Personal Information

Name (Last, First):

Home Phone: | Alternate Phone:

Age: Birth Date: | Sex:

Social Security Number:

Physical Address:

Mailing Address:

E-mail:

Employer:

Occupation:

Business Address:

Diagnosis and brief description of illness:

Allergies:

Emergency Contact:

Phone: | Relation:

Spouse Information

Name (Last, First):

Employer: | Phone:

Occupation:

Business Address:

Where are you staying while you are here?

Phone: | Room Number:

How did you hear about us?

RENO INTEGRATIVE MEDICAL CENTER

6110 Plumas Street Suite B, Reno, NV 89519
(775) 829-1009

Please fill this out **only** if you want your medical information shared with another person (spouse, parent/guardian, or relative). We will **not** share any health information without your consent.

I, ____, give Reno Integrative Medical Center permission to share my protected health information with:

Name: ____
Relation: ____

Name: ____
Relation: ____

Name: ____
Relation: ____

Name: ____
Relation: ____

Patient Signature: ____Date:____________

This authorization is in effect for one year from the above date, unless written notification is received from the patient.

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AGREEMENT CONCERNING SCOPE OF PRACTICE

To our new patients:

The purpose of this letter and agreement is to clarify our position as to the scope and the extent of the services which will be rendered to you from this office.

You have come to this office with the desire to improve your general health and the condition of your immune system, through special nutritional support, and through the use of certain immune-enhancing substances. A degenerative disease, such as cancer, may or may not be associated with a nutritional deficiency or a failure of the immune system.

It is important that you understand that our primary concern in your case will be the improvement of your over-all condition and your ability to resist or combat disease through improving your nutrition and enhancing your immune system. We will not be specifically treating cancer or any other degenerative disease, which you may have. **We will not be your primary physician** unless otherwise specifically agreed. This means that we make no claims or assurances regarding any diagnosis, treatment, alleviation or cure of any specific disease process. It will be your obligation to place yourself under the care of a general practitioner or appropriate specialist in your area for the care of any specific disease entity.

In our nutritional, non-toxic management of a patient, we regularly recommend a variety of vitamins, minerals, homeopathic remedies, enzymes and immune system builders or enhancers. Our purpose in doing so will not be to treat any specific disease which you have, or believe that you have, whether known or unknown to you or to us. Instead, our purpose will be solely the improvement of your nutritional status, your general over-all health, and the condition of your immune system.

We anticipate, but in no way guarantee, and improvement in your feeling of well-being, weight gain where indicated, reduction of pain and decrease in the need for pain-relieving medication when this is indicated. However, you should understand that you may or may not enjoy any or all of these benefits, because they do not occur predictably in every patient, and in some patients they do not occur at all. It should also be understood that many physicians practicing traditional medicine consider this type of treatment to be of no value, that they may even refer to it as "quackery," and that you may be discouraged by such traditional physicians from seeking such alternative or non traditional care, ostensibly because it may cause you to lose valuable time in obtaining "proven" treatments such as surgery, radiation and chemotherapy. Our patients are encouraged to use other modalities such as traditional chemotherapy, radiation and surgery if they wish to. And they will be encouraged and supported by every member of our medical staff.

Electro-diagnostic instruments may be utilized to pinpoint various weaknesses, toxins, or underlying illnesses in the body, which impair or slow the healing process. Patients suffering from degenerative disease, including cancer, often harbor some underlying conditions which need to be eliminated from the body through the use of homeopathic preparations or other means of detoxification.

As implied previously in this letter/agreement, our views regarding nutrition and immune system enhancement are not necessarily shared by such conventional organizations as the American Medical Association, the U.S. Food and Drug Administration, the American Cancer Society, the printed and electronic media, the various state medical boards, and the National Cancer Institute, to name a few.

This letter/agreement and the methods employed by this office are applicable to, and in accordance with, the laws of the state of Nevada only, and not necessarily the laws of other states. This office, including all physicians, nurses, and other personnel, disclaims responsibility for the consequences from the use of any of its methodologies carried out in any state other than Nevada, or any physician, nurse, or health practitioner outside this office.

When you sign this agreement you will be signifying that you wish for us to prescribe or administer to you such nutrients, minerals, vitamins, immune system enhancers, biological, homeopathic compounds, hormones, drugs, devices or procedures which, in our opinion, appear to be indicated in your case, irrespective of the opinions of the aforementioned organizations or authorities.

The terms of this letter/agreement apply to all treatment and care given by this office, including nurse practitioners, nurses, laboratory technicians, and other personnel employed by this office. This agreement shall be interpreted in accordance with the laws of the State of Nevada, and any dispute will be subject to the rules of mandatory arbitration with an arbitrator who is familiar with alternative medicine.

Yours for optimum health,
ROBERT A. ESLINGER, D.O., H.M.D.

I, ______________________________________, have read and understand the terms and conditions indicated in this letter/agreement, and hereby place myself under the care of Dr. Robert Eslinger, and his staff for nutritional and immune support only, realizing that he/they will not be my primary care facility for any disease entity of specific condition and unless otherwise specifically agreed.

Patient Name: ____

Patient Signature: ______________________________Date:__________

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Patient Name: ______________________________ Date: ________________

Payment Agreement

I agree to provide payment in full to Reno Integrative Medical Center for all medical services and/or supplies rendered to me during today's visit and future visits.

Patient's Signature: ________________________________

Insurance Billing

_________ Not applicable. I have no medical insurance coverage.

Patient's Signature: _________________________________

_________I have medical insurance coverage.

I hereby acknowledge, by this statement that I have been fully informed that Robert Eslinger D.O., H.M.D., does not accept assignment of insurance and that it is my responsibility to bill my insurance company, using the attending physician's statement (referred to as a superbill) which his office provides.

I have been informed and fully understand that the above doctors **do not** participate in any aspect of the Medicare program and therefore, does not complete Medicare claim forms.

Patient Signature___________________________________

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PATIENT STATEMENT OF INTENT

By my signature below I acknowledge the following:

1. I wish to consult Dr. Eslinger, solely for reasons concerning my own personal health.
2. I am not associated with and do not represent any enforcement, regulatory, or investigative agency of either the municipal, state, or federal government, or any other investigative agency which monitors any aspect of health care or the practice of medicine.
3. I am not consulting the above health care professionals in order to report to or otherwise provide any information to any enforcement, regulatory, or federal government, or any other investigative agency.

By my signature below I certify that I have read the above statements and that they are true.

Signature:____ Date:__________

Witness:____ Date:__________

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CONSENT OF DISCLOSURE AND REQUEST FOR RESTRICTIONS ON DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Reno Integrative Medical Center to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the top of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it.

You have a right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling our office at 775-829-1009.

This authorization provides that:

- I may revoke this authorization at any time provided that the revocation is in writing to the Privacy Officer at this practice.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form

Signature: ____**Date:**____________

Witness: ____ **Date:** ____________

Request of restriction of the uses and disclosures of the following protected health information contained in my medical record: ________________________________

____

____

I understand that this practice is not required to agree to this restriction. If agreeing to the restriction, the practice may not use or disclose Protected Health Information except if the restricted health information is needed to provide me with emergency treatment.

Signature: ___________________________________ **Date:**_______________

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IMPORTANT MEDICAL LIABILITY INFORMATION

This is to inform you that our practitioners do not have medical malpractice liability insurance. We realize that despite the best of care and intentions errors may occur, and medical errors may lead to harm. As part of our liability risk-management policy, all patients and/or legal guardians will be asked to sign a copy of this form attesting to the fact that they are aware that all of our practitioners do not have medical liability-malpractice insurance. In addition, we now require that all patients formally agree to utilize an alternative dispute resolution, consisting of either formal mediation and/or formal binding arbitration instead of litigation for any and all legal disputes involving any professional actions of any and all of our practitioners and/or staff.

Either of these alternative dispute resolution methods are quicker and more cost effective in reaching an equitable solution for all parties involved. Due to extreme overcrowding of the court system and very high costs of litigation these alternative dispute resolution methods are being increasingly employed as an alternative to the more costly and slower method of litigation by the legal system. By signing this form you are formally agreeing to abide by the terms described in this document.*

Print Name:____

Sign Name: ______________________________Date:__________

Witness:________________________________Date:__________

*Our practitioners understand that some may feel uncomfortable in signing this form. If that is the case, please do NOT sign. Although our practitioners and staff will not be able to provide any professional services in this situation, we will be happy to provide any medical records in our possession to you so you can select the health care provider of your choice for your continued care.

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We request that each of our patients enter into the following agreement which informs the patient of the type of treatment we furnish and provides for arbitration of medical malpractice disputes.

Please read the following agreement carefully and be sure that you consent to each of the provisions before you choose to sign. Ask for an explanation of any term or provision which you do not fully understand.

Treatment and Arbitration Agreement:

In order to allow, Dr. Eslinger, to render medical services to me (us), which would not otherwise be rendered, I, (we) hereby enter into the following agreement: I (we) understand that the above named physician may prescribe or recommend orthomolecular medicine, homeopathic medicine, nutritional supplements, vitamins, herbs, and physical therapy, in addition to drugs, surgery, and psychotherapy. I (we) understand that if I (we) do not wish such treatment, I am (we are) free to select another physician.

I (we) hereby agree that any and all medical malpractice disputes, that is, any dispute as to whether any medical services rendered by the above named, their staff, or assistants, were unauthorized or unnecessary or grossly negligent, or improperly, or otherwise in competently incompletely rendered, will be determined by submission to arbitration as provided by Nevada Law, and not by lawsuit or resort to court process, except as Nevada Law provides for review or arbitration proceedings. **All parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury or before the court, and are instead accepting the use of arbitration.**

I (we) further agree that this agreement is and shall be binding upon my (our) legal representatives, heirs, defendants, next of kin, legatees, and distributes. This agreement applies to all past, present and future services on behalf of the above named, their staff or assistants, and may not be altered or amended except by written agreement.

I (we) have read and understood this agreement and it is agreed to this _____day of _____________ 20__.

Signature of Patient: _________________________________Date:_________

Witness:____Date:__________

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: ______________________________

Date of Birth: ______________________________

I have received this practice's Notice of Privacy Practices. The Notice provides me with details of the uses and disclosures of my protected health information. I understand that this practice reserves the right to change the items of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, the practice will provide me a revised Notice of Privacy Practices upon request.

Signature: ______________________________

Date: ______________________________

Relationship to patient (if signed by a personal representative of patient.):______________________________

HEALTH HISTORY

Confidential

Patient Name____ Today's Date ______________

Age_______ Birthdate ______________ Date of last physical examination ______________________

What is your reason for visit? ____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period __________

Date of last Pap Smear __________

Have you had a mammogram? __________

Are you pregnant? __________

Number of children __________

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

____

____

____

____

____

Pharmacy Name ______________ Phone ______________

ALLERGIES To medications or substances

____

____

____

____

____

(Vers.M2SSS04)

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All information is strictly confidential

FAMILY HISTORY

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates.____________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS

Check (✓) which substances you use and describe how much you use.

✓	Substance	Description
	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

✓	Exposure
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ ________________
Signature of Patient, Parent, Guardian or Personal Representative — Date

______________________________ ________________
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

______________________________ ________________
Reviewed By — Date

NOTICE OF PRIVACY PRACTICES
WE CARE ABOUT YOUR PRIVACY

1) **Our Pledge Regarding Medical Information:** We here at Reno Integrative Medical Center are vigilant to protect patient confidentiality. No information regarding our patients is shared or distributed with any other person or organization without the patient's signed authorization. Any questions or comments may be directed to our Privacy Compliance Officer.

2) **Our Legal Duty:**
   - **A) Law Requires Us to:**
     - **1)** Keep your medical information private.
     - **2)** Give you this legal notice describing our legal duties, privacy practices, and your rights regarding your medical information.
     - **3)** Follow the terms of the notice that is now in effect.
   - **B) 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.
   - **C) Notice to Change the Privacy Practices:** Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

3) **Use and Disclosure of Your Medical Information:** This is how we 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.
   - **A) 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 other health care providers to assist them in treating you.
   - **B) To Aid in Your Insurance Company reimbursing you for the treatments you have received here.**
   - **C) Funeral Director, Coroner, and Medical Examiner:** We may share the medical information about a patient who has died with a Funeral Director, Coroner or Medical Examiner to help them carry out their duties.
   - **D) Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

E) **Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

F) **Victims or Abuse, Neglect, or Domestic Violence:** We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

G) **Workers Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

H) **Health Oversight Activities:** We may disclose medical information to an agency providing health oversight or oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

I) **Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4) Your Individual Rights

A) You Have a Right to:

1) Look at or get copies of your medical information. You must make your request in writing. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2) Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3) Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency.)
4) Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5) Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation.
6) You have the right to obtain a paper copy by making a request in writing to our Privacy Compliance Officer.

Questions and Complaints: If you have any questions about this notice, or if you believe your rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

These privacy practices are in effect as of January 1, 2003 and will remain in effect until further notice.

Please be aware that we utilize an "open treatment" and "check out" environment. It is possible that an incidental disclosure of your personal health information may occur.