Dr. Stacey Dee Kupperman, N.D.

Hello,

Congratulations on your decision to take a proactive step towards better health! I really look forward to working with you and helping to guide you through this incredibly important process. My goal is to build a relationship with you and create a space in which we can work together to build better health for you. I will be educating you, supporting you, and encouraging you to make the necessary changes for the goal of better health. I like to get a very thorough picture of where you are at today with your health. This involves a lot of questions about you and your history. The first step in gathering this information is for you to fill out the Health History Summary form provided below. Yes – it is a long one. But, please trust that all the questions asked are very important for me to be able to get the full picture of you. Please take the time to fill this out thoroughly and bring it in with you to your first visit. It also may be necessary to have some laboratory work done to get a picture of your body's biochemical picture. I ask you to please bring in, or send via fax or email, copies of any blood work and imaging reports you are able to access from the last 6-12 months. Or, I would be happy to make copies of the labs at my office. I also want you to have a clear understanding of my financial policy, so I ask that you read this policy at the end of the intake and also sign this to bring in with you to your first visit, along with the intake form filled out. Please feel free to contact my staff if you have any questions about your first visit with me.

Thank you so much and I look forward to meeting you.

Dr. Kupperman

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7250 Beverly Blvd Los Angeles, Suite 101 CA 90036

PATIENT INTAKE FORM

Name: _____Male ☐ Female ☐ Age:_____ Date of Birth_____

Address:_____

City:_____State:_____ Postal Code: _____

Phone (Home): _____ (Work): _____(Cell):_____

E-mail: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow (er) # of children: _____

Occupation: _____Employed By: _____

Highest level of education: ☐ High School ☐ Some college ☐ College graduate ☐ Post Grad

Insurance? Y/N Insurance Company _____ Policy _____Group # _____

Name of Insured _____ Relation to Insured _____

Type of insurance: ☐ PPO ☐ HMO ☐ Other _____

Do you have a primary care physician (PCP)? Y/N Name of PCP _____ Phone:_____

Emergency Contact:_____ Phone:_____Relation: _____

How did you hear about my practice? _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority, along with prior treatments or approaches employed for given health concern

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

What do you believe is causing your most important health concerns?

_____

_____

Medical History

Please check only those that currently pertain to you

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- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Back, Muscle, Joint pain
- ☐ Bladder/Urinary problems
- ☐ Candida
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Rheumatic fever
- ☐ Lung problems
- ☐ Mononucleosis
- ☐ Influenza
- ☐ Rheumatism
- ☐ Malaria
- ☐ Female Gynecological problems
- ☐ Gallstones
- ☐ Gum/Teeth problems
- ☐ Heart attack
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Measles
- ☐ Depression
- ☐ Overweight
- ☐ Psychological problems
- ☐ Pneumonia
- ☐ Eczema
- ☐ Hay fever
- ☐ Pleurisy
- ☐ Chronic swollen glands
- ☐ Skin problems
- ☐ Stroke
- ☐ Suicide
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Chronic fatigue
- ☐ Liver problems
- ☐ Chronic sinusitis
- ☐ Cancer
- ☐ Gout
- ☐ Bowel disease
- ☐ Constipation
- ☐ Hives
- ☐ Hypoglycemia

List any other major illnesses or diseases that you have or have had

_____
_____
_____
_____
_____

Blood type: _____
Date of last physical exam: For what reason?_____
Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) Y/N Most Recent_____

Please list all Surgeries and Hospitalizations—including date occurred:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans:_____

Ultrasounds:_____

Other imaging or diagnostic testing:_____

Please list all CURRENT medications you are taking,

Medications:	Reason:	Date began:	Dose:	Helps? Yes or no

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Please list all CURRENT supplements, vitamins, and herbs you are taking
Please bring in all supplements you are taking to your first visit, or take photo ***of front and back of each item and email the office prior to visit. Please indicate specific dosage you are taking, i.e. 500 mg 2x/day, or 1 capsule 2x/day*

Supplement	Brand	Reason:	Date began:	Strength/Dose:	Helps? Yes or no

List all PAST prescription medications taken for longer than 3 months:
_____
_____
_____
_____

Please List All Sensitivities/Allergies/Reactions
Drugs:

1. _____describe reaction: _____
2. _____describe reaction: _____
3. _____describe reaction: _____
4. _____describe reaction: _____

Foods Allergies:

1. _____describe reaction: _____
2. _____describe reaction: _____
3. _____describe reaction: _____
4. _____describe reaction: _____

Food Sensitivities:

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1. _____describe reaction: _____
2. _____describe reaction: _____
3. _____describe reaction: _____
4. _____describe reaction: _____
5. _____describe reaction: _____
6. _____describe reaction: _____
7. _____describe reaction: _____
8. _____describe reaction: _____

Environment:

1. _____describe reaction: _____
2. _____describe reaction: _____
3. _____describe reaction: _____
4. _____describe reaction: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diptheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Gardasil D I N if yes what year _____
Influenza Vaccine? If so when _____
Other? _____
Any vaccination reactions:_____

Personal Health Habits

Height: _____ Current weight: _____ Weight 1 year ago: _____Max weight _____ Year_____

Smoker? YES NO PAST Amount/Day _____Years Smoking _____Year Stopped _____

Alcohol use? YES NO PAST Type:_____ Frequency: _____

Recreational drug use: YES NO PAST Type:_____ Frequency: _____

Caffeine intake YES NO PAST Type:_____ Frequency: _____

What is your energy level (scale of 1-10, 1 = no energy, 10 = great energy) _____

Do you exercise regularly? YES NO

Type:_____Frequency: _____

Type:_____Frequency: _____

Type:_____Frequency: _____

How many hours do you sleep per night? _____ Do you wake feeling refreshed? _____

Do you have difficulty falling asleep, staying asleep, or both/none? _____

_____

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Bowel Movements per day? _____ Do you ever feel constipated? _____

Any blood, mucus or food particles present in stool? Y N If so, describe: _____

How would you rate your stress level? □ Minimal □ Average □ Considerable □ Unbearable

How do you deal with stress? _____

How much water do you drink per day? Approx ounces/day_____

Do you currently follow any of the following special diets/ nutritional programs? (Check all that apply)

□ Vegetarian □ Vegan □ Allergy Elimination □ Low Fat □ Low Carb □ High Protein □ Paleo

□ Blood Type □ Low sodium □ No Dairy □ No Wheat □ Gluten Free

□ Other: _____

Family History

	Living? Age	**Major Health Problems**, i.e. cancer (if so what type), High blood pressure, heart attack/stroke, heart disease, asthma, mental illness (type), TB, autoimmune disease, diabetes, thyroid problems (type), osteoporosis, endocrine, other	**If deceased, cause of death, age of death**
Father			
Mother			
Siblings (m/f)			
Maternal grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Children (age, m/f)			
Spouse			
Other Relatives with relevant disease history			

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Review of Systems (Please circle Y if you have the problem now, N if never, P if had in past

General:

Date of last full physical?_____ if abnormal, explain:_____

Skin:

Rash:	Y	N	P	Color Change:	Y	N	P
Hives:	Y	N	P	Lump:	Y	N	P
Psoriasis/eczema:	Y	N	P	Itchy:	Y	N	P
Dry:	Y	N	P	Warts/moles:	Y	N	P
Cancer:	Y	N	P	Perspiration:	Y	N	P

Date of last dermatology checkup?_____ if abnormal, explain:_____
Any personal history of skin cancer? ____yes _____no

Head:

Headache:	Y	N	P	Migraine:	Y	N	P
Dandruff:	Y	N	P	Head Injury:	Y	N	P
Oil/dry hair:	Y	N	P	Hair loss:	Y	N	P

Eyes:

Dry/Watery:	Y	N	P	Blurry vision:	Y	N	P
Double vision:	Y	N	P	Cataracts:	Y	N	P
Glaucoma:	Y	N	P	Styes:	Y	N	P
Strain:	Y	N	P	Discharge:	Y	N	P
Dark under eyelid:	Y	N	P	Itchy:	Y	N	P

Date of last visual acuity exam?_____if abnormal, explain: _____
Date of last ophthalmologic exam? _____ if abnormal, explain: _____

Nose:

Frequent colds:	Y	N	P	Nosebleeds:	Y	N	P
Congestion:	Y	N	P	Post nasal drip:	Y	N	P
Polyps:	Y	N	P	Seasonal allergies:	Y	N	P

Mouth/Throat:

Canker sores:	Y	N	P	Cold sores:	Y	N	P
Sore throat:	Y	N	P	Gum disease:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	P		Hoarseness:	Y	N	P

Do you visit the dentist regularly? ___yes ____no If yes, how frequent? _____
Do you have dental problems, gum inflammation or gingivitis? Circle which and explain: _____

Neck:

Stiffness:	Y	N	P	Swollen glands:	Y	N	P
Full movement:	Y	N	P	Tension:	Y	N	P

Respiratory:

Cough:	Y	N	P	TB:	Y	N	P
Shortness of breath with exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath sitting:	Y	N	P	Pneumonia:	Y	N	P
Shortness of breath lying down:	Y	N	P	Asthma:	Y	N	P

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Wheezing: Y N P Painful breathing: Y N P

Cardiovascular:

High blood pressure:	Y N P	Rheumatic Fever:	Y N P
Low blood pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y P	Palpitations:	Y N P
Edema:	Y N P	Chest pain:	Y N P

Gastrointestinal:

Heartburn:	Y N P	Bowel movement frequency:_____	
Indigestion:	Y N P	Recent change in BM:	Y N P
Bloating:	Y N P	Diarrhea or constipation:	Y N P
Nausea :	Y N P	Hemorrhoids:	Y N P
Vomiting:	Y N P	Gall bladder disease:	Y N P
Change in Appetite:	Y N P	Liver disease:	Y N P
Pancreatitis:	Y N P	Ulcer:	Y N P

If over age 50, have you had a colonoscopy? ____yes, _____no

Dates of colonoscopy? _____
Any positive findings on colonoscopy? ___yes___no, if yes, explain:_____

Urinary Tract:

Incontinence:	Y N P	Pain with urination:	Y N P
Frequent infections:	Y N P	Kidney stones:	Y N P
Urgency:	Y N P	Discharge/blood:	Y N P

Musculoskeletal:

Weakness:	Y N P	Arthritis:	Y N P
Stiffness:	Y N P	Leg cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P

Nervous System

Paralysis:	Y N P	Sciatica:	Y N P
Tingling/numbness:	Y N P	Carpal tunnel syndrome:	Y N P
Seizures:	Y N P	Fainting:	Y N P

Mental/Emotional:

Depression:	Y N P	Anger/irritability:	Y N P
Suicidal:	Y N P	High-strung/tense:	Y N P
Anxiety:	Y N P	Fear/Panic:	Y N P

Male Genitalia:

Sexually transmitted disease: Y N P

Sexually active: Y N P

If yes, please elaborate: _____

With: ☐ men ☐ women ☐ both

Hernia: Y N P

Testicular pain/swelling: Y N P

Discharge: Y N P

Prostate disease/symptoms: Y N P

Trouble with sexual function or libido? Y N P

Date of last prostate exam? _____

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Trouble with urination (frequency, urgency, pain, dribbling?) _____

Any additional information you would like to share? _____

_____

Female Genitalia:

Do you have any menstrual problems? If so what? _____

Age periods began:_____

How often periods occur (i.e. every 28 days, every 2 weeks, etc): _____

Last Menstrual Period? This means when was day 1 of last period? _____

How long periods last (days you bleed): _____

If menopausal, since what age:_____

If perimenopause or menopause, list any symptoms _____

Times Pregnant:_____ Miscarriages:_____ Abortions:_____ How many births:_____

Periods:

Heavy Bleeding: Y P N

Cramping: Y P N

Pain: Y P N

PMS: Y P N

Food Cravings: Y P N

Sexual Active: Y N P With: □ men □ women □ both

Healthy Libido: Y N P

Pain With Intercourse: Y N P

Vaginitis: Y N P

Vaginal dryness?: Y N P

Last Pap Smear:_____ Diagnosis: _____

Ever have abnormal PAP?: Y P N

If abnormal, when, what was found? _____

How frequently do you have gyn exams/pap smears?_____

Any Birth Control (please list types and ages used):_____

Do you have any unusual vaginal itching, burning or discharge? Y N P if so, please describe:

_____

Sexually Transmitted Diseases: Y P N if yes what_____

Any cervical cancer history? Y P N if yes when _____

Any ovarian cancer history? Y P N if yes when _____

Any breast cancer history? Y P N P if yes when _____

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Mammography: Y P N if yes when _____

Thermography: Y P N if yes when _____

Dexa Scan Y P N If Yes, what were the results:_____

Use of Hormones: Y P N type _____

Do you perform regular breast self exams? _____

Is there anything else you want to share?

_____
_____
_____
_____
_____

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Dr. Stacey D Kupperman, ND
Financial Policy

Thank you for choosing me as your healthcare provider. I will do my best to provide you with the highest quality medical services. I feel that it is very important that my patients have a clear understanding of my expectations regarding billing and payment. Please read and sign the following financial policy prior to your treatment. Should you have any questions, feel free to ask.

Dr. Stacey D. Kupperman, ND is not currently billing insurance at this time. Naturopathic medicine is covered by very few insurance companies in California. Payment will be expected at time of service. If you would like to submit paperwork to your insurance company on your own, please ask and you will be provided you with the appropriate *Superbill* to do so.

Some of the laboratory work performed at the office and through adjunct lab testing locations are covered by insurance. If this is the case, your insurance information must be provided and sent with the labs. The laboratory companies will bill your insurance company. Please understand that although they will attempt to bill your insurance company for you, if your insurance rejects coverage, you will be required to provide full payment for these services. Please understand that this is all handled by the independent lab companies, and Dr. Kupperman is not involved in the insurance billing process.

If a payment is made by check and the check is returned for non-sufficient funds, you will be charged an additional $20 to your account. If that happens, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If your account has not cleared by then, we will refer it for collection action.

I also may ask for a credit card number from you up-front. This is because I offer the option of phone consultations for my patients' convenience. This will require a credit card to be charged in my office to cover this consultation. I also offer to ship my patients supplements to their home if they are unable to come to the office to pick up refills. Again, for this service, it is required to have a credit card number on hand in the office.

Showing up on time for your scheduled appointment is very important. If you are unable to make your appointment, you will need to give our office at least 24 hours notice. Unless otherwise agreed upon**, the full cost of the appointment will be charged without this notification.**

Fee Schedule:

Initial Consultation: $495.00

Follow Up Appointments: rates vary depending on time requirements and complexity

Standard Follow Up Appointment – (30-45 min): $175
Extended Level 1 Follow Up Appointment – (45-60 min): $200
Extended Level 2 Follow Up Appointment - (60+ minutes): $225 and up

I HAVE READ AND FULLY UNDERSTAND Dr. STACEY KUPPERMAN'S POLICY.

Signature of responsible party_____Date_____

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INFORMED CONSENT FOR TREATMENT

Dr. Stacey Kupperman provides efficacious therapies for the treatment of acute and chronic system disorders. These therapies, many of which have been in continuous use throughout the world for decades, have been documented as effective and safe in respected journals worldwide. In spite of this evidence, many state and national medical authorities consider some of these therapies "experimental" and "non-prevailing". Currently, the FDA has not given official approval of the following therapies offered by Dr. Kupperman: Intravenous hydrogen peroxide, mega-dose vitamin C, IV chelation (using EDTA, DMPS and DMSA) or oral chelation, IV vitamin/mineral replacement infusions, and bio-identical hormone replacement therapy.

I understand that by signing this Consent for Treatment using Investigational Therapies document, I will become a patient of Dr. Kupperman who may use therapies discussed in this document.

I have been given neither assurance of improvement or recovery nor guarantee of safety or efficacy as a participant in this program. Neither I nor my heirs shall hold Dr. Kupperman liable or responsible for any presumed reaction or obvious reaction considered undesirable resulting from the therapy used that I have chosen to have performed on or within my body. Therefore, it is my right to contract for any and all of the above therapies, and is my right to stop at any time during the program of therapies that have been agreed upon by myself and Dr. Kupperman or her designates.

I hereby authorize Dr. Stacey D Kupperman, ND, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Medicinal use of nutrition: Therapeutic nutrition, nutritional supplementation, and intravenous and muscular vitamin injections
BioIdentical Hormone Therapy: The use of compounded bio-identical hormones to help restore and balance optimal hormone levels.
Botanical medicine: Botanical substances may be prescribed as teas, alcohol or glycerite based tinctures, capsules, tablets, creams, plasters, 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.
Lifestyle counseling and hygiene: Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
Physical medicine: Hydrotherapy, stretching, manipulation, and electrical muscle stimulation.
Psychological Counseling
Pharmaceutical prescribing if indicated

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

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures. **Notify Dr. Kupperman if you experience any symptoms which may be secondary to the above procedures.**

Potential benefits: restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain, and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

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 the pregnancy.
Notice to Women receiving hormone therapy: All females receiving hormone therapy must agree to see a gynecologist and receive yearly PAP and breast exams.

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With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Kupperman regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself, or my representative, or unless it is required by law. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____ _____

Signature of patient Date

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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.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization**. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

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Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or legal guardian), acknowledge that **Dr. Stacey D. Kupperman** has provided a written copy of its Notice of Privacy Practices for Protected Health Information for (print name of patient): _____

_____ __/___/20___
Signature of Patient, Parent or Legal Guardian Date (mm/dd/yyyy)

_____ _____
Printed Name Relationship

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OFFICE POLICIES

PATIENT NAME: _____ DATE OF VISIT: _____

Welcome to the medical office of Dr. Stacey Kupperman. We understand you have to come to our office to receive specialized evaluation and care. Our staff will do their best to assist you in your needs. To help you understand our office, please read and initial the following statements:

____ I understand that all appointments are a contract of time with the doctor whose time is reserved for me and that I am ALWAYS responsible to call if I must reschedule an appointment. I agree to provide at least 24 hour notice of cancellation of any appointment. By being a patient you are required to reserve your date by giving a credit card to hold your appointment. If the patient forgets or is a no show, the patient will be charged a fee for the missed appointment (detailed below). Keep in mind, that time slot could have gone to another patient.

____ I understand that Dr. Kupperman's time is reserved for me, and that if I arrive late to my appointment, or do not have my intake paperwork completed, my appointment may be shortened to honor other appointments which follow mine. Regardless of time spent, I am responsible for the full cost of the appointment scheduled.

____ New Patient Appointments

- All new patients are required to provide a valid credit card number, including expiration date, security code, and billing zip code, in order to schedule a new patient appointment. This card will be kept on file and may be charged for appointment cancellations and no-shows.
- If you cancel your new patient appointment with less than 24 hours' notice and choose not to reschedule, your credit card will be charged 50% of the initial consultation fee (see Cancellation Policy below).

____ **Cancellation Policy**

- **A minimum of 24 hours' notice is required to cancel any appointment. If you cancel any appointment within 24 hours of your scheduled appointment, your credit card will be charged 50% of the booked appointment fee.**
- **If you fail to show for your appointment without notification, your credit card will be charged for the full price of the visit.**

____ Phone/Skype Appointments: Dr. Kupperman also provides patients with phone and/or skype consultations. The charges are billed like an office visit and are based on medical necessity.

____ Email Policy: Dr. Kupperman is happy to answer quick questions via email, such as clarification on treatment plans and matters that do not involve medical treatment or advice. Any email correspondence that extends beyond basic questions and concerns, involves changes in symptoms, new symptoms, medical advice, changes to prescriptions, or any matter that Dr. Kupperman determines to be beyond what is appropriate for email correspondence will require the patient to schedule an office visit to address such matters.

____ Laboratory Testing & Fees

- Discounted rates on blood tests are available for uninsured patients, and fees for this service are collected up front, paid directly to the doctor.
- A lab handling fee is charged for all laboratory tests.

____ Laboratory Testing Review and Release

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- All lab tests ordered require scheduled appointment time with Dr. Kupperman to review and discuss. Lab results are not released to patients outside of a scheduled in-office or phone appointment, or can be released to another provided with a medical release request.

____ Payment

- There are no refunds on any labs, services or products.
- Payment for visits, supplements and other services, and copayment or coinsurance (when applicable) is required at time of service.
- We gladly accept cash, checks, debit cards and all major credit cards.

____ We attempt to provide emergency care to our patients when possible, but our office is not intended to treat acute emergencies. If you have an emergency please dial 911 or go to your nearest emergency room.

____ Any patient that has not been seen in our office within the last 6 months will need a followup appointment for refill authorizations, new prescriptions or any laboratory work.

____ We are sometimes able to verify your insurance policy, but it is your responsibility to know your insurance benefits for office and lab coverage for both in and out of network. Please contact your insurance provider for details of your plan if unsure of these benefits.

____ I understand that the extent to which my health goals are successful will be determined by the amount of energy, commitment and dedication I give to support the work I am endeavoring into. I am responsible for my health.

Office Fees for Dr. Kupperman:

Initial Consultation: $495.00
Follow Up Appointments: rates vary depending on time requirements and complexity
Brief Follow Up Appointment (15-30 min): $125
Standard Follow Up Appointment – (30-45 min): $175
Extended Level 1 Follow Up Appointment – (45-60 min): $200
Extended Level 2 Follow Up Appointment - (60+ minutes): $225 and up

I have read and initialed each policy rule. I understand that if I don't follow them, any charges made to my account will be my sole responsibility.

PATIENT NAME (printed) _____

Signed_____ Date_____

Parent or Guardian_____ Date_____

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Physician's or Duly Authorized Representative Signature (Date)

By_____
Print or Stamp Name of Physician, Medical Group or Association Name

By:_____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By:_____
Patient's Signature (Date)

_____
Print Patient's Name

By:_____
Patient's Representative's Signature (if applicable)(Date)

_____
Print Name and Relationship to Patient

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.

edition date 11/2009

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DIET DIARY FOR (name) _____ DATE BEGIN_____ Diet Diary Guidelines: Write down EVERYTHING you eat for meals and snacks. List BRAND NAMES of foods you bought in a supermarket. List EXACT INGREDIENTS of home-made foods. The purpose of this diary is NOT to judge your eating habits, but to learn more about your nutritional, biochemical, hormonal needs and strengths. Under BM, please list the time you had a bowel movement and if it was D (diarrhea) and C (constipation).

Times	Times	Times	Times	Times	Symptoms Times	BM Time(s)
Day						
Day						

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Day						

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