THE CENTER FOR NATURAL & INTEGRATIVE MEDICINE

KIRTI M. KALIDAS, M.D., N.D.
Board Certified Internal Medicine & Naturopathic Medicine

Welcome!

Thank you for choosing our office. Our goal is to truly integrate the best of conventional with natural medicine and guide you towards optimal health. We strive to provide our finest care and services in a professional, warm and supportive environment. We look forward to meeting with you and being able to provide a **"Bridge to health, hope, and healing".**

In order to maximize your time with the our doctors, please fill out all forms as soon as possible and mail, e-mail or fax back to our New Patient Coordinator. To secure your appointment we must receive these forms at least 48 hours before your scheduled appointment. If for any reason you feel you cannot complete these forms in time, please contact our New Patient Coordinator and we will accommodate you.

Email: drkkalidas@yahoo.com
Phone: (407) 355-9246
Fax: (407) 370-4774
Address: 6651 Vineland Rd, Suite 150
Orlando, FL 32819

By faxing or emailing your completed packet, you are acknowledging that you have read, understood, and agreed to our office policies.

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HEALTH HISTORY SUMMARY

Date: _____

Name: _____ Age: _____ Birth date: _____ Blood Type_____

Address: _____ City: _____ State: ____ Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax_____E- Mail_____

SSN: _____Married/ Single/ Divorced Male/ Female

Occupation: _____ Full or Part Time? Employer: _____

Nearest Relative: _____ Relationship: _____ Phone: _____

Who else can we reach?
In case of emergency? _____ Relationship: _____ Phone: _____

How did you hear about the Natural & Integrative Medicine? _____

Last physician or health practitioner seen? _____ When: _____

Date of last blood test? _____ What kind? _____

Your Current Health Problems

What is your main reason for coming in today? _____

_____

_____

How long has your main problem been troubling you?

_____

Describe the circumstances that led to your main health problem.

_____

List other health problems that are troubling you in order of importance: Length of time

1) _____

2) _____

3) _____

4) _____

Other problems: _____

What kind of treatment have you received and from whom?

_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem? _____ For any other problem? _____

What was the therapy and what were the results?

_____

_____

Your Health History

The general state of your health is: excellent ___ good ___ avg. ___ fair ___ poor ___, and on the average your energy level from 1 to 10 (with 10 being the highest) is: _____

At what time of day is your energy the best? _____ Worst? _____

What is your current approximate weight? _____ Height? _____ Weight one year ago _____

As an adult what has been your maximum (excluding pregnancy) _____ and minimum weight _____

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? _____

1) _____ date _____

2) _____ date _____

3) _____ date _____

4) _____ date _____

5) _____ date _____

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? _____ Have you in the past? _____ If so, when? _____

Are you currently working with a Doctor of conventional medicine? (M.D. or D.O.) _____

What childhood illnesses have you had?

___Measles	___Mumps	___Chickenpox	___Whooping Cough
___Polio	___Diphtheria	___Rheumatic Fever	___Scarlet Fever
___Smallpox	___Typhoid Fever	___Tuberculosis	___Mono - how long _____

Previous surgeries and hospitalizations (include dates)

_____
_____
_____

Which of the following have you had? Indicate *now* or *past* as well as how often and date.

Now or Past		Year	Now or Past		Year	Now or Past		Year
_____	Pneumonia	_____	_____	Diabetes	_____	_____	Gonorrhea	_____
_____	Tonsillitis	_____	_____	Asthma	_____	_____	Venereal Disease	_____

_____	Chronic Ear Infections _____	_____	Eczema _____	_____	Syphilis _____
_____	Chronic Infections _____	_____	Heart Disease _____	_____	Epilepsy _____
_____	Canker Sores _____	_____	Herpes _____	_____	High Blood Pressure _____
_____	Allergies _____	_____	Hepatitis _____	_____	Nucleosis _____
_____	Thyroid Problems _____	_____	Weight Problems_____	_____	Anemia _____

Do you have any allergies to any drugs, herbs, foods, animals or other? _____ If yes, please describe.

_____

Which of the following do you currently use?

	Amount (how often, how much and how long)		Amount (how often, how much and how long)
Alcohol	_____	Tobacco	_____
Hormones	_____	Coffee	_____
Cortisone	_____	Laxatives	_____
Sedatives	_____	Antacids	_____

Other Medications (please give full name, dosage and how long you have been taking the medication)

_____

_____

_____

Vitamins/Herbs _____

_____

Family History

Please list ages, health problems and cause of death if deceased

	Living (age)	Health Problems	Deceased (age)	Cause
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Grandparents				
Maternal Grandmother	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____

Paternal
Grandmother_____ _____ _____ _____

Paternal
Grandfather _____ _____ _____ _____

What is your nationality? Please list all backgrounds and give approximate percentage

_____

You currently live with? Spouse ____ Partner ____ Parents ____ Friends ____ Children ____ Alone

Are you? Married _____ Separated _____ Divorced _____ Widowed ____ Single ____ In a Supportive Relationship

What is your current level of education? _____ Are you satisfied with this? _____

Do you have any children? _____ How many? _____ Ever had Toxemia during pregnancy? _____

Do your children have any health problems? _____

Do you have any blood relative (aunt, uncle, sibling, parent, grandparent) who has had any of the following?

___Allergies ___Arthritis ___Asthma ___Cancer ___Diabetes ___Anemia
___Depression ___Skin Disease ___Heart Attack ___Genetic Prob. ___High B.P. ___Stroke
___Ulcers ___Cataracts ___Thyroid Prob.___Hypoglycemia ___Seizures ___SickleCells
___Venereal Disease

What is your weakest organ system and why? _____

Personal Habits

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry about most in life? _____

Do you exercise? _____ If yes, what kind, how much and how often? _____

Do you have a religious or spiritual practice? _____ If yes, what? _____

On a scale of 1 to 10 (with 10 being great), how would you rate the quality of your sleep? _____

Do you have problems falling or staying asleep? _____ How many hours do you sleep at night? _____

Do you wake up at night? _____ If yes, what time(s) do you usually wake up? _____

Do you ever sweat while sleeping? _____ How frequently and how much do you sweat? _____

Do you wake up feeling refreshed? _____ Do you ever nap or rest horizontally? _____How long? _____

What do you normally feel like temperature wise compared to others? *Warmer Cooler Average*

What are the temperatures of your hand and feet generally? *Warm Cool Average*

Do you enjoy your work? _____ Do you take vacations? _____

Are you currently in a happy, satisfying relationship with someone? *Very Much Mostly Somewhat Not*

How often do you suffer from colds, the flu, sore throat, yeast infections throughout the year?

_____

When you rise quickly from a sitting or lying position, do you ever get dizzy? _____ How often?_____

Female Reproduction

Age of first menses _____ If periods have stopped, at what age did they stop?_____

Are your cycles regular? _____ Period begins every _____ days. How long are your periods? _____

Are your periods heavy *medium* *light* and what color is the blood light *red* *dark red* *medium* *clots*

Do you have any spotting or bleeding between periods? _____ Any cramps with period? _____

Do you have any premenstrual symptoms? *Water Retention* *Breast Tenderness* *Irritability* *Depression*

Headaches *Mood Swings* *Food Cravings*

Other _____

Number of pregnancies _____ Number of abortions _____ Number of live births _____

Number of miscarriages _____ Any problems getting pregnant? _____

Do you get yearly PAP smears? _____ Any abnormal PAPs? _____ Any breast lumps? _____

Are you currently sexually active? _____ How often? _____ Is this more or less than last year? _____

Do you use birth control? _____ What type of birth control do you currently use? _____

Have you ever been physically or sexually abused? _____ How old and how often? _____

Male Reproduction

How often do you have to get up at night to urinate? _____ Has this increased in recent years? _____

Any problems with impotency (getting or maintaining an erection)? _____ Any sores on penis? _____

Do you have any abnormal discharge from the penis? _____ Any venereal diseases? _____

Any prostate problems? _____ Ever have your prostate examined, if so, when? _____

Are you currently sexually active? _____ How often? _____ Is this more or less than last year? _____

Do you use birth control? _____ What type of birth control do you currently use? _____

Have you ever been physically or sexually abused? _____ How old and how often? _____

Digestion

Do you have any problems with gas, bloating or fullness after eating? _____ How often? _____

How severe? _____ Do you have gas in *upper abdomen* *lower abdomen* *both areas?*

How long have you had this problem? _____ How often do you have bowel movements? _____

Do you ever have any *blood* *mucus* *undigested food* *black* stools? Any rectal itching? _____

Do your stools tend to be *formed* or *loose*? How often do you have diarrhea? _____

Do you ever have alternating constipation and diarrhea? _____ How often do you have thin, long and narrow

stools? _____ How often do you have small and hard stools? _____

Do you ever have yellow or light colored stools, if so how often? _____

How often do your stools have a strong disagreeable odor? _____

Have you ever fasted? _____ Juice or Water? _____ For how long have you fasted? _____

How did you feel while you were fasting? _____

Have you traveled outside the US in last five years? _____ Have you been camping in last five years?_____

Kidneys and Bladder

Have you had recurrent bladder infections? _____ How were they treated? _____

How many bladder infections have you had in the last three years? _____

Have you ever had any burning sensation during or after urination? _____

Is your urine *dark yellow bright yellow cloudy pale clear*? Does your urine have a strong odor? _____

Do you have difficulty starting or stopping urination? _____ Do you have difficulty perspiring? _____

Do you perspire when you exercise? *Lightly Moderately Heavily* Do you perspire when not exercising?
If so, at what times? _____ Does your perspiration have a strong odor? _____

Does your body temperature tend to run lower *higher or average* compared to others? _____

Occupational/Household

How long have you lived at your present address? _____ Where have you lived previously?_____

Please describe location, if old or new construction, damp or moldy conditions, etc.

_____

Do you have specialized air filtration at home? _____ Do you live in the city? _____

Do you work in an office building? _____ Do the windows open? _____

Do you have specialized air filtration at your work place? _____

Do you work in the presence of toxic fumes or chemicals? _____

Do any of your hobbies involve toxic materials? _____

Are you currently exposed to second hand smoke? _____ Do you use *bottled filtered* or *tap* water?

Is there anything else you would like to comment on?

_____

_____

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CONSENT FOR TREATMENT, FINANCIAL POLICY AUTHORIZATION & ACKNOWLEDGEMENTS

AUTHORIZATION OF TREATMENT:

I, _____, hereby authorize medical treatment of myself or my minor child by physicians, medical assistants and staff at The Center for Natural & Integrative Medicine (CNIM).

NOTICE AS TO NATURE OF SERVICES: I seek the medical and health care services of the Center for Natural & Integrative Medicine, its employees and staff. I understand that this medical practice uses some diagnostic and treatment methods that some may consider holistic, complementary or alternative. Some of these methods have not been accepted by "mainstream" medicine. I understand that the principles of this practice are based on Naturopathy, a primary care health system, in which we believe that the body has an inherent ability to heal itself given the right tools. Treatment modalities provided by CNIM are based on functional and science based evidence.
Some of the characteristic qualities of medicine that are used in this practice include the following:

1. A person's lifestyle including his or her diet, exercise patterns, sleep habits and stresses are believed to be directly related to the development and maintenance of illness. CNIM will evaluate these factors and seek to help the patient give up negative life style patterns and establish more positive ones regardless of age or type of medical problem.

2. Although prescription and over-the-counter medications are used when the physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs.

3. In addition to recommending that a patient take nutritional supplements by mouth, it is sometimes recommend that a patient receive a series of injections either intravenously or by intramuscular injection. Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems), and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken by mouth.

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Initials

4. For some patients, we recommend homeopathy, based on appropriate history. It is based on the principle of "like cures like," and uses extremely tiny concentrations of animal, vegetable or mineral substances to stimulate the body's healing mechanisms. Although homeopathy is fairly well established in some European countries, India and other countries worldwide, it is generally not at all accepted by consensus mainstream medicine in the United States.

5. Because CNIM looks for imbalances in the body and for trends that may result in illness if not addressed, tests are sometimes ordered that may be considered by consensus mainstream medicine to be either unnecessary or of no value. These may include tests for nutritional status, such as blood levels of vitamins and minerals, hormone levels, test for heavy metals or tests for allergies.

6. CNIM feels that environmental factors may play a major role in health and disease. Some of the diseases of unknown cause maybe triggered or perpetuated by common environmental substances, many of which are man-made. Individuals may vary greatly in their susceptibility to various substances, so that one individual may be made deathly ill by an exposure to a substance while another is not at all affected. CNIM will attempt to identify offending substances and help patients to detoxify from past exposures that are affecting them.

7. CNIM very much believes in persons being involved in their own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. Consultations are encouraged with consensus mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.

8. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

9. Sometimes medications are used that are approved by the FDA to treat one condition; however, that same medication may be used for treatment that has not been FDA approved. Perhaps the best example is the use of EDTA chelation therapy to treat all forms of atherosclerotic cardiovascular disease and other degenerative diseases.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE: I understand that no physician or any other practitioner that I see at The Center for Natural & Integrative Medicine is acting as my primary care physician. As such, emergency services are not offered. I understand that even though my physician(s) and The Center for Natural & Integrative Medicine practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions that I may have.

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Initials

This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform The Center for Natural & Integrative Medicine of who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at The Center for Natural & Integrative Medicine in order to properly and safely coordinate my care.

NO GUARANTEES: I understand that CNIM does not make any representations, claims or guarantees that I will be helped with my medical problems or conditions by undergoing treatment at CNIM. However, CNIM will do their best to help me accomplish my healthcare and wellness goals.

REVOCATION OF AUTHORIZATIONS: These authorizations will remain active unless revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

NUTRITIONAL SUPPLEMENTS: I understand that CNIM makes nutritional supplements and other recommended products available. Many of these products are not available through retail outlets or the quality is superior to retail brands. These are provided for the convenience of patients. I am in no way obligated to purchase these products from this office. I am free to purchase any recommended supplements or other products from any source that I choose.

NOTICE TO MEDICARE PATIENTS: The doctors at CNIM have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at CNIM. I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said service(s).

CLAIM MANAGEMENT: My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.

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I understand I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent to me upon the availability of the appropriate documentation. CNIM does not typically send information directly to insurance carriers due to problems experienced with carriers misplacing claims. I am responsible for **the payment of services provided by CNIM in full at the time of service without regard to insurance coverage**. I am entitled to know the cost of all services and procedures in advance and I will ask if they are not told to me.

FINANCIAL INSURANCE RESPONSIBILITY FOR ALL SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit; The Center for Natural & Integrative Medicine does not accept assignment. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other parties responsible for coverage of my medical expenses because differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical diagnostic testing and/or services requested by my treatment practitioner(s). CNIM will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for CNIM to take action to secure payment of an outstanding balance owed. Charges are based on time spent in consultation with the physician and appropriate services rendered. The initial office cost is $375.00. Follow-up visits cost between $150.00 and $180.00 based upon the complexity of the visit and the time spent.

Full payment is expected at the time of services rendered.
Any and all past due patient balances will be collected before my appointment.

In addition to the fee for the office visit, the cost for lab work or other specialized testing deemed appropriate to my case will be applied to my balance.

Questions are always welcome. Most of the labs and testing done at the CNIM office are more specialized. The discussion of these labs and test results are usually in-depth and lengthy. Therefore a follow-up appointment is usually scheduled. If an office visit is not possible, a telephone consultation may be scheduled, which will be billed in a manner similar to a follow-up visit – according to complexity and time spent.

Our practice is committed to providing the best treatment for patients. All appointments are considered confirmed at the time they are made. I will receive one courtesy call as a reminder of the appointment. **Because a substantial amount of time has been set-aside for me, I will be charged a $125.00 fee for a missed new appointment and $50.00 for follow-up appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.**

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Initials

PATIENT ACKNOWLEDGEMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party. I have read, understood and agree to the foregoing. I understand that I have the right to review this consent with a lawyer if I choose before accepting any medical services from The Center for Natural & Integrative Medicine. I have executed this consent freely and willingly understand its provisions. I recognize that CNIM will rely upon my signing of this document in accepting me as a patient. I acknowledge receipt of a copy of this consent if I have requested it.

I do hereby acknowledge that by signing this statement of understanding that I acknowledge and understand that some, and perhaps all, of the medical, preventative, nutritional, and diagnostic services provided at the Center for Natural & Integrative Medicine on or after the date of my signing this statement may be innovative, non-traditional or unconventional. (Definition: services that are not necessarily recognized by traditional medicine, some physicians, some 3rd party purveyors of the AMA, as acceptable testing/evaluation techniques and/or medical and nutritional recommendations or therapies).* I also understand that these unconventional services may be viewed by 3rd party insurance purveyors as non-covered services, in that they might be considered unreasonable or unnecessary under any medical insurance program. I also realize that my insurance coverage may not pay for such uncovered services and that I will be personally responsible for payment to The Center for Natural & Integrative Medicine to take action for the purpose of recovering any sum of money owed for services rendered, I understand that I will pay all costs including reasonable attorney fees, should that become necessary. I understand that all outstanding balances bear interest at the maximum rate allowed by law.

I understand that my signature is consent for any and all treatments offered and given to me or my minor child at CNIM and that I will not be required to sign individual consent forms or any treatment received at The Center for Natural & Integrative Medicine.

Signature of Patient or Responsible Party:_____

Patient Name:_____

Date:_____

Witness: _____

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RELEASE OF CONFIDENTIAL INFORMATION

_____
(Initials)

This is to inform you that due to Federal Law (HIPAA), effective April 15, 2003, we may only release medical information to the following:

1.) Healthcare providers involved in your care
2.) Insurance companies to secure payment
3.) Laboratories involved in your care
4.) Attorneys with your permission
5.) Friends/family and/or others you specify below:

_____
_____
_____
_____

_____
(Initials)

Appointment reminders and any information regarding your treatment may be called to (check below):

_____My home or answering machine
_____My office or voice mail
_____Other_____

_____
(Initials)

A copy of "Notice of Privacy Practices" is available for your review.

_____
Print Patient Name

_____ _____
Patient Signature Date

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PATIENT INFORMATION

Date: _____

Name: _____ Age: _____D.O.B:_____

Address: _____City_____State:_____Zip:_____

Home#:_____Work#:_____Cell#:_____

Fax#:_____ E-Mail:_____SS#:_____

Martial Status: Single Married Divorce Gender: Male Female

Occupation: _____Employer:_____

Nearest Relative: _____ Phone #:_____

Emergency Contact: _____ Phone#:_____

How did you hear about us? _____

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICES RENDERED

I have read, understand and agree to the following:
Please initial in each space

( ) 1. Acknowledgement of the Center's office policies
( ) 2. HIPPA Rules and Regulations
( ) 3. Consent for Treatment, Financial Policy Authorization & Acknowledgements
( ) 4. Because a substantial amount of time has been set aside for me, I will be charged a $125.00 fee for a missed new appointment and $50.00 for missed follow up appointments. I understand that I need to call the office 48 hours in advance if I cannot keep the appointment in order to avoid this charge.
( ) 5. I understand that I am providing the center with my credit card information below that the center will be keep on file in order to secure my appointment time. I also agree that the center has my authorization to charge my card in the event that I do not give them adequate notice to cancel or reschedule my appointment as per office policy. I understand that my credit card information will only be used as stated above.

Name on Credit Card: _____ Account Number: _____
Card Code: _____ Expiration Date: _____

Signature of Patient or Responsible party: _____Date:_____

Witness: _____ Date: _____

Meta-eHealth.com, a division of Metagenics, Inc., offers a personal health information service through its Web site at www.meta-ehealth.com. Through this service, you may have access to limited amount of information about yourself including information that relates to your treatment by your healthcare practitioner ("Personal Health Information").

How does the Personal Health Information Service work?

Following your first visit to your healthcare practitioner after you enroll for the personal health information service, your practitioner will send your Personal Health Information to Meta-eHealth.com for posting on the personal health information service area of the Web site. Thereafter, your Personal Health Information will be updated by your practitioner as necessary, to reflect changes in your treatment. The Personal Health Information service area is structured to allow you to access your Personal Health Information through use of a personalized password created by you. Following enrollment, Meta-eHealth.com will send to you, via electronic mail, a temporary password to be used for your first visit to the Personal Information Service area. You may keep that password or personalize it. You will be asked to enter your password for all future visits to the Personal Information Service area. In order to protect the privacy of your Personal Health Information, you are responsible for keeping both your temporary and personalized passwords confidential. Please see the Privacy Policy on the Web site for details of how Meta-eHealth protects your personal information. If at any time you decide to terminate your enrollment in the personal health information service, your Personal Health Information will be deleted from the Web site and no record of your Personal Health Information will be maintained.

The personal health information service is offered free of charge to persons receiving care from participating practitioners. In some cases, your practitioner may recommend that you purchase specific therapeutic products that may be available through the Web site. If so, you may access the online store through the Web site and order products which will be shipped directly to you or your practitioner.

If you would like to enroll in the personal health information service, please read the Sign-Up Form carefully. If you are in agreement with its terms, complete the requested information and then sign and date the Sign-Up Form.

Meta eHealth™
www.meta-ehealth.com

SIGN-UP FORM

Please tell us about yourself			**Your healthcare practitioner**		
first name	last name		first name	last name	
street address		apt/unit	office address	suite/unit	
city	state	zip	city	state	zip
email address					

By signing below, you confirm that:

1. You wish to enroll in the Personal Health Information Service offered through Meta-eHealth.com Website, which is a secure, encrypted Web site operated by Meta-eHealth.com, a division of Metagenics, Inc.
2. You understand that the above-mentioned healthcare practitioner will send Meta-eHealth.com information provided by you to your practitioner on Meta-eHealth forms ("Personal Health Information"), and that Meta-eHealth.com will post such information on the Web site, in an area to which access is restricted through use of a password.
3. You authorized the above-named practitioner to disclose to Meta-eHealth.com and its business partners your Health Information for the exclusive purpose of providing you with the Personal Health Information Service.
4. You grant to your practitioner and to Meta-eHealth.com and its business partners only the right to receive, retrieve, and store your Personal Health Information, including information which may be privileged and confidential under the laws of any jurisdiction, in connection with the operation of the Web site and the provisions of the Personal Health Information Service. Your Personal Health Information will not be disclosed to any third party except as authorized by you or as required by law.
5. You understand that your initial access to your Personal Health Information will be through a temporary password sent to you by Meta-eHealth via electronic mail and that subsequent access will be through use of a personalized password created by you. You understand that you are responsible for maintaining the confidentiality of your passwords.
6. You understand that your Personal Health Information will be confidential between your practitioner, you, Meta-eHealth and its business partners; however, you acknowledge that your Personal Health Information may be disclosed by Meta-eHealth if required by law. Please see Meta-eHealth's Privacy Policy on the Web site for details of how Meta-eHealth protects your personal information.
7. YOU UNDERSTAND THAT YOUR USE OF THE PERSONAL HEALTH INFORMATION SERVICE AND THE WEB SITE IS INCLUDING, WITHOUT LIMITATION, DISCLAIMERS AND EXCLUSION OF LIABILITY.
8. You understand that you may choose to terminate your enrollment in the personal health information service at any time by information your practitioner and by informing Meta-eHealth via electronic mail. If your enrollment in the personal health information service terminates, you understand that your Personal Health Information will be deleted from the Web site and that no record of your Personal Health Information will be maintained by Meta-eHealth. Your enrollment in the Personal Health Service may also terminate if you terminate your relationship with your practitioner, or if your practitioner terminates his/her relationship with Meta-eHealth.

witness signature

witness name (please print)

signature

date

patient's guardian/representative

relationship to patient

date