

**Sonas Integrative Medical Center, LLC**

3750 North Main, Suite 4

Durango, CO 81301

Tel: 970.247.2500 Fax: 970.247.2505

**New Patient Information Sheet  
(Please Print Clearly)**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: F M

Martial Status: S M D W Other: \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

\*How did you hear about us? \_\_\_\_\_

**This clinic is not a Medicaid provider. Are you covered by Medicaid or Medicare? Yes \_\_\_ No \_\_\_ (Check one)**

**If you checked "YES" to the above question, you need to complete the form: MEDICAID/MEDICARE PATIENT REQUEST FOR MEDICAL SERVICES.**

**PRIMARY INSURANCE INFORMATION: (Print Clearly)**

Insurance Company: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured/Subscriber Name: \_\_\_\_\_ Insured/Subscriber Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Relation to Patient:  Self  Spouse  Other: \_\_\_\_\_

**Please read and sign**

I understand and authorize payment of all medical benefits to be paid directly to Sonas Integrative Medical Center, LLC. I hereby authorize Sonas Integrative Medical Center, LLC to release/furnish any medical information necessary for insurance claim. The patient/ responsible party is personally & fully responsible for payment of any balance not paid by their insurance within 45 days of billing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(parent or guarantor of child)

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**INFORMED CONSENT**

Due to governmental and medical establishment laws, regulations, and oppositions to freedom of choice, and the prevailing attitude that non-standard therapies constitute fraud, we ask that every patient seen at Sonas Integrative Medical Center, LLC read and sign this sheet.

The medical practitioners believe that the therapy recommended in your particular case, would be proper but it is important for you to understand that they cannot guarantee results and that no results can be implied or warranted. The human body and mind are extremely complex and even seemingly benign treatment may have serious and unexpected side effects or reactions, and possible life threatening results, due to the individual makeup of any particular person.

Third party insurance carriers often do not cover medical care that is not standard or not considered to be “usual and customary” by the insurance company. You are responsible for the medical expenses, regardless of whether they are covered by your insurance company.

Your signatures on this form is to be interpreted to mean that you have been given and understand this information, and that having been fully informed, you wish to obtain and consent to receive the therapy recommended.

**I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND WISH TO OBTAIN THERAPY INDICATED.**

SIGNED \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

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**MEDICARE/ MEDICAID PATIENT  
REQUEST FOR MEDICAL SERVICES**

Sonas Integrative Medical Center, LLC is an integrative medical clinic. Some medical treatments provided by the medical practitioners and staff are not accepted as “reasonable and necessary” under Medicare federal guidelines. Therefore, Medicare will not cover these costs and you will be financially responsible for those services rendered. Medicaid cannot be billed nor have medical claims filed with these carriers for those services rendered

For those covered by Medicare or Medicaid, or those who are 65 years old, older, on Federal or State disability, and wish to proceed with integrative care, please read and sign the following:

I have chosen to engage the professional services of Sonas Integrative Medical Center, LLC, the medical practitioners, and the medical staff strictly with knowledge that they may render services not deemed as “reasonable and necessary” and that Medicare may not cover these services, and that I will be financially responsible for those costs.

As a Medicaid Beneficiary, I have chosen to engage the professional services of Sonas Integrative Medical Center, LLC, the medical practitioners, and the medical staff strictly as a private patient, and NOT as a Beneficiary of Medicaid. I wholly understand that I will personally be responsible for all charges incurred for such services. I will not send any charges to the above mentioned carrier.

I have made this judgment of my own free will and a fully aware of the consequences of this decision.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

## Sonas Integrative Medical Center, LLC

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### Notice of Privacy Practices

*To our patients:* This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

- Our practice is dedicated to maintain the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement officials.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutional or law enforcement officials if you are an inmate or under the custody of law enforcement officials.
8. For Workers Compensation and similar programs.

### Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your case, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. **You must submit your request in writing** to Sonas Integrative Medical Center, LLC, 3750 North Main, Suite 4, Durango, CO, 81301, Attn: Medical Records, (970) 247-2500.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. **To request an amendment, your request must be made in writing and submitted** to Sonas Integrative Medical Center, LLC, 3750 North Main, Suite 4, Durango, CO, 81301, Attn: Medical Records, (970) 247-2500. **You must provide us with a reason that supports your request for amendment(s).**

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5. **Right to a copy of this notice.** You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

- YES, I wish to obtain a copy of this notice today.
- NO, I do not wish to request a copy of this notice at this time.

6. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Sonas Integrative Medical Center, LLC, 3750 North Main, Suite 4, Durango, CO, 81301, (970) 247-2500. **All complaints must be submitted in writing. You will not be penalized for filing a complaint.**

7. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or your health information privacy policies please contact us.

I hereby read and acknowledge that I have been presented with a copy of Sonas Integrative Medical Center, LLC Notice of Privacy Practices.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Year of: \_\_\_\_\_ Name of Patient \_\_\_\_\_

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding:

- **Appointments**
- **Reminders**
- **Lab results**
- **ETC.....**

**Only list the phone number(s), you want us to call. Please circle YES OR NO.**

Home: \_\_\_\_\_ OKAY to leave message YES / NO

Work: \_\_\_\_\_ OKAY to leave message YES / NO

Cell Phone: \_\_\_\_\_ OKAY to leave message YES / NO

Other: \_\_\_\_\_ OKAY to leave message YES / NO

Fax: \_\_\_\_\_ OKAY to leave fax YES / NO

Email: \_\_\_\_\_ OKAY to email YES / NO

SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

*Thank you for your permission.  
Sonas Integrative Medical Center, LLC*

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**HEALTH HISTORY QUESTIONIONNAIRE**

*Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you are unsure of with a question mark. All information contained in these pages is completely confidential.*

**PERSONAL INFORMATION**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

If the patient is under the age of 18:

Name of Mother: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Phone: \_\_\_\_\_

When did you last receive medical care? \_\_\_\_\_ Where: \_\_\_\_\_

**HEALTH HISTORY**

*Please list any know allergies (environmental, drug, food):* \_\_\_\_\_

*Do you take any of the following over-the-counter medication? Please check any that apply:*

\_\_\_\_\_ Aspirin      \_\_\_\_\_ Ibuprofen or acetaminophen      \_\_\_\_\_ Antihistamine      \_\_\_\_\_ Sleeping pills  
\_\_\_\_\_ Laxatives      \_\_\_\_\_ Appetite depressants      \_\_\_\_\_ Antacid      \_\_\_\_\_ Medicine to stay awake

*Please list any pharmaceutical and/or natural medications (including vitamins) that you are taking or have taken in the last year:*

Medication	Dosage	Dates	Reason for taking

**PAST MEDICAL HISTORY**

*Please list your current health problems and/or symptoms:* \_\_\_\_\_

Any Complications from childhood illness? Please circle any that apply.

Measles                      Mumps                      Rubella                      Whooping cough                      Chicken pox  
Rheumatic fever              Scarlet fever              Polio                      Other: \_\_\_\_\_

*Please list any adult illnesses, accidents/injuries, hospitalizations or surgeries not already listed:* \_\_\_\_\_

Immunizations (circle all that apply):

DPT              MMR              Polio              Hepatitis B              Influenza              Pneumonia              Varicella              Other: \_\_

Screening Tests (circle all that apply):

Hematocrit              Urinalysis              Tuberculin              Skin test              Pap smear              Mammogram              Occult stool              cholesterol

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## REVIEW OF SYSTEMS

For the following conditions and symptoms, please indicate any that apply to you by marking "C" for CURRENT or "P" for PAST:

### GENERAL:

Weight Change  
 Fatigue  
 Weakness  
 Fever  
 Chills  
 Night sweats  
 Dental problems  
 Frequent antibiotic use

### SKIN:

Skin, hair, or nail changes  
 Itching  
 Rashes  
 Sores  
 Lumps  
 Moles

### HEAD:

Trauma / Injury  
 Headache  
Frequency? \_\_\_\_\_  
 Nausea  
 Vomiting

### MOUTH/NECK:

Bleeding gums  
 Hoarseness  
 Sore throat  
 Swollen neck

### EYES:

Glasses  
 Contact lenses  
 Blurriness  
 Tearing  
 Itching  
 Impaired Vision

### EARS:

Hearing loss  
 Tinnitus  
 Vertigo  
 Discharge  
 Earaches  
 Ear Infections

### NOSE,

### SINUSES:

Runny nose  
 Stuffiness  
 Sneezing  
 Itching  
 Allergies  
 Epistaxis

### RESPIRATORY:

Shortness of breath  
 Wheezing  
 Cough  
 Pneumonia  
 Asthma  
 Bronchitis  
 Emphysema  
 Tuberculosis  
 Last chest X-ray \_\_\_\_\_

### CARDIAC:

High blood pressure/hypertension  
 Murmurs  
 Chest pain  
 Palpitations  
 Painful breathing w/ activity  
 Edema  
 Last EKG \_\_\_\_\_

### GI:

Appetite  
 Nausea  
 Vomiting  
 Indigestion  
 Painful swallowing  
 Changes in bowel movements  
 Color \_\_\_\_\_  
 Diarrhea  
 Constipation  
 Hemorrhoids  
 Abdominal pain  
 Jaundice  
 Hepatitis

### URINARY:

Frequency  
 Hesitancy  
 Urgency  
 Puss in urine  
 Painful urination  
 Color change

in urine

Blood in urine  
 Nocturia  
How many? \_\_\_\_\_  
 Incontinence  
 Kidney stones  
 UTIs

### VASCULAR:

Leg edema  
 claudication  
 Varicose Veins  
 Thromboses / Emboli

### MUSCULO-SKELETAL:

Muscle weakness or pain  
 Joint stiffness  
 Decreased range of motion  
 Instability  
 Redness  
 Swelling  
 Arthritis  
 Gout

### NEUROLOGIC:

Loss of sensation  
 Numbness / tingling  
 Tremors  
 Weakness / paralysis

Fainting / blackouts  
 Seizures

### HEMATOLOGIC

Anemia  
 Easy bruising / bleeding  
 Petechiae  
 Purpura  
 Transfusions

### ENDOCRINE:

Heat / Cold intolerance  
 Excessive sweating  
 Polyuria  
 Polydipsia  
 Polyphagia  
 Thyroid Problems  
 Diabetes

### PSYCHIATRIC:

Mood swings  
 Anxiety / nervousness  
 Depression  
 Tension  
 Memory loss  
 Difficulty sleeping  
 Physical abuse  
 Feel unsafe at home

When and where are your symptoms worse?  
\_\_\_\_\_ Morning \_\_\_\_\_ Afternoon  
\_\_\_\_\_ Other

\_\_\_\_\_ At home  
\_\_\_\_\_ Evening

\_\_\_\_\_ At work  
\_\_\_\_\_ Overnight

\_\_\_\_\_ Upon waking  
\_\_\_\_\_ No pattern

## FAMILY HISTORY

If you or anyone in your immediate family has or had any of the following conditions, please indicate who was affected (self, mother, father, sister, brother, child):

Cancer \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Stroke \_\_\_\_\_  
High blood pressure \_\_\_\_\_  
Alcoholism or substance abuse \_\_\_\_\_  
Attempted suicide \_\_\_\_\_

Diabetes \_\_\_\_\_  
Asthma, hay fever, rashes \_\_\_\_\_  
Osteoporosis \_\_\_\_\_  
Depression \_\_\_\_\_  
Autoimmune disease \_\_\_\_\_  
Other \_\_\_\_\_

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### FOR MEN ONLY

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<input type="checkbox"/> Prostate exam _____ / _____ / _____	<input type="checkbox"/> Abnormal discharge from penis
<input type="checkbox"/> Regular self testicular exam	<input type="checkbox"/> Pain or lump in scrotum
<input type="checkbox"/> Impaired fertility	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Sexually transmitted infection(s)
<input type="checkbox"/> Problems with urination (pain, strain, etc...)	<input type="checkbox"/> Other _____

### FOR WOMEN ONLY

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Last menses _____ / _____ / _____	Please check all that apply to you:
Last pap smear _____ / _____ / _____	
Age menses began _____	<input type="checkbox"/> Hysterectomy
Number of pregnancies _____	<input type="checkbox"/> Abnormal pap smear
Number of live births _____	<input type="checkbox"/> Breast pain / lump / nipple discharge
	<input type="checkbox"/> Sexual difficulties
If you are still having periods:	<input type="checkbox"/> Frequent vaginitis / chronic yeast infections
Average number of days of bleeding _____	<input type="checkbox"/> Abnormal vaginal discharge
Average number of days in cycle _____	<input type="checkbox"/> Endometriosis
Bleeding is _____ Regular _____ Irregular _____	<input type="checkbox"/> Polycystic ovary syndrome
_____ Light _____ Medium _____ Heavy _____	<input type="checkbox"/> Sexually transmitted infection
Symptoms _____ Bleeding between periods _____ Mood Swings _____	<input type="checkbox"/> Pelvic inflammatory disease (PID)
_____ PMS _____ Painful menses _____ Breast tenderness _____	<input type="checkbox"/> Uterine fibroids
	<input type="checkbox"/> Impaired fertility
If you are no longer having periods:	<input type="checkbox"/> Sexual abuse
_____ Hot flashes _____ Vaginal dryness _____	<input type="checkbox"/> Regular self breast exam
_____ Dry skin _____ Changes in memory _____	<input type="checkbox"/> Sexually active
_____ Spotting _____ Changes in libido _____	<input type="checkbox"/> Use methods to prevent pregnancy and/or sexually transmitted infections:
_____ Facial hair _____ Changes in mood _____	Current _____
_____ Hair loss _____ Hormone replacement therapy _____	Past _____
_____ Incontinence _____ Urinary tract infections _____	

### LIFESTYLE HISTORY

Please check any that apply to you and fill in corresponding details:

---

<input type="checkbox"/> Exercise _____ hours per week	Weight one year ago _____
<input type="checkbox"/> Tobacco use	Maximum weight _____
<input type="checkbox"/> Alcohol use	When? _____
<input type="checkbox"/> Recreational drug use	Sleep _____ hours per night _____
<input type="checkbox"/> Occupation _____	Is this enough? _____ Yes _____ No
Hours per week _____	Meals per day _____ Bowel movements per day _____
Do you enjoy your work? _____ Yes _____ No	Level of stress: _____ Low _____ Average _____ High
<input type="checkbox"/> Toxic exposure	
Major life change(s) in last year? _____	