Center for Integrated Health
203 Sycamore Valley Road West
Danville, CA 94582
925.838.2138
www.CarolBanyasMD.com

Intake Form

Name: ____ Today's Date: ___________________

Address: ____

City: ____________________State: _____ Zip: __________ Email: ______________________________

Date of Birth: ____________ Age: _______ Sex: M / F (Circle)

Home Phone: _____________Business Phone: ____________ Cell or Preferred Contact #: _____________

Is it ok to leave detailed messages on your voicemail?____

Occupation: ____________________________ Employer: _____________________________________

Emergency Contact: _______________________________________ Telephone: _____________________

Do you grant permission to discuss your medical care with your emergency contact? Yes/No

Credit card type (please circle one) VISA MASTERCARD AMERICAN EXPRESS

Credit Card #____ Expiration Date_____________________

Security Code on Back of Card___________________________Billing ZipCode____________________

-Payment is due at the time of service. Insurance coverage is not accepted, however, you may file with your insurance for reimbursement if this is available to you. We are not a Medicare Provider and are unable to issue SuperBills for reimbursement for submission to Medicare. If you arrive for your appointment without payment, your credit card on file will be charged. A $25.00 service fee will be placed on all returned checks.
-Cancellation Policy - Please provide notice 72 business hours in advance if you need to cancel or reschedule an appointment. No shows or less than 48 hours notice for cancellation will be billed the full cost of the visit.
-Office hours are by appointment only. We are closed on Monday and Friday. Please allow 24 business hours for a return phone call. If you are experiencing an emergency, please call 911 or head to your nearest emergency room.
-Medication refills are provided at the time of your appointment. You will be provided enough refills to carry you over until your next visit. Failure to keep scheduled appointments or complete necessary lab work may result in a delay for your refill. We do not process refills by phone - please call your pharmacy and request for them to fax us at 925-838-2138. Any controlled substance requires an office visit. **No Exceptions.** Please provide up to 72 hours for any refill requests.

I have read and understand the above policies, as verified by my signature below.

Signature____Date________________________________

Medical History

Reason for visit: ____

____

____

Current Medications and Supplements/Vitamins and Minerals: If more room is needed, please attach additional sheet of paper.

Medication Name	Dose	Reason for taking	Prescribing Doctor

Past Medications and Supplements/Vitamins and Minerals

Supplement Name	Dose (if known)	Reason for taking

Surgeries: ____

Hospitalizations: ____

Past injuries or accidents (What & When): ____

____

Do you or any family members have any of these illnesses? Please answer yes to any of the following that you are currently are experiencing or have experienced in the past. Please note any relevant information in the column to the right including dates, type, cause (if known), specific diagnosis, treatment, and family history. If you do not have exact dates, please give an approximate time period, such as, "in my 30's"

Depression___________________________________
Anxiety____
High Blood Pressure: __________________________
Heart Disease: _______________________________
Diabetes: ____________________________________
Thyroid Problems: _____________________________
Depression: __________________________________
Mental Illness: ________________________________
Epilepsy (Seizure): ____________________________
Parkinson's ___________________________________
Obesity: ______________________________________
Tuberculosis: __________________________________
Hepatitis: _____________________________________
Allergies: _____________________________________
Sleep Disorder: _________________________________
Vascular Problems/Blood clot or Stroke:___________
Ovarian Cyst___________________________________
High Cholesterol_______________________________

Bipolar Disorder_________________________________
Schizophrenia___________________________________
Crohn's/Ulcerative Colitis: _______________________
Arthritis: ______________________________________
Asthma: _______________________________________
Fibromyalgia/Chronic Fatigue ____________________
Alzheimer's/Dementia: ___________________________
Anemia: _______________________________________
Liver Disorder: __________________________________
Sexually Transmitted Disease: _____________________
Kidney Disorder: _________________________________
Urinary Disorder: ________________________________
Addiction: ______________________________________
Cancer or Tumors_________________________________
Unexplained weight loss or gain____________________
Uterine Fibroid___________________________________
Eating Disorder___________________________________
Other____

Lifestyle Habits (please list if appropriate how much/day):

Alcohol: ________________________ Caffeine: __________________________ Tobacco: ________________________

Nutrition: Please list what a typical meal consists of:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Dessert: ____

Beverages (including how many cups/ounces per day you drink): ___________________________________

Any known food sensitivities: ____

Any food cravings (types): ____

Exercise:

Type: ____

Times per week: _____________ Duration of Workout: ______________________Do you break a sweat? __________

Women's Health:

Date of last menstrual period: ___________________________ PMS symptoms: ______________________________

Contraception (if any list method): ________________________ Vaginal Discharge: ____________________________

Menopausal/Menstrual cycle systems: ____

Last Pap: ________________________________ Any abnormal Pap's: ________________________________

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HIPAA NOTICE OF PRIVACY PRACTICES

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities may include calling you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Lay, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance or on the use of disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to select another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services is you believe your privacy rights have been violated by us.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgment that you have signed this Notice of Privacy Practices:

Signature ____ Date _____________________

Printed Name____

Center for Integrated Health
Carol Banyas M.D., Ph.D.
203 Sycamore Valley Road West
Danville, CA 94526
925.838.2138

Patient Informed Consent

I understand that as a patient at The Center for Integrated Health, I may receive a range of mental health and wellness services including conventional allopathic treatments, alternative/complimentary medical treatments and psychotherapy. The type and extent of services that I receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me.

I consent to participate in the evaluation and treatment offered to me by Carol Banyas M.D., Ph.D. I understand that either The Center for Integrated Health or I may discontinue treatment at any time.

I understand that while each recommended treatment may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications or supplements may have unwanted side effects.

Though my provider will do his/her best to fully advise me on the pros and cons of each treatment option, I understand that it is also my responsibility to voice any concerns and ask questions if I am confused about any of the recommended therapies. I acknowledge that there is no guarantee of the outcome and/or that a given treatment will be effective for me personally.

I consent to participate in the evaluation and treatment offered to me by Carol Banyas M.D., Ph.D. I understand that either The Center for Integrated Health or I may discontinue treatment at any time.

If I have any questions regarding this consent form or about the services offered at The Center for Integrated Health, I will discuss them with Dr. Banyas. I have read and understand the above.

Patient Signature: ______________________________________

Patient Name (printed)___________________________________

Date____

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Agreement for Arbitration

Arbitration means you waive your right to a jury trial. Due to the high costs of medical malpractice insurance and litigation, this office requires every patient sign an arbitration agreement. This means that all potential disputes are resolved through arbitration and not in court. This is mandatory for anyone who chooses to be a patient in our practice.

ARBITRATION AGREEMENT
Agreement between the patient signed below (or patient's designated guardian) and the clinicians of our practices: In the event of a dispute of any nature arising between the parties or their heirs at any time, as a result of clinicians providing medical services, advice, treatment, informed consent, prescriptions, tests and procedures whether in person or by phone, text, writing, internet, in the home, office, hospital or otherwise: The parties hereto agree to submit the dispute to binding arbitration under the rules of the Independent American Arbitration Association. An award rendered by the arbitrator(s) shall be final and binding upon the parties, and judgment on such award may be entered by either party in the highest court having jurisdiction. Each party hereto specifically waives his/her right to bring the dispute before a court of law and stipulates that this agreement shall be a complete defense to any action instituted in any local, state or federal court or before any administrative tribunal. The patient represents that he/she is giving his/her consent knowingly and voluntarily without any element of force, deceit duress or other form of constraint or coercion, with a general knowledge of the medical and psychiatric procedures outlined above, is aware of the circumstances and is physically and mentally competent to give consent.

Patient Signature: ____________________________Date: ___________________