HEALTHY BY NATURE
VITASHOT BAR • NATUROPATHIC MEDICINE • VITADRIP LOUNGE

VitaShot and VitaDrip
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

Are there any specific health concerns you hope to address with VitaDrip or VitaShot therapy?

1) _____
2) _____
3) _____
4) _____

What other conditions, symptoms, or concerns are you primary health concerns in order of importance.

1) _____
2) _____
3) _____
4) _____

Have you ever had a vitamin IV treatment? Y N
If yes, please describe what kind of treatment was performed: _____
Have you ever had an adverse reaction to an IV vitamin treatment? Y N
If so explain_____

Please List All Sensitivities/Allergies/Reactions:

Shellfish? _____
Drugs _____
Foods _____
Environment _____

Medical History

Please check only those that currently pertain to you:

❑ Alcohol abuse
❑ Allergies
❑ Female Gynecological problems
❑ Gallstones
❑ Skin problems
❑ Stroke

Dr. Stacey Kupperman, N.D. HealthyByNatureMed.com T 310.310.9717 F 310.496.1779
7250 Beverly Blvd Los Angeles, Suite 101 CA 90036

❑ Anemia	❑ Gum/Teeth problems	❑ Hypoglycemia
❑ Asthma	❑ Heart attack	❑ Thyroid problems
❑ Arthritis	❑ Heart problems	❑ Tuberculosis
❑ Back, Muscle, Joint pain	❑ High blood pressure	❑ Ulcers
❑ Bladder/Urinary problems	❑ Kidney problems	❑ Pleurisy
❑ Epilepsy	❑ Depression	❑ Liver problems
❑ Diabetes	❑ Overweight	❑ Cancer
❑ Rheumatic fever	❑ Psychological problems	❑ Gout
❑ Lung problems	❑ Pneumonia	❑ Constipation
❑ Eczema	❑ Bowel disease	❑ Hives
❑ Influenza	❑ Hay fever	❑ Rheumatism

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

_____

_____

Date of last physical exam _____ For what reason? _____

Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) Y / N

Please list all CURRENT medications you are taking:

Medications:	Reason:	Date began:	Dose:	Helps? (yes/no)

Please list all CURRENT supplements, vitamins, and herbs you are taking:

Medications:	Reason:	Date began:	Dose:	Helps? (yes/no)

Family History	**M**	**F**	Sibling		**M**	**F**	**S**		**M**	**F**	**S**
Arthritis	❑	❑	❑	Thyroid Disease	❑	❑	❑	Multiple Sclerosis	❑	❑	❑
Depression/Anxiety	❑	❑	❑	Heart Disease	❑	❑	❑	Epilepsy	❑	❑	❑
Dementia	❑	❑	❑	Lung Disease	❑	❑	❑	Parkinson's Disease	❑	❑	❑
Diabetes	❑	❑	❑	Kidney Disease	❑	❑	❑	Stroke	❑	❑	❑

Cancer (types and member): _____

Other: _____

_____

Is there anything else you want to share?

_____

_____

_____

Thank You. We Look Forward to Working With You on Your Path Towards Better Health!

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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
Bio-Identical 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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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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