Dr. Matthew Castanho

Naturopathic Physician
Fitness Specialist
Nutritionist
1622 Main Street, East Hartford, CT 06108
Tel: 860.470.6791
Email: drmcastanho@gmail.com
www.DrCastanho.com

Dear Patient: Please **PRINT and FILL OUT** this questionnaire and bring it with you for your appointment on:

_____ at _____ AM/PM

PATIENT INFORMATION FORM

Name: _____Date of First Visit: _____

Address: _____

City: _____State: _____Zip Code: _____

Tel. # (cell): _____(home): _____(work): _____

Email: _____

Age: _____ Date of Birth: _____ Sex: Female☐ Male☐

Social Security Number: _____

Married☐ Separated☐ Divorced☐ Widowed☐ Single☐ Partnership☐

Live with: Spouse☐ Partner☐ Parents☐ Children☐ Friends☐ Alone☐

Student Status: Non-student☐ Part-time☐ Full-time☐

School Name: _____

Occupation: _____Hrs per week: _____Retired☐

Employer: _____Work Address: _____

How did you hear about our clinic? _____

Has any other family member already been a patient at the clinic? _____

In case of emergency, contact: _____

Relationship: _____Phone #: _____

Address: _____

HEALTH HISTORY QUESTIONNAIRE

Have you ever received Naturopathic care? If yes, with whom and when?

_____

Please List Specific Health Concerns in **Order of Importance** to you:

1. _____

Date Began: _____

What makes it better?_____ Worse? _____

Have you seen other health care providers for this? Yes☐ No☐

If yes, what medications or treatments were given? _____

_____

2. _____

Date Began: _____

What makes it better?_____ Worse? _____

Have you seen other health care providers for this? Yes☐ No☐

If yes, what medications or treatments were given? _____

_____

3. _____

Date Began: _____

What makes it better?_____ Worse? _____

Have you seen other health care providers for this? Yes☐ No☐

If yes, what medications or treatments were given? _____

_____

Do you have any opinions regarding what may have **caused** your health concerns?

_____

_____

How much effort are **you** willing to put into getting better?

None 0 1 2 3 4 5 6 7 8 9 10 **Whatever it takes**

Do you have any known **contagious diseases** at this time? Yes☐ No☐

If yes, what? _____

Allergies (Medicine, Food, Environmental): _____

_____

Please list any **hospitalizations or surgeries** with **dates**: _____

_____

_____

Please indicate: **SELF** or a **RELATIVE** have experienced any of the following:

☐ Alcoholism_____
☐ Allergies _____
☐ Anemia _____
☐ Arthritis _____
☐ Asthma _____
☐ Autoimmune disorder _____
☐ Cancer _____
☐ Depression_____
☐ Diabetes _____
☐ Eczema _____
☐ Glaucoma _____
☐ Gout _____
☐ Hay fever _____
☐ Heart attack _____
☐ Heart disease _____
☐ Hemophilia_____
☐ High blood pressure _____
☐ High cholesterol_____
☐ Mental health condition _____
☐ Migraines _____
☐ Obesity _____
☐ Osteoporosis_____
☐ Other addiction_____
☐ Psoriasis _____
☐ Seizures _____
☐ Fibrocystic breast_____
☐ Stroke _____
☐ Suicide attempt_____
☐ Thyroid disorder_____

CURRENT MEDICATIONS

Do you take or use? Please check all that apply

Laxatives☐ Pain Relievers☐ Antacids☐ Cortisone☐ Appetite Suppressants☐

Antibiotics☐ Tranquilizers☐ Thyroid Medication☐ Sleeping Pills☐

Please list ANY **prescription**, **over-the-counter medications**, **vitamins**, or other **supplements** you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please indicate any of the following:

☐ Smoke How long: _____ Number/day: _____

☐ Alcohol Type: _____ How often: _____

☐ Caffeine What drink: _____ How often: _____

☐ Sugar How much: _____ How often: _____

☐ Artificial sweetener Type: _____ How often: _____

☐ Exercise Type: _____ How often: _____

☐ Food cravings What: _____ How often: _____

☐ Sleep problems Type: _____ How often: _____

☐ Weight changes Gain ☐ Loss: ☐ When: _____

☐ Diet restrictions What: _____

Which of the following treatments are you interested in specifically?

☐ Herbal medicine ☐ Clinical nutrition ☐ Spinal manipulation ☐ Homeopathy

☐ Hormone balancing ☐ Detoxification ☐ Other: _____ ☐ No preference

I hereby consent that all above information is accurate, to the best of my knowledge, and agree to pay, in a timely manner, any and all fees incurred by services and supplements rendered by Dr. Matthew Castanho, ND. I recognize that Wholesome Place, Inc. does not participate with insurance plans and is an out-of-network practice. I am responsible for the consultation fees outlined on the website, www.drcastanho.com, and that prescribed supplements, out-of-network tests, and other services rendered by Dr. Castanho beyond that of the consultation fees are my responsibility.

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

NATUROPATH INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Naturopathy is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of naturopathic treatments including various procedures within the scope of the practice of naturopathy on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed naturopaths who now or in the future treat me while employed by, working or associated with, or serving as back-up for the naturopath named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that my naturopathy care may involve various modalities of treatment, which, subject to the limitations of the scope of practice of naturopathy, may include but not be limited to the following: Venipuncture, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that naturopathy is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: Bruising; numbness or tingling near the venipuncture or needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of may include nerve damage and organ puncture from acupuncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses, and may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my naturopath and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than naturopathy. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathy and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

PROVIDER NAME: Dr. Matthew Castanho, ND

(Date)

PATIENT SIGNATURE: **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

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 state and federal law, and not by a lawsuit or resort to court process, except as state and federal 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the healthcare provider and/or other licensed healthcare providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the healthcare provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at https://www.namadr.com or by calling 1-800-358-2550 to request a copy of the rules.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE