☐ Rare ☐ 0-1 drinks /week ☐ 2-5 drinks/week ☐ 6-10 drinks /week ☐ 10+/ week

Do you smoke or chew tobacco? _____ If yes, how many packs/cans? _____If you used to, when did you quit:_____ Total number of years?_____

Do you exercise? _____ What form_____

How often? (hours/day and days/week)_____

How much water do you drink daily?_____

Do you regularly consume products containing caffeine? (Coffee, tea, soft drinks, or energy drinks) ☐ Yes ☐ No

If yes, please specify type and quantity/day: _____

How do you relax? _____

What are your primary interests or hobbies? _____

DIET:
Number of meals eaten per day: 1 2 3 more than 3
Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

List the primary foods **excluded** from your diet: _____
_____

FAMILY HISTORY

Have any of your blood relatives had any of the following conditions?

Put an X in each box that applies	MOTHER	FATHER	SIBLING	Maternal		Paternal	
				G-Mother	G-Father	G-Mother	G-Father
ALZHEIMERS							
ARTHRITIS							
AUTOIMMUNE D/O							
ASTHMA							
CANCER (list type)							
DIABETES							
DRUGS/ALCOHOL ABUSE							
EPILEPSY							
HEART DISEASE							
HIGH BLOOD PRESSURE							
MENTAL HEALTH DISORDER							
OSTEOPOROSIS							
REPRODUCTIVE DISORDER							
SKIN DISORDERS							
STROKE							
THYROID D/O I (Hypo or Hyper)							
OTHER (please list)							

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NEW PATIENT INTAKE FORM

Patient Name:_____DOB:_____Date of Service:_____

MEDICATIONS AND SUPPLEMENTS List all current prescription medications, non-prescription medications, and supplements:		
Prescription Medications		
Name	**Prescribing By**	**Dosage**

Supplements: Please list homeopathics, herbs, vitamins and Minerals		
Name	**Prescribing By**	**Dosage**

Over the Counter:		
Name	**Prescribing By**	**Dosage**

Patient Signature: _____**Date**: _____

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NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

Dr. Abida Zohal Wali, ND

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor. I have also read and understand Ocean Pacific Integrative Health Center Privacy Policy, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996**.**
I understand that the methods of diagnosis and treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to the following listed below:

- **General diagnostic procedures:** (including but not limited to ordering of clinical lab works and imaging studies, perform venipuncture, pap smears, general physical exams, neurological and musculoskeletal assessments)
- **Naturopathic physical medicine:** e.g. craniosacral technique, muscle energy stretching, therapeutic massage techniques, hot and cold hydrotherapy, electromagnetic energy, and other related treatments.
- **Medical use of nutrition:** therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections and IV therapy.
- **Oral Chelation**: the ingestion of specific substances used to bind toxic heavy metals for purposes of detoxification.
- **Western Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories
- **Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses
- **Psychological and Lifestyle counseling:** promotion of wellness including recommendations for exercise, nutrition, sleep, stress reduction and balancing of work, spiritual awareness, and social activities.
- **Contraception:** e.g. OCPs, diaphragms, cervical caps

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks, Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic, and hydrotherapies; allergic reactions to prescribed herbs or supplements; side effects of natural medicines; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

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Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements to eliminate the potential for drug-herb interactions. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. **In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.**

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content and understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Ocean Pacific Integrative Health Center or any of its personnel regarding cure or improvement of my condition. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

_____ _____

PATIENT NAME (printed) **Date**

_____ _____

PATIENT SIGNATURE **Relationship to patient**
(or parent, legal guardian, patient representative)

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HIPPA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Dr. Abida Zohal Wali, N.D.

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

I hereby consent to the use and disclosure of my protected health information by the Ocean Pacific Integrative Health Center for the purposes of treatment, payment and healthcare operations, or as otherwise required by law. By my signature below I acknowledge receipt of the Notice of Privacy Practices from the Ocean Pacific Integrative Health Center.

_____ _____

patient or legally authorized individual signature **Date** **Time**

_____ _____

Printed name if signed on behalf of the patient **Relationship**
(parent, legal guardian, personal representative)

HIPPA RELEASE FORM

In accordance with HIPPA laws, we need your authorization to speak with anyone regarding your personal medical information. In the area below, please complete the information to let Ocean Pacific Integrative Health Center know how you would like us to handle your private medical information.

I, _____, give Ocean Pacific Integrative Health Center permission to speak with the following people regarding my personal medical information.

Name	**Relationship**
_____	_____
_____	_____

_____ _____

patient or legally authorized individual signature **Date** **Time**

This form will be retained in your medical record.

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OFFICE FINANCIAL POLICY AND DISCLOSURE STATEMENT
Dr. Abida Zohal Wali, N.D.

In our continued commitment to provide the highest quality of care available to all of our patients and to have those services comfortably affordable, the following has been implemented regarding our financial policy.

Payment is due at the time of service. We accept cash, check, and most credit/debit cards. A $30.00 fee will be charged for any check returned for insufficient funds or otherwise dishonored. The patient (legal guardian) agrees to be personally and fully responsible for total payments of all services performed in this office.

Communication Via Email:

Communications over the Internet and / or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via email. If you prefer not to communicate via email, we will be happy to discuss with you other routes of communication.

Ocean Pacific Integrative Health Center will not communicate health information that is specially protected under state and federal law (*e.g.,* HIV/AIDS, substance abuse, mental health information) via email.

I understand and agree to the following:

- I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address. _____
  Initials
- I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated via email. _____
  Initials
- I understand that all email communications may become part of my medical records. _____
  Initials
- I agree to hold Ocean Pacific Integrative Health Center and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email. _____
  Initials

Please Note Our Cancellation Policy:

Our patients are very important to us. Missed appointments are costly and take away valuable appointment time from others. Therefore, we ask that you be aware of your commitment. A reminder email will be send to the email address you provided **one week** before your appointment, and a courtesy reminder call will be made one business day before your appointment. A $50 service charge will be applied to your account for any missed appointments or cancellations with less than 2 business days notice as follows:

Missed appointments with less than 2 business days notice. _____
Initials

Cancellation left on the voicemail with less than 2 business days notice._____ (deadline for Tuesday appointments are on Friday)
Initials

Courtesy reminder calls will be made one business day before your appointment. This is only a courtesy call and cancellation charges will apply as stated above if you cancel your appointment _____
Initials

We hope you can appreciate our position. Our goal is to offer highest quality of care and to hold the costs down for all our patients. When time is lost without regard to others, we cannot achieve this goal**.**

I, _____, being a patient of Ocean Pacific Integrative Health Center hereby acknowledge that my health insurance policy is an arrangement between my insurance company and myself, and that all services rendered to me at Ocean Pacific Integrative Health Center are charged directly to me, and that I am personally responsible for payment at time of service. Ocean Pacific Integrative Health Center is not a participant in Medicare or HMO insurance plans. I agree that I am responsible for billing my own insurance company for services rendered. Ocean Pacific Integrative Health Center will provide me with the proper invoice and medical codes to bill my insurance company. Ocean Pacific Integrative Health Center does not guarantee that I will receive reimbursement from my insurance carrier.

By signing below, I agree to the policies and practices of Ocean Pacific Integrative Health Center as stated above.

_____ _____
patient or legally authorized individual signature **Date**

_____ _____
Printed name if signed on behalf of the patient **Relationship**
(parent, legal guardian, personal representative)

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