

REVIEW OF SYSTEMS: Circle only the ones you NOW have or have had RECENTLY

General Weakness Fatigue Fever Chills Night Sweats Fainting	Skin Color Changes Nail Changes Hair Changes Moles/Warts Rashes Itching Sores Dryness	Head Headaches Injuries Bumps Last Eye Exam _____ Glasses Contacts Cataracts	Eyes Blurred Vision Glaucoma Redness Itching Burning Swelling Pain Dryness Tearing	Ears Hard of Hearing Deafness Ringing Discharge Earache Itching Loss of Balance Dizziness Room Spins	Nose Decreased Smell Bleeding Pain Discharge Obstruction Post Nasal Drip Deviated Septum Runny Nose Sinus Congestion	Mouth Bleeding Gums Sores Dental Problems Pain Bad Breath Loss of Taste Dry Mouth Ulcers Blisters	Throat Soreness Bad Tonsils Hoarseness Pain Trouble Swallowing Recurrent Infection Voice Problems	
Neck Enlargement Stiffness Soreness Lumps Masses	Breasts Discharge Lumps Pain/Tender Bleeding Nipple Changes Skin Changes	Lungs Cough Phlegm Blood Short of Breath Wheezing Pain Congestion Inhalant Exposure	Heart Murmur Palpitations Rapid Heartbeat Swollen Extremities Cold Extremities Chest Pain Pressure Varicose Veins Blood Clots Blue Extremities	Blood Anemia Low Blood Iron Easy Bruising Easy Bleeding Swollen Nodes Painful Nodes Sugar in Blood Red Spots	Gastrointestinal Abdominal Pain Nausea Vomiting Bloating Belching Heartburn Indigestion Irregular Bowel Habits Constipation Diarrhea Gas/Flatulence Hemorrhoid Hernias Poor Appetite Food Intolerance Blood Stools Black Stools			
Genitourinary Urgency Incontinence Staining Back Pain Frequent Voiding Stones Burning Blood/Urine			Gynecological Spotting Between Periods Menstrual Cramping Spotting After Periods Discharge Itching Painful Intercourse Irregular Periods Hot Flashes Pain Between Periods Contraception (Type) _____ Age of First Period _____ Age of Menopause _____ Duration of Cycle _____ Duration of Flow _____ No. of Pregnancies _____ No. of Births _____ No. of Miscarriages/Abortions _____ Nausea of Pregnancy _____				Menstrual Flow: Heavy Moderate Light Last Period: _____ Last Pap: _____ Last Mammo: _____	
Musculoskeletal Muscle Pain Muscle Weakness Muscle Cramps Joint Stiffness Joint Pain Joint-welling		Neurological Seizures Vertigo Dizziness Tingling Memory Loss In Coordination Loss of Facial Expressions Weak Grip Paralysis Difficulty of Speech Hand Trembling Numbness Loss of Sensation		Psychiatry Hyperventilation Insecurity Depression Troubled Sleep Irritable Anxiousness Undecidedness Timid		Endocrine Hallucinations Loss of Memory Alcoholism Drug Addiction Drug Dependency Suicidal Thoughts Extreme Worry Sexual Problems Weight Loss Weight Gain Hoarseness Heat Intolerance Cold intolerance Breast Changes Hair Changes Extreme Thirst Voice Changes		
Immunizations/Vaccinations DPT Mumps Smallpox Typhoid Tetanus German Measles Red Measles Influenza Polio MMR		Blood Type A+ A- B+ B- AB+ AB- O+ O- Other: _____	Blood Transfusions No. of Transfusions: _____ Date(s) / / / / / / / Reasons		Last Chest x-ray Date / / Normal/Abnormal Last Tb Skin Test Date Positive/Negative	Allergies _____ _____ _____		

PAST MEDICAL HISTORY: Circle only the ones you have had in the PAST.

Past general state of Health: Excellent Good Fair Poor

Hay Fever	Tonsillitis	Stroke	Diabetes	Mental Illness	Other: _____
Mumps	Sinusitis	Ulcers	Syphilis	Alcoholism	
Measles	Goiter	Jaundice	Gonorrhea	Depression	_____
Rheumatic Fever	Breast Trouble	Gallstones	Hernia	Nervous Breakdown	_____
Allergies	Asthma	Liver Trouble	Sexual Problems	C.M.V.	_____
Anemia	Bronchitis	Hepatitis	Prostate Problems	E.B.V.	_____
Cancer	Pleurisy	Parasites	Hemorrhoids	Candidiasis	_____
Tumor	Pneumonia	Dysentery	Arthritis	Strep Throat	
Blood Disease	Tuberculosis	Colitis	Gout	Hyperactivity	
Leukemia	Heart Trouble	Polyps/Fissures	Migraines	Whooping Cough	
Skin Acne/Boils	Varicose Veins	Kidney Infections	Epilepsy	Chicken Pox	
Cataracts Phlebitis	Kidney Stones	Paralysis	Styes	Hypertension	
Bladder Trouble	Polio				

Family History

Blood Relatives Only	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					

Children (Names and Ages): _____

Social History

Current Weight _____ Usual Weight _____ Maximum Weight _____ Minimum Weight _____

Mental Work	Physical Work	Exercise	Smoking	Alcohol
Heavy Moderate Light No. Hours per Day _____	Heavy Moderate Light No. Hours per Day _____	Heavy Moderate Light Types _____ No. hours per Week _____	Current Previous No. Packs per Day _____ No. of Years _____ Others _____	Beer Amount/week _____ Liquor Amount/week _____ Wine Amount/week _____ No. of Years _____
Caffeine (Coffee, Tea, Cola) Cups per Day _____ No. of Years _____ Aspirins No. per Day _____ No. of Years _____ Others _____	Please write in boxes what you generally eat			Drugs No. Doses per Week
	Breakfast	Lunch	Dinner	_____ Vitamins _____ Laxatives _____ Antacids _____ Diet Pills _____ Pain Pills _____ Water Pills _____ Nerve Pills _____ Potassium _____ Nutrasweet _____ Saccharin Others: _____ _____ _____ _____

OUR OFFICE FINANCIAL POLICY

We are pleased to serve your health care needs and are committed to providing you with the best possible care. The medical staff wants to ensure that your visit is educational, and medically beneficial.

Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or financial policy or your responsibility.

- All patients must sign in and complete our "Identification Data Form" before seeing the doctor. We will also have you sign your chart on each visit.
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- We accept checks, Visa, Mastercard, Discover, American Express, or cash.

MISSED APPOINTMENTS

We do require 24 hours cancellation notice. It is the policy of our office to charge for missed appointments. Please help us serve you better by keeping scheduled appointments.

REGARDING INSURANCE

It is the policy of this office that all office visits will be paid in full at the time of the visit, unless prior arrangements are made. Insurance forms are not accepted as payment for office visits. WE DO NOT ACCEPT INSURANCE. We are not on any insurance list. We will provide you with a superbill so that you may submit to your Insurance if you are eligible for reimbursement. **INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** We are not party to this contract. We will not become involved in disputes between your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary. You are responsible for the timely payment of your account.

MEDICARE/MEDICAID/CHAMPS/WORKER'S COMPENSATION

We have been notified by Medicare and Medicaid, that services provided by our office are not covered. They do not cover homeopathy, acupuncture, chelation therapy or any other alternative treatment. We will provide you with a letter from Medicare to use as an Explanation of Benefits so you may submit to your secondary insurance if needed.

I have read and completely understand the above policy. I agree to be personally responsible for any professional services rendered.

SIGNATURE _____ DATE _____

Your Rights

Following is a statement of our rights with respect to your protected health information.

You have the right to inspect a copy of 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 our 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 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 use 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 our 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 if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number, 702 385-1393.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____



A BRIEF LOOK AT ARBITRATION FOR THE PATIENT

Introduction

Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be a favored method of resolving disputes by the United States Supreme Court.

If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is arbitration?

Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After the arbitration hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages which apply in court proceedings also apply in arbitration.

Does arbitration prevent you from making a claim?

No. By selecting arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (i.e., from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it prevent you from obtaining a financial award?

No. Arbitration does not restrict or prevent you from obtaining a financial award in any manner. If the arbitrator accepts and agrees with your claim he will determine a damage award.

The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system.

May I be represented by an attorney of my choice?

Yes. Any party to arbitration may be represented by an attorney of his or her choice, at his or her own expense. The arbitrator will hear the facts and decide the matter whether or not the parties are represented by lawyers.

Who is bound by this agreement?

If you choose to sign the arbitration agreement, you will be agreeing to bind yourself and anyone who could bring suit in connection with treatment or services provided to you by the doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with treatment or services provided to that person by the doctor. Likewise, the doctor or anyone suing on behalf of the doctor is bound.

What does arbitration cost?

In general, arbitration is less expensive than court actions. The arbitrator's fees are ordinarily shared equally by the parties. The amount of those fees will depend upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?

Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are substituting an arbitrator for a jury to resolve your claims. You can still call and question witnesses, present evidence, and have an attorney of your choice, at your expense. This agreement generally helps to lower litigation time and costs for both patients and physicians. Further, both parties are spared the rigors of a trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

PHYSICIAN-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 Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily 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 binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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 both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A notice or demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

Article 6: Condition of Treatment: I understand that signing this arbitration agreement is not a condition of my receiving medical treatment.

I understand that I have the right to receive a copy of this 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.

_____ **INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED
"A BRIEF LOOK AT ARBITRATION FOR THE PATIENT."**

By: _____
Physician or Duly Authorized Representative Signature (Date)

By: _____
Patient's Signature (Date)

By: _____
Print or Stamp Name of Physician, Medical Group or Association Name

Print Patient's Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (if applicable) (Date)

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.

I. 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call 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 Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' 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 on the use or disclosure indicated in the authorization.

I _____ give my permission to Milne Medical Center
to speak to _____ name of person
relationship to me _____ regarding my health condition and treatment plans.

I understand the HIPAA laws and do fully release Milne Medical Center from any
confidentiality restriction with regards to my care.

_____ name _____ date

Additional family members who may receive my health information.

_____ relationship _____

_____ relationship _____

_____ relationship _____



Milne Medical Center
Integrative Medicine
Robert D. Milne, MD

INSURANCE REIMBURSEMENT INFORMATION

Although we do not accept insurance as payment in our office, your insurance company may reimburse you directly for the services you receive from Dr. Milne or his Associate. We furnish you with a CPT and diagnosis coded superbill that most insurance companies will need to process your claim form. Usually, all you need to do is to send a *COPY* of the superbill form along with a *COPY* of your insurance card and your insurance company will send the payment directly to you. Because Dr. Milne and his Associate are Board Certified and are licensed by the Nevada Board of Medical Examiners, the office visits and treatments are CPT coded as all physicians generally do, and therefore should be reimbursable. It may be helpful to contact your insurance company prior to your appointment if you have any specific questions. If you must go to a physician on a particular PPO, or HMO list and stay within your network, it is possible that your reimbursement will be a lesser percentage, example: in network is usually 80/20 reimbursement, out of network could be 60/40. Again, it is helpful to contact your carrier and discuss these questions with them. Your contract is between you and your insurance company. Dr. Milne and his Associate are not under contract with any carrier.

WE ARE NOT A MEDICARE/MEDICAID PROVIDER. This means that Medicare/Medicaid does not cover any of the services we provide. Thus, your secondary insurance may not pay your claims, either. However, we do provide a letter that you may send to Medicare/Medicaid stating that we are not providers and in some cases, this will allow your secondary insurance to reimburse you for payment.

If you have any other questions regarding these items, please feel free to contact us and we will do our best to answer them for you.

NEURAL THERAPY

Neural therapy is the injection of local anesthetics into carefully selected points of the body, in a manner in which it is possible to cure or greatly ameliorate a large variety of predominantly chronic health problems.

Although first described in 1925, Ferdinand Huneke, M.D. of West Germany recognized in 1940 that 1/3 of all chronic disorders were the result of interference fields or blockages of energy flow due to scars. He realized that formerly healthy tissue can act as an interference field if there is scar tissue, inflammation, or unresolved foreign bodies present. If there is a hereditary or acquired weakness in an organ, these interference fields can block the normal flow of electromagnetic energy, and produce disease symptoms. By injecting a small amount of local anesthetic such as procaine into the interference field, we are able to normalize the cellular functions, thus restoring the free flow of energy throughout the body.

Procaine and lidocaine, while generally used as local anesthetics, also possess the ability to bring about changes in the function of individual nerves of the autonomic nervous system, and consequently the cells and tissues served by the system. Essentially, these medications re-establish the cells' polarity and the neural communication network.

Physicians in Germany, Europe, and South America use neural therapy. We have found neural therapy to be very helpful in rheumatism, sciatica, joint inflammation, eczema, asthma, pelvic disorders, stomach problems, and neurological dysfunction.

Usually, scars or interference fields need to be injected only once, and as a rule, the patients will notice (as a side benefit) that their scars become softer and less noticeable after treatment.

Please be sure to notify your physician of any scars that need to be injected.

CONSENT FOR INJECTION THERAPY

I have noted on my intake form all of my known allergies, including drug medications, all medications that I am currently taking, including prescription drugs, over the counter remedies/medications, herbal therapies and supplements, aspirin and any other recreational drug or alcohol use. I understand that I will be advised whether I should avoid taking any or all of these medications on the days before or after any procedure is administered to me. _____(initial)

There are occasions that Dr. Milne may feel it is necessary to administer trigger point injections or other necessary injections as part of his treatment plan for a patient. Additionally, Dr. Milne may direct his associates or medical assistants to administer injections. I understand that I will be informed of what the treatment is for and what to expect in the post-injection period, including but not limited to: estimated recovery time, anticipated activity level and the possibility of additional procedures. If necessary, Dr. Milne will answer any and all of my questions regarding this procedure. _____(initial)

I certify that I have read and understand this treatment agreement. _____(initial)

After discussion with Dr. Milne and or his medical assistants, I authorize and direct Dr. Robert Milne to perform the procedure of trigger point injections on areas he feels are needed for my treatment plan.

After discussion, I will further authorize Dr. Milne and or his medical assistants to administer any other necessary procedures, that in their judgment, may be necessary or advisable should unforeseen circumstances arise from a procedure.

_____ Print Name
_____ Signature _____ Date
_____ Signature of legal representative
If patient is not of legal age or unable to sign _____ Date
_____ Witness _____ Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternative of the proposed procedure to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands the benefits and what I have explained.

_____ Robert D. Milne, M.D. _____ Date