Dear New Patient:

Welcome to Cornerstone Progressive Health! Health is the most important thing you have, and you have taken a serious step to improve yours. Congratulations! We look forward to being of service to you.

Our physicians specialize in functional medicine and heavy metal detoxification. We take a holistic approach to patient assessment and diagnosis, while utilizing natural therapeutics to treat health concerns. We also provide many other treatments in our facility to aid in your healing and for use on a maintenance basis to keep you healthy. Please refer to our website at CornerstoneProgressiveHealth.com for more detailed information on our medical facility.

The initial visit with the doctor will be 60 minutes. Please allow plenty of time (1 ½-2 hours) for discussing your plan of care, education on homeopathic or nutritional supplements, lab work and/or additional treatments that may be prescribed for you.

Before Your First Visit

Complete the Office Policy, Consent Forms, and Questionnaires in this informational packet and bring them with you to your scheduled appointment.

Bring any medications or supplements you take, dosage, and time of day you take them (there is a section in this packet for this information to be listed), and any recent medical records or lab work within the last 6 months.

Bring any other information that you feel will be pertinent to your care.

We look forward to supporting you on your health journey!

Office Policy, Consent & Patient Responsibility

The following information is provided to facilitate a common understanding of rights, roles, and responsibilities in this professional, therapeutic relationship.

- **Physician Visits and Treatments.** These are only available by appointment. Please be aware that our office is **not** designed to handle acute emergency situations. In emergencies, refer to your pediatrician, family practitioner, or local emergency department for acute care. **Please keep your primary care provider**, as Cornerstone Progressive Health practitioners are not primary care providers.

- **Treatments with other physicians or healthcare providers should not be discontinued.** We endeavor to work with other practitioners to ensure the best, comprehensive medical care. Please let the practitioners at our office know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). Consult your prescribing physician before discontinuing medications. It is your responsibility to disclose any changes in your condition, symptoms, contact information, medications, or treatments between visits.

- **Office Hours.** Our hours of operation are Monday-Thursday, 8:30am-4:30pm.

- **Email and Phone Messages Policy.** Please allow 2-3 business days for your emails/messages to be returned. Our staff is trained to handle most queries related to laboratory testing, dosing, pricing, and scheduling. When it comes to your personal medical decisions, supplements, symptoms, problem solving, and getting the doctor's opinion, the doctor will handle these and charges will be incurred. Please send questions and correspondence to cphpatients@gmail.com

- **For follow-up visits: In Person** – we require you to bring a list of your concerns or questions, in order of priority and an updated list of supplements/medications with dosage and time of day taken to each appointment to make your time with the doctor as efficient as possible. **Phone Consults (Telemedicine)** – email or call in a list of your concerns or questions, in order of priority and an updated list of supplements/medications with dosage and time of day taken.

- **We have a twenty-four hour cancellation policy.** If your appointment is missed without 24 hours prior notice, you will be charged a missed appointment fee of either $100 (for a new patient appointment), or $50 (for a missed follow-up office visit). You will be charged only if your appointment is missed without proper cancellation. We have a list of people waiting for appointments; if you need to cancel or reschedule, please do so as soon as possible to avoid any misunderstandings or missed appointment charges.

- **Telemedicine:** The doctor will call you on the number you have provided the staff. A credit card on file is needed for payment. Phone consults are charged at the same rate as office visits and payment will be charged at the end of the visit. If a patient is paying by check, then the check will need to be received before the phone consult. We would like you to be available up to 15 minutes after your consult. After speaking with the doctor, you will be put on hold and forwarded to the front desk. At that time, staff

will discuss the doctor's recommendations, blue sheet, suggested products, therapies, appointment scheduling, and payment. If the staff are unable to speak with you after the consult, they will email you the doctor's recommendations and charge your credit card for the length of the visit. You may call back at your convenience to discuss any questions and/or order products.

- **Controlled substance prescriptions** require a monthly, in office appointment with the doctor, please schedule accordingly. These prescriptions have zero refills, will only be written in the office, during the appointment with the doctor, and require a signature to show it has been picked up.

- **Product Pickup.** Please call ahead to have products prepared for pickup.

- **Supplements Back-orders & Return Policy:** Back-ordered supplements will be held for thirty days. Return policy for unopened supplements is thirty days from date of purchase. Unopened supplements may be returned for office credit, providing they have not been opened and they are returned within thirty days of purchase.

- **Medicare patients** will be required to sign a Medicare Patient Contract, which is a waiver saying you will NOT send your bill to Medicare and you will pay the invoice at the time of the office visit.

- **We do not provide medical records/notes to insurance companies (ie. Life insurance, motor vehicle accident claims, disability claims, etc.)**

- **Insurance Claims, Disability Requests, and Life Insurance Applications:** We give patients copies of all their doctor reviewed labs. We do not give out progress notes. The doctor keeps their notes private. The doctor does not fill out FMLA or Disability Claims. You need to use your primary care provider for those purposes.

Statement of Informed Consent

The Patient (And Others Legally Responsible for the Patient):

You have the right, as a patient, to be informed about your condition and how integrative and alternative medicine may be applied in a treatment plan. This disclosure is intended to provide an opportunity for you to make an informed decision so that you may give or withhold your consent to treatment that may be considered unconventional by physicians

trained only in the United States. **Notice:** *Refusal to consent to the integrative and alternative procedure(s) shall not affect your right to future care or treatment.*

I voluntarily request that Dr. Patricia and/or other affiliated healthcare personnel that may be deemed necessary, treat my condition (or the condition of the person for whom I am responsible) as described below. I understand that some or all of the following integrative and alternative treatments are planned for me (or the person for whom I am responsible), and I voluntarily consent and authorize the following:

administration of homeopathic remedies, herbal and nutritional therapies, off-label use of pharmaceuticals, neural therapy, oxidative therapy, prolotherapy, prolozone, intravenous therapies, including but not limited to, high dose Vitamin C, Major Auto-Hemotherapy, Chelation therapy, and physical and/or quantum physical modalities (including TKM, light, laser, PBM, color, electromagnetic, and magnetic therapies), and extended neurological examination, including neuromuscular and autonomic nervous system response.

I understand that no warranty or guarantee has been made regarding the results of treatment. I realize that there may be risks and hazards in treating this present health condition, with or without conventional medicine, and there may also be risks and hazards related to the planned integrative treatment, including worsening of present symptoms, development of new symptoms (especially detoxification reactions) and undesirable interactions between various treatments, both conventional and alternative.

I have been given the opportunity to ask questions about the treatment of this health condition using conventional, integrative, and alternative methods. I have had the opportunity to discuss the possible risks and hazards of treatment and non-treatment and believe that I have sufficient information to give informed consent. I certify this form has been fully explained to me, that I have read it (or have had it read to me), and that I understand its contents. I also certify that Cornerstone Progressive Health has provided this Disclosure and Consent Form to me, and fully explained the diagnostic and treatment options available, and has made no guarantees to me as to the success of this treatment.

For Patients Receiving IV Therapy, Prescription Medications, and Treatments

We are happy to provide for your IV needs. Please read our requirements for receiving chelation. These are based on guidelines set by ACAM and the Nebraska State Medical Board.

- You must be seen in our clinic by one of our practitioners for plan review and laboratory evaluation every twelve months.
- You must complete a visit with the physician at least once a year, or more frequently, as the medical condition requires.

By signing below, I acknowledge that I have read, understand, and agree with the terms and conditions contained within this Office Policy & Consent Form.

Signature of Patient or Other Legally Responsible Person Required Below: Date:

____

Printed Name of Patient or Name of Guardian, if applicable:

____

Medicare Contract

I acknowledge and agree that this agreement/contract has been entered into with Cornerstone Progressive Health to provide integrative healthcare, office visits, IV Therapies, and Nutritional Supplements. This is not an emergency or urgent health care situation.

I agree not to submit a Medicare claim or to request Cornerstone Progressive Health submit an insurance claim on my behalf under the Social Security Act, as amended *42 U.S.C. 1395a) for services, even if such services are otherwise covered under Medicare part B.

I agree to be responsible for the payment of Cornerstone Progressive Health services (including certain laboratory tests recommended by my provider).

Medicare will not provide reimbursement for Cornerstone Progressive Health services and no Medicare fee limits will apply to charges for office visits, IVs, and/or supplements. I acknowledge that Medicare plans under 42 U.S.C. 1882 do not, and other supplemental insurance plans may not make payments for our services.

As a Medicare beneficiary, I have the right to have the service provided by other physicians for whom a payment would be made under Medicare, 42 U.D.V. 1395a. Cornerstone

Progressive Health is not excluded from participating in Medicare Part B under 42 U.S.C. 1128, but free chooses not to do so.

I understand that by signing this contract, I am forgoing my right to receive Medicare benefits for Cornerstone Progressive Health:

____

Signed Date

____

Printed Patient Name

CORNERSTONE PROGRESSIVE HEALTH CONTACT AUTHORIZATION FORM
DISCLOSURE OF PERSONAL MEDICAL INFORMATION

____

FULL NAME **DATE OF BIRTH**

In an effort to keep your information private, we will not discuss or disclose your personal/medical information unless you give us written permission below.
Is there anyone else we may speak to regarding your care? If so, please list all approved persons & relationship (this includes any information regarding lab results, prescription medications and supplements, protocols, appointments, etc.):

Name: __________________________ Relationship:	Phone Number: ____________________ Okay to leave a message? Yes No Email:
Name: __________________________ Relationship:	Phone Number: ____________________ Okay to leave a message? Yes No Email:

Name: ______________________________ Relationship:	Phone Number: ______________________ Okay to leave a message? Yes No Email:
Name: ______________________________ Relationship:	Phone Number: ______________________ Okay to leave a message? Yes No Email:
Name: ______________________________ Relationship:	Phone Number: ______________________ Okay to leave a message? Yes No Email:

Patient Information Page - Adults (skip to page 9 for Minors)

Today's Date: ____/____/____

Name: ____

Nickname, if applicable: ____

Date of Birth: ____/____/____

Height: ________ Weight: ________ Current Age: _____

Home Address: ____

City: _________________ State: _____ Zip Code: _________________

Cell Phone: (_____)___________________

Ok to leave a detailed message regarding labs/medications/etc.? **Yes No**

Appointment reminders via Text, Email, Voicemail**: Yes No**

Work Phone: (_____)__________________ Ok to leave a message? **Yes No**

Email: ____

Occupation: ____

Circle one: Single / Married / Divorced

Spouse Name: ____ Phone: (_____)____________

Emergency Contact: ____________________________________ Phone: (_____)____________

Relationship: ____

Who may we thank for referring you to our office?

____

Children: Number of children (name & date of birth):

____

____

____

____

____

Patient Information Page - Minors (ages 18 & under)

Today's Date: ____/____/____

Name: ____________________________________ Date of Birth: ____/____/____

Nickname, if preferred: _________________________________

Parents/Guardians: ____

Parents/Guardians Phone Numbers: ____

(Please circle which phone number is best to contact with questions, appointments, etc.)

Height: ________ Weight: ________

Home/Mailing Address: ____

City: _________________ State: _____ Zip Code: _________________

Ok to leave a detailed message regarding labs/medications/etc.? **Yes No**

Appointment reminders via Text, Phone, Email**: Yes No**

Parents/Guardians Email: ____

Current grade in school: ____________________________________

Emergency Contact other than parents/guardians: _____________________________

Phone: (_____)____________

Relationship: ____

Who may we thank for referring you to our office?

____

Present Health Concerns

Please list your most important health concerns If possible, please list them in order of importance to you. For example, #1 is the most important and #5 is the least important.

1)____

____

____

2)____

____

____

3)____

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4)____

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5)____

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____

Allergies

Please list all food, environmental, and/or medication allergies:

____

____

Hospitalizations/Surgeries/Procedures

Please list all previous medical procedures, surgeries, hospitalizations, and serious illnesses.

Approximate Date/Year	Surgery / Hospitalization / Procedure / Serious Illness / Injury

Current Medications & Supplement Information (Please make one for each doctor visit)

In order to help facilitate the visit between you and your practitioner, please fill in this form with any vitamin, mineral, amino acid, or other supplement that you may be taking. Please include both prescription and non-prescription/over the counter medication (E.g. Prozac, Tylenol, etc.):

Medication/Supplement Name (eg. Vitamin C)	Form: (eg. Powder, capsule, tablet)	Dosage (eg. 100mg)	Frequency: (eg. 2x daily)	Duration: (eg. 3 months)

Please mark if you have any of the following:

____ Breast Implants

____ Other surgical implants or Body Modification

____ Tummy Tuck

____ Face Lift

____ Pacemaker

____ Moles removed

____ Body piercing

____ Tattoos Color Black

____ Metal or plastic in your body (permanent retainers, braces, pins, plates, etc.)

____

Other: ____

Past Accidents or Physical Traumas

Please list any accidents or physical traumas you may have suffered, or any scars you may have, and their location:

____

____
____
____
____
____

Personal Habits (note - this is strictly confidential)

Do you currently use recreational drugs, if yes, please list? ______________________________

____
____
____

How often: ____

Have you used substances in the past? Yes No

If yes, which ones, and for how long?

____
____

Do you currently smoke? Yes No

If yes, how much ____________ Cigarettes Cigars Vape Chewing Tobacco

If you drink alcohol, what do you drink and how often?

____
____
____

Exercise

Do you exercise? If so, how often and what activities?

____
____
____
____

Dental History

Please check all of the following that apply to you:

Gum disease		Root canals	
Sensitive teeth		Crowns	
Bleeding gums		Bridges	
Amalgam (silver) fillings		Extractions	
Jaw pain		Orthodontics	

Women Only

Please check all of the following that applies to you:

Pregnant		Menopause Symptoms	
Breastfeeding		Hysterectomy	
Irregular periods		Premenstrual Symptoms	

Date of last menstrual period: ____

Number of days of your average menstrual flow: ________________________________

Menstrual Flow: Heavy Clotty Light Painful

Anything else you'd like to share about your menstrual cycle:

____
____
____
____

Electromagnetic Exposure

How many hours do you spend daily doing the following, please check all of the following that applies:

Watching TV		Wearing a headset	
Working on a computer		Wearing a wrist or smart watch	

Talking on a cellphone		Talking on a Bluetooth	
Sleeping next to a plug-in alarm clock		Sleeping next to a Bluetooth speaker	
Near electrical equipment (copy machine, power lines, computer, etc.)			

Toxic Exposures

Please check all of the following that apply to you:

____ I place lawn care chemicals on my lawn yearly

____ I use cleaners such as Clorox, Windex, mildew removers, etc. in my house

____ I eat mostly non-organic food

____ I am very sensitive to perfumes, candles, air fresheners, fragrances

____ I eat tuna or other fish more than 2 times per week

____ I have worked or lived on a farm that uses pesticides, herbicides, and/or fertilizers

Family History

Please mark all of the following that apply as follows: P-paternal/father, M-maternal/mother, GP-grandparents, S-siblings.

ADHD		Cancer		Gluten sensitivities	
Addiction		Depression		Irritable bowel syndrome	
Allergies		Diabetes		Ulcers	
ALS		Eczema		Kidney disease	
Alzheimer's		Epilepsy		Liver disease	
Anxiety		Heart Disease		Multiple Sclerosis	
Arthritis		High blood pressure		Parkinson's	

Asthma		Hypoglycemia		Stroke	
Autism		Celiac disease		Thyroid	

Any other pertinent personal or family history:

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____
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____