Patient Contact Information

Name: ____ Date: _________________

Name of Guardian(s) (if applicable) ____

Relationship of patient ____

Address: ____

City: _________________________________ State: __________________ Zip______________

Telephones: Cell: _________________________ Home: _______________ Work: ____________________

Email: ____

Would you like our newsletter? ___________

Age _____ Date of Birth ________________ Gender ___________

Marital Status _________________ Number of Children ______________

Occupation ________________________________ Hours per week _______________

PATIENT INFORMATION

Name *(Last, First, M.I.):*		**Today's Date**	
Address *(Street.):*		**Date of Birth**	
(City, State, Zip.):		**Occupation**	
Email		**Employer**	

Phone	H:	M:	W:

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children ***(Names, Ages)***		
EMERGENCY CONTACT INFO	**Name** *(Last, First, M.I.):*	
Phone	H:	M: W:
Relationship to Patient		

Primary Care Physician:		**Physician's Phone Number:**	
How did you hear about Newport Longevity Center?			

MEDICAL HISTORY

**Naturopathic Healthcare is possible only when the physician has the complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.*

Please comment about your major health and wellbeing concerns in order of importance to you. It will help if you include to what extent they affect your daily life now.

1.		**Date of Onset:**	
2.		**Date of Onset:**	
3.		**Date of Onset:**	
4.		**Date of Onset:**	

When and where did you last receive medical healthcare?	
For what reason?	

Medications & Supplements

Please list all prescription medications that you are currently taking, the doses and for what conditions:

Please list all natural supplements that you are currently taking, the doses and for what conditions:	

Personal Past & Current Medical History		
Please specify diagnosis	**Date of Onset**	**Treatments**
Have you undergone a course of antibiotics recently?		

General					
Height:		**Weight (lbs):**		**Weight 1 year ago:**	
Maximum Weight (lbs):			**When?**		

Hospitalizations, Surgery, Imaging			
What hospitalizations, surgeries, X-Rays, CT Scans, EEG, EKG have you had?			
Procedure	**Year**	**Procedure**	**Year**

Patient's or Authorized Person's Signature:

Patient Name (please print):	Patient Signature	Date
RESPONSIBLE PARTY: fill out if you are not the patient but are responsible for the bill.		

Responsible Party		**Relationship to Patient**	

New Patient Policies

Our goal at Newport Longevity is to provide you with the highest level of Naturopathic Medicine. We are committed to helping you on your journey to health and healing.

Forms: All relevant forms for you to fill out are available at our website www.newportlongevity.com

Fees: Your fees for service are dependent upon the level of service and individual components. All payments are due at the time of service. We accept cash, personal checks and all major credit cards. There is a $50 processing charge on all returned checks.

Appointment and Appointment Cancellation Policy: You may book your appointments at any time they are available. For cancellations, we require 24 hour notice, failure to do so will result in a missed appointment charge of $60. You may cancel by calling our office at 949-630-0304.

Insurance: We do not accept any insurance.

Medical Records: Medical records can only be released with your authorization. A medical release form can be found on our website.

Prescription Refill Requests: You can request prescription refills by calling Newport Longevity. It may take up to 72 hours to process refills. Please plan ahead.

Emergencies: In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room. Newport Longevity Center does not maintain regular on-call on nights or weekends

Scope of Practice: Newport Longevity does not provide primary care medicine; you are required to have a primary care doctor.

You are aware that any therapy, no matter how well appointed may not achieve desired results in resolving your situation and improving your health

You are aware that our preferred method of communication is by phone or voicemail not email or text messages.

You will be informed of conventional and alternative therapies relevant to your situation

You have the choice to accept, refuse or terminate any or all therapies at any time

You agree to implement the agreed upon therapies exactly as instructed

You are responsible for seeking professional medical attention from Newport Longevity or another medical professional if your condition worsens

You are aware that improvements in health and well-being require on-going care and agree to follow up visits and additional treatments

You are aware that you may be referred to another doctor for additional treatment as needed

You agree to follow up appointments every three months to safely monitor your hormones or as recommended by your doctor.

I, ____ have read and understand the above and by signing below I agree to abide by the policies of Newport Longevity.

_______________________________________ Date: _____________

Signature

Consent for Naturopathic Treatment

Newport Longevity
2000 Harbor Blvd C-100
Costa Mesa, CA 92627
949-630-0304 phone949-630-0330 fax

I, _________________________ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor where signatories to this form or not. I have also read and understand the attached NOTICE OF Privacy Practices, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but not limited to nutritional counseling, western herb, homeopathy, nutritional supplements, oral chelation, hydrotherapy, injections and IV therapies.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of the practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medications and nutritional supplement (which are from plant, mineral, animal and other sources) that have been recommended are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomach ache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from the emergency room or call 911.

I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of my treatment with the above named doctor and or clinic.

Patient Name: ____

Patient Signature: ____ Date: ______________

Relationship if Guardian: _____________________________________

You are entitled to a copy of this consent after it is signed and dated, please notify staff.

Newport Longevity Center

2000 Harbor Blvd C100

Costa Mesa, CA 92627

Credit Card Payment Authorization Form for New Client Consultation

Sign and complete this form to authorize Newport Longevity Center to make a one-time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account. Furthermore, this charge will be made even if you should miss your scheduled consultation.

Please complete the information below and fax this form to 949-630-0330:

I ______________________________ authorize Newport Longevity Center to charge my credit card

(full name)

account indicated below for $385.00 on or after ____________________. This payment is for

(date)

Hormonal/Nutritional/Homeopathic Consultation.

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name ____

Account Number ____

Expiration Date _____________

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) ______

Billing Zip code ______

SIGNATURE ____ DATE ____________________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form

Consent for Use or Disclosure of Health Information

Our Privacy Pledge

Section A: Patient giving consent

Name: _________________________________ for self or minor _________________________________

Section B: To the Patient: Please Read the Following Carefully

Purpose of Consent: By signing this form you will consent the use and disclosure of your protected health information to carry out your treatment, payment, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent.

Our notice provides a description of our treatment, payment, and healthcare operations, the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent.

We reserve the right to change our privacy practices as describe in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practice at any time on our website www.newportlongevitycenter.com

Right to Revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the above contact. Please understand that revocation of this consent will not affect action taken in reliance on this consent before receipt of your revocation, and that we may decline to treat you or continue treating you if you revoke this consent

I, _______________________________________ have had the full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to use and disclose any of my protected health information to carry out treatment, payment and healthcare operations.

____

Signature

____

Date

Doctor-Patient 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 California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the doctor including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the doctor(s) and the doctor(s)partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the doctor(s) to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata 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 or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately 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 which 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 California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.; Discovery shall be conducted pursuant to the Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

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 California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the doctor(s) with in thirty (30) days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date is Effective as of the date of first medical services. ______ (Patient Initials)

If any provision if 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 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 DEDIDE BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. (SEE ARTICLE 1 OF THIS CONTRACT)

____ Date: _____________________

Signature

If this consent is signed on behalf of the patient such as a legal guardian then complete the following:

Patient Representative Name: _________________________ Relationship to Patient: ____________________________________

A signed copy of this document is to be given to Patient/Original is to be kept in Medical Record Files