INTERNAL MEDICINE
&
WELLNESS THERAPIES, INC.
6815 Fair Oaks Blvd
Carmichael, CA 95608
Ph: (916) 481-4389, Fax: (916) 481-4307
www.drbisharat.com

Greetings and Welcome to Our Office

Thank you for choosing us to take care of your health needs and allowing us to serve you. We are a unique office with many features that are both the standard of care in Internal Medicine and also advances in the field of Integrative Holistic care. We believe that health is not just the absence of disease it is the sense of well being that comes from balance in our lives. We make every effort to use ideas derived from the natural power to heal that we all have, and blend that with standard medications when needed.

As a new member of this office, you will be offered a comprehensive assessment of your health. Each step of the way you will encounter dialogue with your provider to fully grasp how you can take charge of your health. It is our wish to offer prevention to you. This means we will try to assess trends that we see and then take corrective measures before there is an actual problem in your health. A critical part of our prevention team are the nutritionists. **You will get a complete nutritional assessment as part of our initial evaluation here.** This benefit is covered by your insurance.

Holistic Services

We offer other excellent services to assist you in your health and healing needs. These include:

* Holistic Nutrition consultation for healthy weight loss, diabetes, and cholesterol management
* Heart math for stress reduction, a form of bio-feed back
* Therapeutic massage for body pain syndromes
* Infrared treatment for body pain, stress reduction and general healing
* Yoga therapy, a form of mind body therapy based on yoga principles, offered privately
* Functional Medicine, for complex medical problems
* Group appointments of important health topics, like osteoporosis, men's health, healthy forms of exercise, diabetes, healthy food choices and explanations of why they are important

To access these treatments, you will be assessed first by a provider and then the treatment will be applied for your insurance to cover a visit.

Hours

To best utilize our office, we are open Monday through Thursday. Our first appointment is at 7:30 AM, and we close at 5 PM. We are closed daily from 12 - 2 PM for lunch. Our phone lines are open at 9 AM to 5 PM, closed for lunch from 12 to 2 PM. We are also open on Friday, 8:00 AM and close at 4 PM for prescheduled appointments only. We close for lunch from 12-1 PM. Phone lines are closed on Fridays. We have urgent care hours from 11 AM - 12 PM and 4 PM - 5 PM, Monday thru Thursday. To be seen for a same day, urgent care appointment, please call the office at 9 o'clock to schedule. These appointments are not for routine care, but are for short term problems that arise and need our immediate attention. We ask that you arrive 15 minutes before your appointment and complete the intake form. We request that you complete this form every time you come in because it is your chance to outline your needs and wishes for your time with the provider. This is so important because it also allows us to efficiently meet your expectations. The providers make every effort to stay on schedule however, medical care can have many unexpected events that need immediate focus and attention. We very much appreciate your patience when these moments arise in the office.

Medications

We are a fully electronic office, and our work is done entirely on computer through our Electronic Medical Records program (EMR). We are connected with pharmacies that work electronically as well. Medications are therefore sent via EMR. If you need medications renewed, please contact your pharmacy first to request the renewal. We require 3 business days to respond to the pharmacy. Patients who are on controlled substances will need to be seen monthly for medication renewal, and for written medication contracts to be signed, per US DEA. Other monitoring methods will be required as well.

Payment

For all office visits, payment is due at the time of service. If we need to bill, we will add a processing fee of $10. For scheduled appointments that are failed by the patient, there is a "No Show Fee" of $25 that is placed against your account. If you need to change or cancel an appointment, please give us a 24 hour notice, so that we can offer that time to someone else. We bill through an outside billing company, Medical Billing Associates, who can assist you with your billing questions, should anything arise. We are happy to serve anyone who is uninsured or otherwise wants to pay cash for their visits. We are sensitive to economic issues, and our prices are very reasonable.

It is our sincerest hope that you find these services beneficial in your quest for good health and well-being. We welcome your constructive feedback that will make us more effective in achieving our goal with you.

Sincerely,

Katherine Bisharat, MD

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NEW PATIENT INFORMATION

Dear Patient: Thank you for choosing Internal Medicine and Wellness Therapies, Inc as your primary care provider. Please take a moment and thoroughly answer all pertinent questions on this form. Thank you

NAME:

ADDRESS:	BIRTHDAY:	RACE:	M F
CITY:	SSN:		
STATE: ZIP:	EMAIL		
HOME PHONE:	CELL PHONE:		
EMERG. CONTACT:	PHONE:		

ALLERGIES TO MEDICATIONS

Drug:	Reaction:
Drug:	Reaction:
Drug:	Reaction:

IMMUNIZATIONS

Date(s)	**Date(s)**
Hepatitis A series	Flu
Hepatitis B series	Pnuemonia
Tdap	Other

MEDICATIONS
Specify here or provide list

1	6
2	7
3	8
4	9
5	10
Pharmacy Name & Street ONLY	

PAST MEDICAL/SURGICAL HISTORY
Check ALL that apply to YOU

○ Allergies _____	○ Cancer_____	○ Gallbladder Disease	○ Osteoporosis
○ Anemia	○ Cardiac Arrythmia	○ GERD	○ Peptic Ulcer Disease
○ Angina	○ Coronary Artery Disease	○ Headache, Migraine	○ Renal Disease
○ Anxiety	○ Depression	○ Heart Disease	○ Seizure Disorder
○ Arthritis _____	○ Diabetes _____	○ Heart Valve Disorder	○ Stroke
○ Asthma _____	○ High Cholesterol	○ Hepatitis _____	○ Thyroid Disease
○ Atrial Fibrillation	○ High Triglycerides	○ Liver Disease	○ Other_____
○ Blood Clots	○ Hyperlipidemia	○ Irritable Bowel Disease	○ Other_____
○ COPD	○ Hypertension	○ Myocardial Infarction	○ Other_____

PLEASE PROVIDE DATES

○ Angioplasty	○ Gastric bypass	***Female Only***	***Health Maint. Info.:***
○ Appendectomy	○ Hernia Repair	○ Bilateral Tubal ligation	Last Physical Exam
○ Arthroscopy	○ Hip Replacement	○ Breast Augmentation	Last Colonoscopy
○ Back Surgery	○ Knee Replacement	○ Breast Biopsy	Last Sigmoidoscopy
○ Blood transfusion	○ LASIK	○ D & C	Last PSA Test
○ CABG	○ ORIF	○ Hysterectomy	○ ***Other Surgeries***
○ Cardiac Pacemaker	○ Thyroidectomy	○ Mastectomy	
○ Carpal Tunnel Release	○ Tonsillectomy	○ Myomectomy	
○ Cataract Extraction	***Male Only***	○ Reconstruction Mammop.	
○ Cholecystectomy	○ Prostate Biopsy		
○ Coloectomy	○ TURP		
○ Colostomy	○ Vasectomy		

Female Patients Only

Name of your OBGYN:	
Menopausal stage: Premenopausal Perimenopausal Postmenopausal	Pregnancy History: Pregnant Now: N Y Possible Not Pertinent
Menopausal Details: Age: Year: Type:	No. of Full term births:_____ No. of Premature:_____
Hormone Replacement Therapy: N Y	Abortion(s): Induced _____ Spontaneous_____
Hysterectomy: N Y Type:	Ectopic:_____ No. of Living Children:_____
Age started menstruation:	C-Section: _____ SVD:_____ Multiple Births:_____
Last Menstrual Period: / /	
Last PAP Smear: / /	

FAMILY HISTORY Please check ALL that apply.

Diagnosis:	Mother	Father	Sister(s)	Brother(s)	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father
○ ADD/ADHD								
○ Alcoholism								
○ Allergies								
○ Alzheimer's Disease								
○ Arthritis, Type								
○ Asthma								
○ Blood Disorder								
○ Cancer Type								
○ Cardiovascular Disease								
○ Coronary Artery Disease								
○ Coronary Artery Disease, Prem.								
○ Depression								
○ Develop. Delay								
○ Diabetes, Type								
○ Eczema								
○ High Cholesterol								
○ High Triglycerides								
○ Hyperlipidemia								
○ Genetic Disease								
○ Hearing Deficiency								
○ Hypertension								
○ Irritable Bowel Disease								
○ Learning Disability								
○ Mental Illness								
○ Migraines								
○ Obesity								
○ Osteoporosis								
○ Peripheral Vascular Disease								
○ Renal Disease								
○ Seizure Disorder								
○ Stroke								
○ Thyroid Disorder								
○ Other								

SOCIAL HISTORY

Tobacco Use

Have you ever used tobacco? □ No/Never □ Yes □ Unknown

Tobacco Type	Usage per day:	Age started:	Age stopped:
☐ Cigarette	_____	_____	_____
☐ Cigar	_____	_____	_____
☐ Pipe	_____	_____	_____
☐ Chewing	_____	_____	_____
☐ Smokeless	_____	_____	_____
☐ Snuff	_____	_____	_____

Have you ever tried to quit using tobacco? □ No/Never □ Yes □ Unknown

Tobacco Type:	Quit: Month/Day/Year	Longest Tobacco Free:	Cessation Method:
_____	_____	_____	_____

Alcohol/Caffeine

Do you drink alcohol? N Y

Type of drink(s)_____

Frequency _____Amount _____

Do you drink/consume caffeine? N Y

Type of caffeine: _____ _____

Caffeine per day:_____ _____

Statuses

Demographics

Race: _____

Ethnicity: _____

Preferred Language:_____

Education

Education: _____

Degree Obtained: _____

Employment/Military

Employer: _____

Occupation: _____

Occupational Hazards: _____

Military Experience: N Y Branch: _____

Status: _____ Years Served:_____

Discharge: _____ Veteran: _____

Marital Status/Family/Social Support

Current Status: M S D

Previously Widowed: N Y

Previously Divorce: N Y

Has Children: N Y

Boys_____ Girls _____

Lifestyle

Changes in sleep pattern: N Y

Activity Level: Moderate Sedentary Vigorous Health Club member: Now Previously Never

Type of exercise: _____ _____ _____

Exercise Frequency: 2-3 times/wk 3-4 times/wk daily never occasional _____

Hours/week: 0-5 5-10 10-15 15-20 _____

Hobbies: _____ _____ _____ _____

Animals in the home: N Y _____

Religious/Spiritual

Do you have a religious affiliation?	N	Y	Religion:_____
Do you practice your religion?	N	Y	
Do you have spiritual beliefs?	N	Y	

Home Environment/Safety

Smoke detectors in home?	N	Y	
Carbon monoxide detectors in home?	N	Y	
Is the patient at risk for falls?	N	Y	
Falls in last year?	N	Y	Number/falls:_____
Firearms in home?	N	Y	

Recent travel: Out of state? Where?_____

Out of the country? Where?_____

If medically necessary,
Do you agree to transfusions? N Y

If you are 17 years old or younger, please complete the following information.

Who do you reside with?	Both parents	Mother	Father	
Smokers in the home?	Yes	No		
How many siblings do you have? _____		Their ages?		
School/College Name:				
Grade/Year:				
Learning disability	Yes	No		
Special needs	Yes	No		
Gifted program	Yes	No		
Do you exercise	Yes	No		Hrs per day
Do you play sports	Yes	No		Hrs per day
Do you play computer games	Yes	No		Hrs per day

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

Purpose of this notice

In the course of doing business, IMWT (Internal Medicine & Wellness Therapies) gathers and retains personal information about our patients. IMWT respects the privacy of your personal information and understands the importance of keeping this information confidential and secure. This notice describes how IMWT protects the confidentiality of your personal information that we receive. IMWT has implemented policies and procedures in accordance with federal and state confidentiality and privacy laws to protect your privacy. IMWT is obligated to maintain the privacy and confidentiality of your personal information. IMWT is also obligated to provide you with notice of its legal obligations to maintain the privacy of your personal information and provide you notice if its policies and procedures about privacy and confidentiality. These policies and procedures apply to the past, present and future patients of IMWT.

What is Personal Information?

Personal information is information that identifies who you are and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or past, present, or future payment for the provision of health care to you. Personal information does not include information about you that is publicly available, or that is available, or reported in summary form, but does not identify who you are.

Types of Uses and Disclosure of Personal Information Made by IMWT

Federal law allows IMWT to use and disclose your personal information in order to provide health care services to you as well as to bill and collect payments for the health care services provided to you by our physicians. Federal laws also allow IMWT to use and disclose your personal information as necessary in connection with health care operations of IMWT. For example, IMWT may use your personal information to authorize referrals to specialists and to review the quality of care provided. IMWT may disclose your personal information to health plans or other responsible parties to receive payment for the services provided by our physicians. IMWT might also use your personal information in connection with any grievance or appeal that you may file if you are unhappy with the care you received. Certain governmental agencies may also request access to your personal information in order to monitor the activities of physicians, or providers, or even to monitor your health plan or insurance company. IMWT may use your personal information in connection with disease management programs. IMWT may disclose your personal information in connection with orders or subpoenas.

While federal law allows IMWT and health care providers to use and disclose your personal information and treatment, payment, and health care operations, the law requires these providers to obtain your written consent to do so. Therefore, the first time you see an IMWT participating physician, once the federal rules take effect, the participating physician will ask you to sign a consent form allowing the physician to use and disclose your personal information in connection with your treatment, the payment for your treatment and the physician's health care operations.

IMWT is also allowed by law to use and disclose your personal information without your consent or authorization for the following purposes:

1. When required by law.
2. For public health activities, such as reports about communicable disease or work-related health issues.
3. In reports about child abuse, domestic violence, or neglect.
4. For health oversight activities, such as reports to governmental agencies that is responsible for licensing physicians or other health care providers.
5. In connection with court proceedings before administrative agencies.
6. For law enforcement purposes, such as responding to a court order or subpoena.
7. In reports to coroners, medical examiners, or funeral directors.
8. For tissue or organ donation.
9. For research, with the approval of certain oversight entities; otherwise, use and disclose of your personal information requires your authorization.
10. To avert a serious threat to the health or safety of a person or to the public.
11. For national security and intelligence activities, including the protection of the president.
12. In connection with the services provided under workers' compensation laws.

SIGN PAGE 2

IMWT may disclose your personal information to your family members if it is vital to your health care and well-being.
All other uses and disclosures of your personal information will be made by IMWT only with your written authorization.

Access to personal information

As a matter of federal and state laws, you have the right to review and copy your personal information received and retained by IMWT. If you desire to access to your personal information, you must notify IMWT in writing. We will respond to your request and provide a place and time within business hours for your inspection with a staff member present during review. If you request a copy of the information held by IMWT a copy can be provided. We reserve the right to charge a reasonable administrative fee for copying your personal information as allowed by law.

Right to amend personal information

State and federal law allows you the right to amend your personal information held by IMWT. A request to amend your personal information must be submitted to IMWT in writing as well as your health plan. The amendment must be no longer than 250 words in length. IMWT will attach your amendment to the record of your personal information. Your amended personal information will be made available for your review upon request.

Right to request restriction on disclosure of personal information

State and federal law permits you to request restrictions on the use and disclosure of your personal information by IMWT. IMWT reserves the right to accept or reject your request for restriction. All requests must be made in writing. Upon receipt IMWT will review the request and notify you of the decision to either accept or reject the request. Even if IMWT agrees to honor your request to restrict IMWT uses and disclosures of your personal information, IMWT may cease to honor that restriction without your consent, upon notice to you. In that event, IMWT will continue to honor the request for a restriction in connection with all personal information, which IMWT received or created prior to termination of the restriction. However IMWT will not be obligated to honor the restriction after it provides you notice that it will cease to do so. If you agree to terminate, then IMWT may disclose and use all of your personal information in its possession in accordance with applicable law. All requests for your restriction which are agreed by IMWT will be made part of your personal information and be made available for your review upon your proper request.

Right to confidential communications

You have the right to request that IMWT provide your personal information to you in a confidential manner. For example, you may request that IMWT send your personal information by alternate means or to an alternate address, such as by telephone to a different telephone number or to an office address rather than your home address. Also, you may, for example request that your personal information be sent in a sealed envelope rather than on a postcard.

Right to complain

IMWT is obligated to comply with the privacy practices set forth in this notice. If you believe that an IMWT physician has violated this privacy, contact your health plan, the California Department of Managed Care or the United States Department of health and Human Services office of civil rights.

Rights reserved by IMWT

IMWT reserves all of the rights expressed above. IMWT further reserves the right to amend or change the terms of this notice at any time and to make the provisions of the new notice effective for all personal information we maintain. You may request updates to this notice.

THIS NOTICE IS EFFECTIVE IMMEDIATELY

- ○ I have read the notice of privacy practices (HIPAA).

Patient Name: _____ D.O.B _____

Patient Signature: _____Date: _____

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NO SHOW POLICY

Our office has "No Show" policy for all of our patients. If you have an appointment scheduled with our office and will be unable to keep the appointment we require a 24 hour in ADVANCE notification by phone or email. We ask that you abide by this so we may free up space for patients who may need urgent appointments.
As part of our "No Show Rule " in our office , if a patient missed 2 scheduled appointments and failed to contact our office with at least 24 hours notice prior to the appointment we may ask you to seek care from another provider.

Additionally for each appointment that is NO SHOW there will be a charge of $25.00 for a REGULAR VISIT and $50 for an EXTENDED APPOINTMENT (Nutrition, Physical/PAP, Functional Medicine, Biopsy, Diabetic Education, Paperwork, Classes, ER follow-up, Pre-ops and more…EFFECTIVE IMMEDIATELY.

PAYMENT WILL BE DUE IMMEDIATELY AND MUST BE PAID BEFORE NEXT APPOINTMENT

We ask for your cooperation in this matter we make every effort to accommodate our patients the best we can and we hope that this information will allow patients to cancel in a timely fashion.

If you are more than 5 minutes late, you will be asked to reschedule.

Thank you,
Katherine Bisharat, M.D.

Patient Name _____

D.O.B._____

☐ I have been provided a copy of the no show policy. A copy will be available to me at any time if needed.

Patient Signature_____Date_____

Staff Witness _____Date_____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name:_____ **DOB:**_____

From: Pursuant to the Health Insurance Portability and Accountability Act (HIPPA), I hereby authorize the following provider:

PREVIOUS PHYSICIANS NAME: _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: ( ) _____ **FAX: ( )** _____

TO: To disclose to the party listed below:

PHYSICIANS NAME: **KATHERINE BISHARAT, MD**

ADDRESS: **6815 Fair Oaks Blvd**

CITY: **CARMICHAEL** **STATE:** **CALIFORNIA** **ZIP:** **95608**

TELEPHONE: **(916)481 - 4389** **FAX:** **(916) 481 - 4307**

WHAT: The following protected Health Information:

- ☐ ALL MEDICAL RECORDS INCLUDING INFORMATION REGARDING THE FOLLOWING CONDITIONS:
  - Pap Smear
  - Mammogram
  - Colonoscopy and/or FOBT
  - Blood work
- ☐ ALL MEDICAL RECORDS GENERATED AT OFFICE DURING DATES FROM: TO:
- ☐ ONLY RECORDS AS SPECIFIED:
- ☐ Substance Abuse
- ☐ Psychological Conditions
- ☐ HIV/Aids
- ☐ Billing Information

WHAT:

☐Moving Out Of Area
☐Changing Physicians
☐Specialty Care

I understand this protected health information is being used by the facility for the purpose of providing healthcare or to pursue and receive reimbursement of claim from any and all responsible third parties, as allowed in the subscriber's health plan or insurance policy. This authorization shall be in force and remain in effect 1 year from the date signed below unless I indicate otherwise. I understand that, as set forth in the privacy notice, I have the right to revoke this authorization in writing at any time by sending written notification to Internal Medicine and Wellness Therapies. I understand that my revocation of this authorization will not affect any actions taken by Internal Medicine and Wellness Therapies in reliance on this authorization prior to the time it received my revocation. I understand that I have the right to receive a copy of this authorization upon request.

- **SIGNATURE** _____ **DATE** _____

- **IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE RELATIONSHIP AND AUTHORITY:** _____

- **PRINT NAME OF PERSONAL REPRESENTATIVE:** _____

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I, PATIENT LISTED BELOW, agree to take full and complete responsibility for knowing and understanding my insurance plan benefits, that include, but not limited to deductibles, copayments and co-insurance prior to my consultation, office visit or procedure. I am also responsible for verifying that my primary care and/or specialist are participating providers of my insurance and that any laboratory or other tests and services are covered by my insurance. If any service is not covered by my insurance plan, I will pay all charges.

I agree to pay all copayments at the time of service, as required by my insurance and by this office. If not, my appointment may be rescheduled and an additional fee of $10 will be assessed.

I agree that if my insurance plan is not valid or coverage is terminated at the time of service, I am solely responsible to pay the office visit and/or procedure.

I understand that not all services, laboratory tests and orders are covered by insurance, but I will take full responsibility for verifying my coverage of such tests.

I agree to pay all unpaid bills for services rendered on my behalf and/or my dependents, including any fees assessed in the collections of a debt.

Print Patient Name _____D.O.B._____

Patient/Guardian Signature_____Date_____