



THE CENTER FOR NATURAL & INTEGRATIVE MEDICINE

KIRTI M. KALIDAS, M.D., N.D.

Board Certified Internal Medicine & Naturopathic Medicine

Welcome!

Thank you for choosing our office. Our goal is to treat the **whole person** using the best of conventional and natural medicine and to guide you towards optimal health. We strive to provide our finest care and services in a professional, warm and supportive environment. We look forward to meeting with you and being able to provide a **“Bridge to Health, Hope, and Healing”**.

In order to maximize your time with our physicians, please fill out all forms **completely** and bring them with you. This is invaluable information for the physicians. Please be sure to **arrive at least 20 minutes** prior to your appointment time to complete the registration process. This will enable you to get your full scheduled time with the physicians.

If you have medical records that you want our physicians to review, make copies for yourself and another set for our office to keep in your chart. They will not be returned to you. Please mail us copies of your records. Do not have extensive records faxed, as they are difficult to read.

Phone: (407) 355-9246
Toll Free: (877) 320-9246
Fax: (407) 370-4774
Address: 6651 Vineland Rd, Suite 150
Orlando, FL 32819

You are acknowledging that you have read, understood, and agree to our office policies.

Patient Signature: _____ Date: _____

Patient Name: _____

Office Personnel Signature: _____



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CONSENT FOR TREATMENT, FINANCIAL POLICY AUTHORIZATION & ACKNOWLEDGEMENTS

AUTHORIZATION OF TREATMENT:

I, _____, hereby authorize medical treatment of myself or my minor child by physicians, medical assistants and staff at The Center for Natural & Integrative Medicine (CNIM).

NOTICE AS TO NATURE OF SERVICES: I seek the medical and health care services of the Center for Natural & Integrative Medicine, its employees and staff. I understand that this medical practice uses some diagnostic and treatment methods that some may consider holistic, complementary or alternative. Some of these methods have not been accepted by “mainstream” medicine. I understand that the principles of this practice are based on Naturopathy, a primary health care system, in which we believe that the body has an inherent ability to heal itself given the right tools. Treatment modalities provided by CNIM are based on functional and science based evidence.

Some of the characteristic qualities of medicine that are used in this practice include the following:

1. A person’s lifestyle including his or her diet, exercise patterns, sleep habits and stresses are believed to be directly related to the development and maintenance of illness. CNIM will evaluate these factors and seek to help the patient give up negative life style patterns and establish more positive ones regardless of age or type of medical problem.
2. Although prescription and over-the-counter medications are used when the physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs.
3. In addition to recommending that a patient take nutritional supplements by mouth, it is sometimes recommend that a patient receive a series of injections either intravenously or by intramuscular injection. Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems), and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken by mouth.

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Initials

4. For some patients, we recommend homeopathy, based on appropriate history. It is based on the principle of “like cures like,” and uses extremely tiny concentrations of animal, vegetable or mineral substances to stimulate the body’s healing mechanisms. Although homeopathy is fairly well established in some European countries, India and other countries worldwide, it is generally not at all accepted by consensus in mainstream medicine in the United States.
5. Because CNIM looks for imbalances in the body and for trends that if not addressed may result in illness. Tests are sometimes ordered that may be considered by consensus of mainstream medicine to be either unnecessary or of no value. These may include tests for nutritional status, such as blood levels of vitamins and minerals, hormone levels, test for heavy metals, tests for chronic viruses and bacteria or tests for food allergies.
6. CNIM feels that environmental factors may play a major role in health and disease. Some of the diseases of unknown cause maybe triggered or perpetuated by common environmental substances, many of which are man-made. Individuals may vary greatly in their susceptibility to various substances, so that one individual may be made deathly ill by an exposure to a substance while another is not at all affected. CNIM will attempt to identify offending substances and help patients to detoxify from past exposures that are affecting them.
7. Detoxification, elimination diets and lifestyle changes are frequently recommended with many individualized programs available.
8. CNIM very much believes in persons being involved in their own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. Consultations are encouraged with consensus of mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.
9. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.
10. Sometimes medications are used that are approved by the FDA to treat one condition; however, that same medication may be used for treatment that has not been FDA approved. Perhaps the best example is the use of EDTA chelation therapy to treat all forms of atherosclerotic cardiovascular disease and other degenerative diseases.
11. CNIM believes that true healing occurs with a strong mind, body and spirit connection. We provide additional services such as yoga, meditation, stress reduction, emotional healing, acupressure, acupuncture and massage.

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NOTICE THAT SERVICES ARE NOT PRIMARY CARE: I understand that no physician or any other practitioner that I see at The Center for Natural & Integrative Medicine is acting as my primary care physician. As such, emergency services are not offered. I understand that even though my physician(s) and The Center for Natural & Integrative Medicine practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions that I may have.

This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform The Center for Natural & Integrative Medicine of who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at The Center for Natural & Integrative Medicine in order to properly and safely coordinate my care.

NO GUARANTEES: I understand that CNIM does not make any representations, claims or guarantees that I will be helped with my medical problems or conditions by undergoing treatment at CNIM. However, CNIM will do their best to help me accomplish my healthcare and wellness goals.

REVOCAION OF AUTHORIZATIONS: These authorizations will remain active unless revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

NUTRITIONAL SUPPLEMENTS: I understand that CNIM makes nutritional supplements and other recommended products available. Many of these products are not available through retail outlets or the quality is superior to retail brands. These are provided for the convenience of patients. I am in no way obligated to purchase these products from this office. I am free to purchase any recommended supplements or other products from any source that I choose.

NOTICE TO MEDICARE PATIENTS: The doctors at CNIM have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at CNIM. I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said service(s).

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INSURANCE CLAIM MANAGEMENT: CNIM does not participate with any insurance company. A receipt and an encounter form will be provided to me at the time of visit to submit to my insurance company on my own. CNIM does not prepare or submit insurance claim forms. My treating practitioner(s) will not respond to insurance requests for information, and are not obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.

I understand I may be charged for responding to requests for information. CNIM does not typically send information directly to insurance carriers. I am responsible for **the payment of services provided by CNIM in full at the time of service without regard to insurance coverage**. I am entitled to know the cost of all services and procedures in advance and I will ask if they are not told to me.

FINANCIAL INSURANCE RESPONSIBILITY FOR ALL SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required in full at each visit; The Center for Natural & Integrative Medicine does not accept assignment. I am responsible for charges incurred for all treatment rendered. Differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). CNIM will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for CNIM to take action to secure payment of an outstanding balance owed. Charges are based on time spent in consultation with the physician and appropriate services rendered.

The initial office cost is \$395.00. Follow-up visits cost between \$175.00 and \$200.00 based upon the complexity of the visit and the time spent.

**Full payment is expected at the time of services rendered.
Any and all past due patient balances will be collected before my appointment.**

In addition to the fee for the office visit, the cost for lab work or other specialized testing deemed appropriate to my case will be applied to my balance.

Questions are always welcome. Most of the labs and testing done at the CNIM office are more specialized. The discussion of these labs and test results are usually in-depth and lengthy. Therefore a follow-up appointment is always scheduled 2-4 weeks after the initial visit. If an office visit is not possible, a telephone appointment may be scheduled, which will be billed in a manner similar to a follow-up visit – according to complexity and time spent. Based on the complexity of presentation, we may often recommend close monitoring within the first 3-6 months of treatment in order to tailor the program as we progress towards wellness.

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Our practice is committed to providing the best treatment for patients. All appointments are considered confirmed at the time they are made. I will receive one courtesy call as a reminder of the appointment. **Because a substantial amount of time has been set-aside for me, I will be charged a \$175.00 fee for a missed new appointment and \$75.00 for follow-up appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.**

PATIENT ACKNOWLEDGEMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. I have read, understood and agree to the foregoing. I understand that I have the right to review this consent with a lawyer if I choose before accepting any medical services from The Center for Natural & Integrative Medicine. I have executed this consent freely and willingly understand its provisions. I recognize that CNIM will rely upon my signing of this document in accepting me as a patient. I acknowledge receipt of a copy of this consent if I have requested it.

I do hereby acknowledge that by signing this statement of understanding that I acknowledge and understand that some, and perhaps all, of the medical, preventative, nutritional, and diagnostic services provided at the Center for Natural & Integrative Medicine on or after the date of my signing this statement may be innovative, non-traditional or unconventional. (Definition: services that are not necessarily recognized by traditional medicine, some physicians, some 3rd party purveyors of the AMA, as acceptable testing/evaluation techniques and/or medical and nutritional recommendations or therapies).* I also understand that these unconventional services may be viewed by 3rd party insurance purveyors as non-covered services, in that they might be considered unreasonable or unnecessary under any medical insurance program. I also realize that my insurance coverage may not pay for such uncovered services and that I will be personally responsible for payment to The Center for Natural & Integrative Medicine. I understand that I will pay all costs including reasonable attorney fees, should that become necessary. I understand that all outstanding balances bear interest at the maximum rate allowed by law.

I understand that my signature is consent for any and all treatments offered and given to me or my minor child at CNIM and that I will not be required to sign individual consent forms for any treatments received at The Center for Natural & Integrative Medicine.

Signature of Patient or Responsible Party: _____

Patient Name: _____

Date: _____

Witness: _____

() **Initials**



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FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICES RENDERED

I have read, understand and agree to the following:

Please initial in each space

- () 1. Acknowledgement of the Center's office policies
- () 2. HIPAA Rules and Regulations
- () 3. Consent for Treatment, Financial Policy Authorization & Acknowledgements
- () 4. Because a substantial amount of time has been set aside for me, I will be charged a \$175.00 fee for a missed new appointment and \$75.00 for missed follow up appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.
- () 5. I understand that I am providing the center with my credit card information below that the center will keep on file in order to secure my appointment time. I also agree that the center has my authorization to charge my card in the event that I do not give them adequate notice to cancel or reschedule my appointment as per office policy. I understand that my credit card information will only be used as stated above.

Name on Credit Card: _____ Account Number: _____

Card Code: _____ Expiration Date: _____

Signature of Patient or Responsible party: _____ Date: _____

Witness: _____ Date: _____



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RELEASE OF CONFIDENTIAL INFORMATION

This disclosure pertains to HIPAA – The Health Insurance Portability and Accountability Act of 1996, also known as Kennedy-Kassebaum Act. HIPAA calls for, among other things, security standards protecting the confidentiality and integrity of “individually identifiable health information,” past, present and future. Your medical records will be kept confidential and only you the patient will have access to them, except in certain circumstances, for example for billing purposes, your insurance company may request your records in order to clear a claim. When you signed with your insurance company you already signed for the release of relevant records if necessary. Also, when you need authorization from your insurance company to see a specialist, your insurance company may request a copy of your records. In order to continue your care through a specialist, we may fax or mail or give verbal knowledge of your medical history to the specialist.

_____ This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003,
(Initials) we may only release medical information to the following:

- 1.) Healthcare providers involved in your care
- 2.) Insurance companies to secure payment
- 3.) Laboratories involved in your care
- 4.) Attorneys with your permission

By HIPAA standards, we are not allowed to discuss your medical problems with your spouse, significant other, or adult children. Please indicate if you would like us to speak with your spouse/significant other, or adult child if and when the need arises. Note: if you decide to revoke your permission at any time, we will need a written revocation.

YES, you have my permission to discuss any medical matters pertaining to my health with:

_____ (name of person, please print) _____ relationship
 _____ (name of person, please print) _____ relationship
 _____ (name of person, please print) _____ relationship
 _____ (name of person, please print) _____ relationship

Signature: _____ Date: _____

By HIPAA standards, we are not allowed to leave results of your lab tests, x-rays, diagnostics, medications, etc., related to your specific health condition on your voicemail, answering machine, fax, etc. However, if you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to allow us to leave your information on your messaging systems. Please choose one of the options below. Note: if you would like to revoke your option at any time, we will need your written notification.

_____ Appointment reminders and any information regarding your treatment may be
(Initials) called to (check below):

_____ My home or answering machine Phone # _____
 _____ My office or voice mail Phone# _____
 _____ Other _____

_____ A copy of “Notice of Privacy Practices” is available for your review.
(Initials)

_____ Print Patient Name

_____ Patient Signature

_____ Date



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6651 Vineland Rd., Suite 150, Orlando, FL 32819
Phone: (407) 355-9246 Fax: (407) 370-4774 www.drkalidas.com

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME (*Last, First, M.I.*) _____ Today's Date _____

DOB: ___/___/___ AGE: _____ SEX : Male Female

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____@_____.

BEST DAYTIME CONTACT: Home Cell Work

RACE: Caucasian African American Hispanic Asian Native American Indian Other _____

MARITAL STATUS: Single Married Separated Divorced Widowed Partnered

OCCUPATION: _____ Full-Time Part-Time Retired

REFERRED BY: _____ How did you hear about us? _____

MAIN REASON FOR VISIT:

1. _____ Duration: _____

2. _____ Duration: _____

ALLERGIES: *NO KNOWN ALLERGIES*

Chemicals Drugs (OTC or prescription) Herbs Inhalants Perfumes Pets Other _____

If yes, please list the allergen and the reaction experienced _____

Primary Care Physician: _____ Date of last physical exam: _____
Name: _____ MD/DO

Address: _____ City/State/Zip _____

Phone: _____ Fax: _____

Specialists (*if any*)

1.

2.

PAST MEDICAL HISTORY	
Are you currently working with a doctor of conventional medicine? <input type="checkbox"/> MD <input type="checkbox"/> DO	Name:
What kind of treatment have you received?	From:
Have you ever seen a naturopathic physician, chiropractor, acupuncturist, or other alternative health practitioner for your <i>current problem</i> ?	Name:
Have you ever seen a naturopathic physician, chiropractor, acupuncturist, or other alternative health practitioner for <i>any other problems</i> ?	Name:
What was the therapy and what were the results?	

MEDICAL DIAGNOSIS (Past and Present)

SURGERIES AND HOSPITALIZATIONS	
Reason/Diagnosis	Year

CURRENT MEDICATION			
Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS

Supplement/Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

MEDICAL AND FAMILY HISTORY - *Please select which applies to you*

	Self	Family		Self	Family		Self	Family
Alcohol Abuse			Gallbladder disease/stone			Migraines or Headaches		
Allergies			Glaucoma			Mumps		
Anemia			Gout			Obesity/Overweight		
Arthritis			Heart Attack or Angina			Osteopenia/Osteoporosis		
Asthma/COPD			Heart Failure (CHF)			Other Psychiatric Illness		
Cancer: (type)			Heart Valve Disorder			Palpitations		
Chicken Pox			High Blood Pressure			Polio		
Cholesterol			High Blood Sugar			Pulmonary Hypertension		
Colitis			HIV			Rheumatic Fever		
Constipation			Hyperthyroidism			Seizures		
Dementia			Hypothyroidism			Shortness of Breath		
Depression or Anxiety			Insomnia			Sleep Apnea		
Diabetes Mellitus (DM)			Irregular Heart Rhythm			Strep/Tonsillitis		
Dizziness			Kidney Disease or Stones			Stroke		
Diarrhea			Liver Disease			Thyroid Disorder		
Drug Abuse			Loss of Concentration			Tuberculosis		
Ear Infections			Loss of Consciousness			Ulcers		
Eating Disorder			Measles			Other		
Eczema/Skin Issues			Memory Loss					

LIFESTYLE HISTORY

Exercise None Occasionally Weekly Daily

Diet Are you currently following a diet regime? Yes No

If yes, are you on a physician prescribed medical diet? Yes No

Alcohol Do you drink alcohol? Yes No
If yes, what kind? _____ How often? _____

Tobacco Do you use tobacco? If so, how many packs per day? _____

Safety Do you wear: Seatbelt Helmet

Life What do you enjoy most in your life? _____

What are your main hobbies and interests? _____

Do you enjoy your work? Yes No

Do you take vacations? Yes No

Do you have a spiritual/religious practice? Yes No

Are you fulfilled? Yes No

PREVENTATIVE AND DIAGNOSTIC STUDIES

Basic Tests	Last date done	Results (+ or -)
Blood work, incl. cholesterol		
CA125 (Ovarian Cancer Screening)		
Cardiac test (EKG, echo, stress, etc.)		
Chest X- Ray		
Cholesterol Profile (Heart Disease)		
Colonoscopy		
Dermatologist/Skin cancer check		
Dexa Scan- Bone Density Test		
Hemoccult (Fecal Occult Blood Test)		
Mammogram		
MRI		
Ophthalmologist		
PAP Smear (Women)		
Physical		
Prostate Exam, PSA (Men)		
Sigmoidoscopy (Rectal Exam)		
Thyroid		
Ultra Sound/CT Scans		
Other:		

GENERAL QUESTIONS		
International Travel	Where and When	
Participate in Sports	What type?	
Recreational Drugs	What?	
Sexual Orientation	Heterosexual/Homosexual	
Sexual Abuse	Yes/No	
Physical Abuse	Yes/No	
Ever exposed to chemicals	What type?	How Long?

DIET							
Day 1	Day 2			Day 3			
Breakfast							
Lunch							
Snack							
Dinner							
Dessert/Snack							
Number of Meals Daily							
Protein Intake	Please circle: Red Meat White Meat Pork Game Vegetarian Protein, i.e. tofu or soy protein						
Fat Intake	Please circle: Olive oil coconut nut oils butter margarine fried foods other:						
Carbohydrate Intake	Please circle: Low Medium High Grains? Yes/No Root Vegetables Yes/No						
Vegetable Intake	Please circle: <10% 20-40% 41-60% >60						
Special Diet	Please circle: Low fat High Protein Low Carb HcG? Med. Pres? Other?						
Sweeteners	Please circle: Sweet N Low Splenda Nutrasweet (Equal) Real Sugar Honey Other						
Water	Please circle: Spring Distilled Tap Bottled How many 8 oz glasses daily?						
Soft Drinks	Please circle: Diet Regular How many per day?						
Coffee / Tea	Please circle: Decaf Regular How many a day? __ Tea type: Herbal Black Green Flavored						
Juices	How many per day?		What type?				
Cravings	Please circle: Sweet Salty Fatty Breads Any particular time?						
Cholesterol	Average value = HDL/LDL?						
Overall Diet	Please circle: Excellent Good Average Poor Give Brief Explanation below						
	Y	N	Notes		Y	N	Notes
Partner or spouse overweight?			By ___ lbs.	I cook my meals			
I eat out ___ times per week				I shop for food			
I eat fast foods ___ times/ week				I use a shopping list			
I eat when I am stressed				I plan my meals			
Brief Explanation of Diet or Additional Notes on above:							

WEIGHT LOSS/ GAIN	
Goal Weight:	In what time frame would you like to be at your goal weight?
Birth Weight:	Weight one year ago:
Highest Weight (non-pregnant) and when:	Lowest Adult Weight (after age 18):
If you wish to change your current weight, please describe the main reason:	
When did you begin losing or gaining excess weight? (Give reasons, if known):	
Previous Diets Followed:	Approximate Date & Results of weight loss / gain:

LIFESTYLE QUESTIONNAIRE		
QUESTION	1-10	COMMENTS
Current state of health (10 = best & 1 = worst)		Are you in good general health? Yes No
Emotional support (10 = most & 1 = least)		Are you in a relationship? Yes No
Quality of relationship with spouse or sig. other		Do you feel safe in your relationship Yes No
Exercise (10 = best & 1 = worst)		How often? What type?
Stress (10 = best & 1 = worst)		
Overall quality of sleep (10=best & 1= worst)		
Sleep through the night (10=best & 1= worst)		
How many times per night do you wake up?		Do you urinate on the times you get up?
Smoker (10=best & 1= worst)		2 nd hand smoke? Yes/No Quit? Yes/No When?
Alcohol intake (10=best & 1= worst)		Alcoholic? Yes No Quit? Yes/No
Age at which you felt the best		

ACTIVITY LEVEL		
<i>Please select which applies to you</i>		
<input type="checkbox"/> Inactive: no regular physical activity with a sit-down job		
<input type="checkbox"/> Light Activity: no organized physical activity during leisure time		
<input type="checkbox"/> Moderate Activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling		
<input type="checkbox"/> Heavy Activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling, or active sports at least three times per week		
<input type="checkbox"/> Vigorous Activity: participation in extensive physical exercise for at least 60 minutes per session \geq 4 times per week		
Do you perspire when not exercising?	Y	N
Does your perspiration have a strong odor?	Y	N
Other activities Yoga/Tai Chi/ Qi Gong	Y	N

Patient Name	Date
Because this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. Please circle yes or no if you now or in the past had any of the following conditions. If you answer to any question is yes, please explain on each line.	
GENERAL	
Fever or Chills	Y N
Fatigue	Y N
Do you get dizzy when you rise quickly from sitting or lying position	Y N
Change in Appetite	Y N
Night Sweats	Y N
Any type of Cancer	Y N
Do you suffer from colds, flues, sore throats, or yeast infections throughout the year	Y N
What do you normally feel like temperature-wise compared to others: warmer cooler average	
What are the temperatures of your hands and feet generally: warm cool average	
HEAD	
Headaches	Y N
Dizziness	Y N
Fainting Spells	Y N
Hair Changes	Y N
Seizures	Y N
Abnormal Lumps or Bumps	Y N
EYES	
Eye disease or eye injury	Y N
Wear glasses/Contact lenses	Y N
Blurred/Double vision	Y N
Glaucoma	Y N
Floaters	Y N
Loss of vision	Y N
Inability to focus	Y N
EARS-NOSE-MOUTH-THROAT-NECK	
Hearing loss/ difficulty	Y N
Snoring	Y N
Ringling in the ears	Y N
Sinus problems/Ear infections	Y N
Seasonal Allergies	Y N
Nose bleeds, congestion, ear pain	Y N
Mouth or teeth pain	Y N
Mouth sores that won't heal	Y N
Bleeding gums	Y N
Bad breath or bad taste	Y N
Hoarseness or Voice Changes	Y N
Sore or pain in throat	Y N
Swollen glands in neck	Y N

CARDIOVASCULAR

Heart Attack	Y	N
Pacemaker	Y	N
Chest pain or heavy pressure sensation	Y	N
Palpitations	Y	N
Stroke	Y	N
Swelling of feet, ankles or hands	Y	N
Frequent bruising	Y	N
Shortness of breath at rest or exercise	Y	N
Lightheadedness	Y	N
High Blood Pressure	Y	N
Rheumatic Fever as a child	Y	N
History of High Cholesterol/Triglycerides	Y	N

RESPIRATORY

Smoker If yes, # of packs per day:	Y	N
Frequent coughing	Y	N
Spitting up blood	Y	N
Asthma or wheezing	Y	N

GASTROINTESTINAL

Loss of appetite	Y	N
Nausea or vomiting	Y	N
Frequent diarrhea	Y	N
Stomach pain	Y	N
Bloating or fullness	Y	N
Excessive belching or flatulence	Y	N
Frequent Heartburn	Y	N
Acid Reflux	Y	N
Have you ever been told you have a hiatal hernia	Y	N
Difficulty swallowing	Y	N
Fatty Food Intolerance	Y	N
Ulcer Disease	Y	N
Milk Lactose Intolerance	Y	N
Hemorrhoids	Y	N
Colon Polyps	Y	N
Chronic Constipation	Y	N
Jaundice/Hepatitis/Cirrhosis	Y	N
Do you have hemorrhoids or fissures	Y	N
Do you ever experience rectal itching	Y	N
Change in bowel movement	Y	N
Painful bowel movements/constipation	Y	N
Is your stool: Formed / Loose / Hard / Mucus / Black / Red / Yellow / Pale / Tarry / Blood		
Number of bowel movements a week? a day?		
Do you see undigested food in stool?		
Do you have thin, long, narrow stools?		
Have you ever fasted? Juice or Water How long		
How did you feel while you were fasting?		

GENITOURINARY

Frequent urination				Y	N
Excessive thirst				Y	N
Lack of thirst				Y	N
Burning or painful urination				Y	N
Does your urine have strong odor				Y	N
Bloody or cloudy urine				Y	N
Change of force of strain when urinating				Y	N
Do you have difficulty starting or stopping urination				Y	N
Incontinence or dribbling				Y	N
Kidney stones in last 12 months				Y	N
Bladder Infection in last 12 months				Y	N
Do you awake to urinate in the middle of the night? If yes, # of times?				Y	N
Is your urine: Dark yellow / Bright yellow / Yellow / Light yellow / Clear / Cloudy					
Changes in sexual functioning				Y	N
Sexually Transmitted Infections such as HIV/AIDS, Gonorrhea, Herpes, Syphilis				Y	N
Male Patients					
Any problems with impotency (getting or maintaining an erection)				Y	N
Any sores on your penis				Y	N
Any abnormal discharge from your penis				Y	N
Testicular pain/Swelling				Y	N
Painful Ejaculation				Y	N
Any prostate problems			Date of last prostate exam:	Y	N
Are you sexually active? If so, are you satisfied?				Y	N
Do you use contraception? If so, what type:				Y	N
Breast tenderness or enlargement				Y	N
<i>Please select all that apply</i>	Y	N		Y	N
Premature ejaculations	Y	N	Loss of masculinity	Y	N
Loss of orgasm	Y	N	Performance anxiety	Y	N
Loss of libido/orgasm	Y	N	Loss of confidence	Y	N
Loss of aggressiveness	Y	N	Other	Y	N
Female Patients					
Any breast lumps or concerns				Y	N
Vaginal discharge				Y	N
Are you currently sexually active? If so, are you satisfied?				Y	N
Do you use contraception? If so, what type:				Y	N
Hysterectomy			Total? Y N Partial? Y N	Y	N
Are you pregnant or breast feeding?				Y	N
Are your cycles regular? Period begins every _____ days and last _____ days				Y	N
Age at first onset of period:			Date of last menstrual period:		
What color is the blood (circle):	light red	dark red	medium	with clots	
Miscarriages:	Abortions:	Living Children:	vaginal	C-section	
Partner preference: Male	Female	Both			
Premenstrual- <i>Please select all that apply</i>	Y	N	<i>Please select all that apply</i>	Y	N
Heavy periods	Y	N	Food cravings	Y	N
Painful periods	Y	N	Cramps	Y	N
Water retention	Y	N	Hot flashes	Y	N
Breast tenderness	Y	N	Loss of orgasm	Y	N
Vaginal dryness	Y	N	Loss of libido	Y	N
Mood swings	Y	N	Irritability	Y	N

MUSCULOSKELETAL/BONE/JOINTS/EXTREMETIES		
Joint pain, stiffness, swelling	Y	N
Weakness of muscles or joints	Y	N
Muscle pain or cramps	Y	N
Back pain? Upper Lower	Y	N
Arthritis – Osteo or Rheumatoid	Y	N
Gout	Y	N
Swollen, painful leg veins	Y	N
Swelling of hands, feet or legs	Y	N
Cold extremities	Y	N
Difficulty walking	Y	N
Leg pain or cramping when walking short distances	Y	N
Loss of muscle mass	Y	N
Involuntary painless muscle movement	Y	N
Difficulty rising from a chair	Y	N
Difficulty climbing stairs	Y	N
Do you see a Chiropractor? If yes, how often _____	Y	N
Any regular body treatments/ manipulation/ massage? If yes, how often _____	Y	N
SKIN/ HAIR		
Change in hair or nails	Y	N
Do you have dry or oily hair? Please specify.	Y	N
Do you have hair or pubic hair loss? Please specify.	Y	N
Loss of collagen/ firmness	Y	N
Cellulite	Y	N
Varicose veins	Y	N
Shingles	Y	N
Skin or Toenail Fungus	Y	N
Psoriasis	Y	N
Dry skin	Y	N
Rash or itching	Y	N
Change in skin color	Y	N
Do you scar easily	Y	N
Skin lesions/moles	Y	N
Skin Cancer – Melanoma/Basal Cell/Squamous Cell	Y	N
Do you have a history of skin cancer	Y	N
Do you wear sunscreen? If yes, brand and when do you apply	Y	N
After sun exposure do you: Always burn Sometimes burn Rarely burn Never burn Tan		
NEUROLOGICAL		
Frequent or recurring headaches	Y	N
Light headed or dizziness	Y	N
Fainting Spells	Y	N
Convulsions or seizures	Y	N
Numbness or tingling sensations of arms, legs or face	Y	N
Tremors	Y	N
Paralysis	Y	N
Stroke	Y	N
Loss of balance	Y	N
Loss of strength	Y	N
Falls	Y	N

MENTAL STATUS		
Memory loss or confusion	Y	N
Nervousness	Y	N
Depression	Y	N
Difficulty sleeping	Y	N
Anxiety	Y	N
Panic attacks	Y	N
Self mutilation, cutting/slashing oneself	Y	N
Suicidal thoughts/ideation	Y	N
Nervous Breakdown	Y	N
Psychiatric or psychological counseling	Y	N
Have you ever been sexually assaulted?	Y	N
Is your home environment safe?	Y	N
Any verbal abuse toward you?	Y	N
Any spousal abuse?	Y	N
ENDOCRINE		
Glandular or hormone problems	Y	N
Thyroid disease	Y	N
Excessive thirst or urination	Y	N
Heat or cold intolerance	Y	N
Dry Skin	Y	N
Change in hat or glove size	Y	N
Excessive hair growth	Y	N
Darkening of the skin	Y	N
Diabetes? Type I Type II	Y	N
HEMATOLOGIC/LYMPHATIC		
Slow to heal after cuts	Y	N
Easily bruise or bleed	Y	N
Anemia	Y	N
Painful leg veins	Y	N
Past transfusions	Y	N
Enlarged or swollen lymph glands	Y	N
Excessive bleeding	Y	N
EMOTIONAL		
Do you see a counselor or psychiatrist	Y	N
Depression	Y	N
Anxiety	Y	N
Stress	Y	N
Obsessive Compulsive disorder	Y	N
Your behavior style (check only one):		
<input type="checkbox"/> Always calm & easygoing	<input type="checkbox"/> Sometimes calm with frequent impatience	
<input type="checkbox"/> Never calm; overwhelming ambition	<input type="checkbox"/> Usually calm & easygoing	
<input type="checkbox"/> Seldom calm & persistently driving for advancement	<input type="checkbox"/> Hard-driving and can never relax	

OCCUPATIONAL/ HOUSEHOLD

How long have you lived at your present address?		Do you live in the city?	
What places (city / state / country) have you lived previously?			
Please describe location, if old or new construction, damp or moldy conditions, rain damage, exposure to formaldehyde, new carpets, new mattress, mobile home etc.			
Do you have specialized air filtration at home?	What type?	Y	N
Do the windows open?		Y	N
Do you work in an office building?	What type?	Y	N
Do you have specialized air filtration at your work place?		Y	N
Do you work in the presence of toxic fumes or chemicals?		Y	N
Do any of your hobbies involve toxic materials?		Y	N
Are you currently exposed to second hand smoke?		Y	N
Do you eat canned food?	Frequency:		
What deodorant do you use?			
What type of water do you use?	<i>Bottled</i>	<i>Filtered</i>	<i>Tap Water</i> <i>Alkaline</i>
<i>Spring</i>			
Is there anything else you would like to comment on?			

Stressful Event History	
Please list the most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (insert #): _____	
1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:



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OFFICE POLICIES & PROCEDURES FOR PATIENTS

NEW PATIENT APPOINTMENTS:

- Please allow approximately 2 hours for this appointment. During your first visit we will be conducting a detailed consultation and evaluation of your medical concerns and a physical examination.
- Because of the length of time we have reserved for you, please call the office at least 48 hours in advance to reschedule or cancel an appointment. This would enable another patient to be seen.
- We do charge a missed appointment fee of \$175.00 and require credit card information in order to secure your appointment time.
- Following your first appointment we offer comprehensive new patient seminars to accelerate you on your path to wellness. These orientation seminars have invaluable information on nutrition, supplementation, diet and exercise that may not be covered in your initial appointment. We will fully explain all of our services including office policies, procedures and protocols. In order to facilitate the highest level of patient care and success, we feel that it is necessary for all new patients to attend one of these seminars.
- Since we are non-participating providers with all insurance companies, we require all of our patients to **maintain a relationship with a primary care physician.**

FOLLOW-UP APPOINTMENTS:

- Please be sure to arrive 15 minutes before your scheduled appointment. This will enable us to sign you in, perform vitals and ensure you get your allotted time with the doctors.
- In order to help you on your path to wellness, we recommend every new patient to schedule a Nutrition Consult within a few days of your initial visit. This is an invaluable visit which will help you make positive lifestyle changes and understand how your supplement regimen and food choices have a great impact on your health and well-being. Making these changes can be difficult and challenging at first and this appointment will help you achieve your goals.
- Follow up appointments are scheduled 3-4 weeks after the first appointment. This is the time to discuss test results and to discuss your treatment plan and make any changes if necessary. The 3 visit process (i.e. the first initial visit, the nutritional consult, and the follow up visit) is the best way to get you on track with your protocol and to making a real difference in your health.
- Because of the complexity of most cases, treatment protocols may need frequent adjustments in the beginning. Therefore we may require monthly office visits in the first 4-6 months or more often as deemed necessary by your practitioner in order to facilitate wellness.
- No results will be discussed over the phone. An office appointment or a phone appointment will need to be a scheduled.

MISSED APPOINTMENTS:

- It is understandable if life circumstances cause you to reschedule your appointment.
- Please cancel or reschedule your appointment 48 hours prior to your scheduled time. We do not double book. As your appointment time is set aside specifically to focus on your individual needs, it impacts our office if cancellations occur in less than 48 hours.
- One missed appointment is understandable in emergency situations, but more than one missed appointment will assume a \$75.00 missed appointment fee for follow up appointments.
- With repeatedly missed appointments, it may be difficult for us to continue care. () **Initials**

LATE ARRIVALS:

- If you arrive more than 10 minutes after your scheduled appointment time, it may be necessary to reschedule. However, the missed appointment fee will still apply.
- If you choose to keep your appointment, your visit time will be shortened accordingly.
- Please call us if you are running late.

TELEPHONE APPOINTMENTS:

- As a courtesy to those who are not able to come into the center we offer phone appointments that are billed at the same rate as an office visit.

COMMUNICATION AND PHONE POLICIES:

- Because of HIPPA regulations we communicate only through our office telephones. We cannot and **do not communicate via e-mail**. Please be sure to call our office with any questions.
- It is inappropriate to call our doctors on their cell phones directly at any time.
- During office hours, please call the office and leave a message. Someone from the office will get back to you.
- On week-ends and after hours, please call the office and use the option to be transferred to one of our doctors.
- Phone calls pertaining directly to your recent visit which require 1-2 minutes will be answered. Please understand that often the schedule is full and non-emergency calls will be returned within 24 hours or the next business day.
- More complex discussions will require a follow up appointment. If needed, a phone appointment will be scheduled and will be billed at the same rate as an office visit.

PRESCRIPTION REFILLS:

- At the time of your office visit, the practitioners will be giving you prescriptions with the appropriate number of refills to last you till your next follow up visit.
- Please make sure you have all the prescriptions you need before you leave the office.
- Prescription medications such as medications for blood pressure, diabetes, pain, and thyroid conditions need to be monitored closely. An office visit is required at a minimum every 3 months or as indicated by your physician to evaluate your care, order labs and approve additional refills.
- Failure to make and keep scheduled appointments will make it difficult to continue your care and will result in having refills denied.
- Absolutely, no prescriptions for antibiotics will be called into the pharmacy. You will have to be seen in the office by one of our doctors.
- Refills of prescriptive medications require at least a 48 hour notification. Please ask your pharmacy to fax our office a refill request at (407) 370-4774.
- I.V. prescriptions for both Nutrition and Chelation have a 3 month expiration after which an office visit is required for evaluation and blood work.
- If you have not been seen in our office within 3 months, prescriptions will not be refilled without an office visit for both prescriptions and I.V. treatments.

FOR OUR IV PATIENTS:

- For our chelation and IV patients, our nursing staff prepares the infusion bags on the morning of your appointment.
- Please cancel 24 hours prior to your appointment to avoid incurring a charge of \$50.00 due to the wasted bag.
- We do not call to confirm these appointments. Please schedule your next IV when you check out. We have to be sure that we can accommodate you at the time you wish to come.

() Initials

LAB PROCEDURES AND RESULTS:

- It is imperative that all lab work that has been agreed upon to be performed by you and the practitioner be completed within the time frame discussed. This ensures that the results are available for discussion during your next scheduled appointment and eliminates the need to reschedule as it may become difficult to accommodate your schedule needs.
- Because of the wide variety of testing and companies we use, the receipt of them can vary from several days to several weeks. Rest assured, once completed results are received, we will confirm your next appointment that should already have been scheduled at your last visit. Therefore it is not necessary to call the office to ascertain the receipt of tests performed. We routinely do not call you when they arrive unless the practitioners need to speak to you immediately.
- Allow two full weeks for the results to arrive at our facility.
- In order to ensure the best understanding of your lab results and to answer all of your questions, a follow-up appointment is required. Results will not be discussed over the phone.
- Our staff is not allowed to discuss results over the phone.
- We ask that you wait until your appointment to request a copy of your labs to avoid any confusion about the results.
- Fasting blood work requires that you have nothing by mouth after 10:00 PM besides water the night before.
- (A small amount of water or coffee with no cream or sugar is allowed).
- Use of your prescription medications will not affect the test. Blood should be drawn by 8:00 AM to obtain the correct levels or as otherwise directed by the physician
- If using an outside lab, arrive at the lab no later than 7:30 AM to allow for registration. If labs are being done here, please make sure an appointment has been scheduled. Bring your lab order and any additional testing kits with you to the laboratory.

TEST KITS:

- There will be a 25% restocking fee for any unused test kits that are returned. Returns will not be credited back on a credit card.
- Test kits cannot be returned after 60 days of date of purchase. There will be a 25% restocking fee for any unused test kits that are returned. A credit will be issued to your account. Returns will not be credited back on a credit card.

NUTRITIONAL SUPPLEMENTS:

- Nutritional supplements can be refilled by calling our office prior to pick up, or can be shipped directly with a credit card payment.
- Please allow 3-5 business days from the time you order to the time you receive it.
- There is not a need for an office visit to refill nutritional supplements.
- In most cases you will need to continue on your current regimen until your next visit.
- Supplements cannot be returned after 30 days of purchase date.
- Only unopened supplements will be refunded at full price within 30 days of purchase.
- No refunds will be made in cash or back to your credit card. If a credit is necessary, it will be applied to your account to be used in the office towards other supplements or services.
- Supplements that are open and then stopped either by your physician or yourself for any reason cannot be returned.

AUTHORIZATIONS:

- Because we are non-participating providers, authorizations for prescription medications and specialized testing cannot be obtained through our office.
- This is the most important reason for maintaining a primary care relationship with a physician in your insurance network.

INSURANCE CLAIM MANAGEMENT:

- We are non-participating providers for all insurance companies including Medicare.
- We do not bill Medicare or any other insurance company.
- Because we have opted out of the Medicare program, Medicare does not allow reimbursement for any services rendered by our office.
- The only exception is certain specialized labs where the lab will bill Medicare directly.
- At the time of your visit, we will give you a receipt and an encounter form with appropriate codes which enables you to submit your claim to your insurance company directly. Please be sure to make additional copies for your records. Most insurance companies have a claim form on their website which you can download to attach to your receipt and encounter in order to seek reimbursement.
- Your insurance coverage is a contract between you and your insurance company. For this reason, we do not respond to requests or inquiries from insurance companies for office notes, lab results, and letters of medical necessity or claim appeals. Since we are non-participating providers with all insurance companies, our involvement generally results in denials and is therefore not beneficial in obtaining approval.

MEDICAL RECORDS RELEASE

- A signed release is required before any information in your chart can be mailed/faxed to you, another physician or third party.
- The cost of handling copying of your medical records for yourself will be a minimum of \$10.
- Records are sent to your physician at no charge.
- Copies of your labs are given to you at your follow up visit. Additional copies will be billed at \$1.00 per page.
- If you are having records sent to our office, please have them mailed to our office. Faxed copies are difficult to read.

PAYMENT POLICY

- Please be sure to check out with our financial coordinator after each visit.
- Payments are due in full at the times of service.
- Any and all open balances will be collected prior to your next appointment; otherwise unfortunately we will not be able to continue your medical care.

ADDITIONAL PAPERWORK:

Any additional paperwork that you may require completion of by the Doctor or by a member of our staff, will be billed \$25.00 for every 15 minutes spent on it.

I have read and understand the office policies

Patient Signature: _____ Date: _____

Patient Name: _____

Office Personnel Signature: _____