B12 Injections Informed Consent

Patientf name_____ Date_____

Vitamin B-12 helps maintain good health and has been shown to be beneficial in helping to: Reduce stress, fatigue, improve memory and cardiovascular health, and maintain a a good body weight. It can also assist the body in converting proteins, fats and carbohydrates into energy and is necessary for healthy skin and eyes. B12 Injections are better absorbed by the body since they go directly into the blood stream.

B12 Injections are associated with some common side effects which can include but are not limited to:
1. Risks: I understand there is risk of mild diarrhea, upset stomach, nausea, a feeling of pain and a warm sensation at the site of the injection, a feeling, or a sense, of being swollen over the entire body, headache and joint pain.

2. If any of these side effects become severe or troublesome, I will contact Dr. Shaw, my primary care physician or an urgent or emergency service immediately.

3. I understand that although rare Vitamin B12 injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking vitamin B12 injections should be aware of the possibility. Uncommon side effects are much more serious than the common side effects of B12 injections, and such side effects should be reported to a physician to be evaluated for seriousness. Uncommon and dangerous side effects include:

- rapid heartbeat
- chest pain
- flushed face
- muscle cramps and weakness
- difficulty breathing and swallowing
- dizziness
- confusion
- rapid weight gain
- tight feelings in the chest
- hives, skin rashes
- shortness of breath when there is no physical exertion and unusual wheezing and coughing.

4. Before starting vitamin B12 injections I will make sure to tell Dr. Shaw if I am pregnant, lactating or have any of the following conditions.

- Leber’s Disease
- Kidney disease
- Liver disease
- An infection
- Iron deficiency
- Folic acid deficiency
- Receiving any treatment that has an effect on bone marrow
- Taking any medication that has an effect on bone marrow

• An allergy to cobalt or any other medication, vitamin, dye, food or preservative.

5. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non prescription medications may result in side effects when they interact with the B12 Injection.

6. Treatments: Can be once a month, once a week, twice a week and will be determined by Dr. Shaw.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent B12 Injections with the above understood. I hereby release the doctor, the person injecting the B12 and the facility from liability associated with this procedure.

Patient Signature**_____** ***Date:*****_____**

INTEGRATIVE MEDICAL ASSOCIATES
5050 El Camino Real, Suite #110
Los Altos, CA 94022
(650) 964-6700

Welcome! We strive to provide individualized medical evaluation and treatment in an environment of warmth and caring which is conducive to wellness and a high quality of life. Our philosophy of practice is oriented toward a non-drug approach to medical care, utilizing natural and nutritional therapies and preventive care.

Our work is dedicated to enhancing your wellness through rediscovering and strengthening your own innate healing ability. Integrative Medical Associates seeks to form a working partnership with you, the goal of which is your good health. We invite you to participate as fully as you wish in your own care. Your involvement in your health and healing is vital to our success. We believe our job is to provide the best information and most effective medical care possible.

OFFICE POLICY

First appointments are complex and an hour or more is set aside specifically for you, therefore we require a deposit at time of scheduling. Our office policy requests that for all subsequent visits payment be made, in full, at the time of service. We accept personal checks (If paying by check, we require a credit card on file; this credit card will be utilized in the case of a returned check and accompanied by a returned check fee of $25) Visa, Discover or MasterCard and American Express. We are a non-insurance facility. We are not participants, nor are we providers, in any insurance plans. We cannot verify if your insurance will reimburse for any of our fees. We politely encourage you to contact your individual carrier for specific details regarding your policy.

We do not provide insurance billing. After each office visit, you will be provided a form or 'superbill' statement containing all necessary information to submit directly to your insurance carrier. The 'superbill' can be attached to your insurance form as the "Attending Physician's Statement" portion of the claim form. Should you require any correspondence i.e. letters written to providers, a fee will be charged based on the complexity.

IMA is not a Medicare provider. Medicare patients cannot bill Medicare for their services in the office; however we do offer a 20% discount to all new and established office visits for Medicare patients. *We regret that we cannot treat any patients with Medicare/MediCal insurance at this office.*

In the signing of consent for an underage child, the parent or guardian is vouching for both parents/guardians in requesting treatment at this office.

The physicians in this office are NOT practicing in any type of legally established partnership or corporation. Each physician has their own private practice but shares office space.

FEES

Our fees are structured around time expenditure and services provided:

Initial Consultation- including complete History & Physical (60 min.)	*$495*
Follow-up visit -test Result evaluation & therapeutic recommendations (60 min.)	*$430*
Office Visit- for check-ups and therapeutic reevaluation (30 min.)	*$260*

We welcome your questions and calls about your health. However, at our discretion, a fee will be charged for telephone calls over 5 minutes. Please see the following list for regular phone consult fees:

Brief call (5-10 minutes)	*$60*
Intermediate (11-20 Minutes)	*$160*
Extended (21-30 Minutes)	*$260*

* The above fees reflect office visit charges only. Laboratory fees, nutritional supplements and other services are additional. In addition, as previously indicated we are a *non-insurance facility*. We cannot and do not guarantee any test or procedure will be paid by your insurance. Again, we politely encourage you to contact your individual carrier for specific details regarding your policy.

OFFICE ROUTINE & HOURS

We would ask that you be prepared to make the maximum use of your time with the doctor, by writing down any questions, concerns and other subjects of discussion prior to your visit. It would also suggest you keep a record of what supplements and/or medications you are taking and bring it with you to each visit. New and established patients are also encouraged to bring any pertinent lab test results obtained from other doctor consultations.

The office is open from 9:00 AM to 5:00 PM, Monday through Friday, with exception of major holidays. Telephone hours are from 9:00 AM-12 PM and from 1:30 PM-5:00 PM. The answering system will answer at other times. The answering system will take messages, but it is best if you try to place your calls during the above hours.

Since our office is preventive and consultative, we are not an urgent care, emergency, on-call, after hours, weekends or holidays facility. We do not admit or care for patients in the hospital. We do not provide primary care services. (See primary care form). Patients should also consult and inform their primary care physician of the therapy received in this office for the coordination of patient care. Our staff does not have hospital privileges and we are unable to treat a patient at another facility. Additionally, all patients referred to specialists and/or for additional testing are personally responsible for following-up with these recommendations. If any of our patients are experiencing an emergency medical situation they are advised to contact 911.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, and by notifying us in advance if you are unable to do so. We have a waiting list for appointments and when you give us advance notice we are able to accommodate other patients. Thank you for your courtesy. All appointments must be confirmed within 24 hours of receiving our confirmation call. All patients who fail to arrive for their scheduled appointments or cancel with less than (2) business days advance notice will be charged a missed appointment fee.

The under (2) business day cancellation and missed appointment fees are as follows:

Test Review, Follow-up, Yearly $150.00

New Patient $247.50 (due at time of making 1st appointment, non-refundable unless rescheduled)

_____ Initial

MEDICAL RECORDS

Your medical records are subject to HIPAA policies. Please read our HIPAA/privacy information. Whenever possible, we obtain your direct consent for release of records regarding your care with us. However, the HIPAA policy requires us to release

certain records to insurance or other care providers. A copy of your medical records is available upon request with a charge of $0.25 per page.

SUPPLEMENTS

Most of the supplements we prescribe are available at the office. We maintain a supply of high quality supplements. However, you are under no obligation to purchase these products from us. Some of the supplements are available through various health food stores and other sources. Please be advised, our supplements are purchased only through the most reputable sources who maintain a strict quality process. The use of supplements purchased elsewhere will not affect the quality of care by your physician here. Supplements can only be purchased here if prescribed by your physician. Supplements may not be returned for refund after purchase at this office. Off label use of medications and supplements are often recommended by doctors in this office. For your convenience, patients can use either our supplement phone line (650 964-6700) or online (supplement@intmedassoc.com) to request supplement refills. These orders will be prepared by our staff and will be available for pick-up or can be shipped per your request. Please give us (10) days' notice to refill or replace a product. Payment for products mailed to you can be made by Visa, MasterCard, Discover or American Express, or by prepayment with a check. For more information, please contact our front office staff. Please note that insurance companies almost never consider nutritional supplements as covered items.

PRESCRIPTIONS

Should you have any prescription refill requests, please direct them to your pharmacist first. The pharmacy in turn will contact us for the refill. This will save time and also avoid any errors in prescribing.

EMAIL POLICY

Our doctors and staff see themselves as partners in your healthcare. Therefore, we provide our email address: frontoffice@intmedassoc.com. You can utilize this address for:

1. Requesting an appointment (please allow 24-48 business hours for a call back)
2. Billing questions.

We also provide nurses@intmedassoc.com and you can utilize this address for:

1. Prescription questions (we ask that refill requests be directed to your pharmacy first, they will then contact us for authorization).
2. Symptom updates for physicians.
3. Test results (interpretation of results should be given by physician, please call or email the front office to schedule an appointment or phone consultation).
4. General healthcare questions, please allow 24-48 business hours for response. If you have any "new" healthcare questions, please write them down and bring in to your next scheduled visit.
5. Specific questions for physicians, please allow 24-48 business hours for response. (if correspondence is too lengthy or complex, the front office will call to schedule an appointment or phone consult, please see phone consult fee)
6. If you have an urgent question please call our office and ask for the nurse's line. Please remember we are neither primary care nor on-call physicians, if you feel your situation is an emergency please dial 9-1-1 or visit your nearest hospital.

For supplement questions and refills you may utilize supplements@intmedassoc.com.

*Our office utilizes encrypted wireless communicators.

SERVICE ANIMALS

This facility understands and respects the needs of patients. As such, this facility services patients with severe allergies and in order to facilitate their comfort we ask the following per title III of the ADA:

Prior notification of animal's presence is requested but not necessary.
All animals must be harnessed, leashed or tethered at all times.
The animal must be required because of a disability.
We are allowed to ask what tasks the animal has been trained to perform.
We request the patient and animal enter and exit through our hall entrance, as to
minimize animal's exposure to other patients.
*We appreciate your cooperation.

PERFUMES, SCENTS, SMOKING & CELL PHONES

Many of our patients (and staff) are made ill by perfume and other scented products. Please be considerate and use no perfume or scented products when you are coming into the office. Remember that perfume applied earlier in the day may still cause symptoms in allergic people. Patients wearing strong scents in the office may be requested to reschedule their appointments in order to protect other sensitive patients. Smoking is not permitted on the premises.

We ask that you please do not use cell phones in treatment areas.

Please sign when you have read and understood our office policy.

_____ _____

Signature *Date*

2017

Integrative Medical Associates
5050 El Camino Real #110
Los Altos, Ca 94022
(650) 964-6700

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed an how you can get access to this information. Please review it carefully.

This notice takes effect on 4/01/03 and remains in effect until we replace it.

1.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 organization. We need this record to provide you with the 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.

2. 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.

.Follow the terms of the notice that is now in effect.

We have the right to:

1.Change our privacy practices and the forms of this notice at any time, provide 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 change to Privacy Practices:

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

3.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.

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.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

***Disaster Relief*:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

***Research in Limited Circumstances*:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

***Funeral Director, Coroner, Medical Examiner*:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

***Specialized Government Function*:** 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.

***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.

Initial_____

***Public Health Activities*:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

***Victims of 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 or 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 or 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.

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

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

***Law Enforcement*:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, such as requests 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

You Have a Right To:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. You must make your request in writing. You may get the form to request access by asking one of our front desk staff. If you request copies of your medical records please allow up to fifteen days.
2. You have the right to review your records. You must coordinate a time with our front office staff to to do so.
3. Receive a list of all the times we or our business associates shared your medical information for purposes other that treatment. Payment and health care operations and other specified exceptions.
4. 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).
5. 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 office.
6. Request that we change you 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. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes on any future sharing of that information.
7. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy officer at our office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice of if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint **Initial_____**

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:_____ By:_____

Physician or (Date) Patient's Signature (Date)
Duly Authorized Representative

_____ _____

Print or Stamp Name of Physician/ Medical Grp Print Patient's Name

By:_____ By:_____

Signature of Translator (if applicable) (Date) Patient's Representative (if applicable) (Date)

_____ _____

Print Name of Translator Print Name & Relationship of Patient Representative