PATIENT INFORMATION

David A. Edwards, MD, HMD, Ltd.

Jean Malik, AHP

Advanced Homeopathic Practitioner

Pleaase complete all sections of this form. PLEASE PRINT

Last Name_____ Home Tel #_____

First Name_____ Work Tel #_____

Address_____ Social Security # _____

City _____ Referred By_____

State _____ Zip _____ Religious Preference _____

Birthdate _____ Responsible Party _____

Name of Spouse: _____Emergency Contact _____ Telephone # _____

Gender: Male _____ Female _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Please list any and **ALL KNOWN ALLERGIES** (Penicillin, Novocain, etc.) _____

HOMEOPATHIC MEDICINE - ACKNOWLEDGEMENT

I have been informed/understand that David A. Edwards, MD, HMD and Jean Malik, AHP practice Homeopathic, Nutritional, Orthomolecular, Neural Therapeutic, Herbal, Integrative and Preventive Medicine under licensing authority of the Nevada State Board of Homeopathic Medical Examiners. I have been informed and understand that under current Nevada Revised Statues (NRS) licensed Homeopathic physicians are **PROHIBITED** from practicing allopathic medicine and their prescribing authority is **LIMITED** to methods approved in NRS 630A.040. I have been informed and understand that Homeopathic medicine is currently **NOT** available at any Nevada hospital, and that due to this our practitioners do **NOT** practice at any area hospital, including emergency care. I understand that Homeopathy, medical acupuncture, electro-acupuncture, herbal therapy, neural therapy, neuro integrative therapy, chelation therapy, bio-oxidative and some instrumentation may not be accepted by some insurance companies, the FDA or the AMA. I have been informed and understand the Ninth Amendment to the U.S. Constitution read (in part): "the enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by people". I hereby notify the federal and Nevada state governments, agencies, boards, courts and FDA that I reserve the following right under the Ninth Amendment to the U.S. Constitution: the right to 1. the physician of my choice, 2. an informed choice of all options for personal health care, 3. a drug-free, surgery-free existence, 4. use nutritional supplements based on my own opinion of their need and action, 5. prevent illness and disease using methods of my own choice and 6. self-determination in all matters of health and medical care.

FEDERAL ANTI-FRAUD DISCLAIMER

I have been informed and understand that the physicians of Bio Health Center practice Homeopathic, Nutritional, Orthomolecular, Neural Therapeutic, Herbal, Neuro-Integrative and Preventive Medicine under licensing authority of the Nevada State Board of Homeopathic Medical Examiners. I understand that the determination as to whether any and all medical/health services provided are "covered" by my private insurance/health plan will be made **after** these services have been provided. I understand that I am fully responsible for payment for any and all medical/health services provided by Edwards/ Edge/Malik and I will attest in writing to this at each visit. I understand that payment is due at the time of services unless **specific** arrangements were made **in advance** and that credit can be obtained by using Mastercard™ or Visa™. I understand that any outstanding balance owed will be **subject to a 1.5% monthly interest charge.**

NOTICE TO ALL MEDICARE™ PATIENTS -ACKNOWLEDGEMENT

I understand Dr. Edwards has **"Opted Out"** of Medicare.™ I have been informed that **MEDICARE™** does <u>NOT COVER ANY SERVICES</u> provided by Edwards/Malik, including medical acupuncture, homotoxicology, nutritional therapy, electro-acupuncture, chelation therapy, neural therapy, bio-oxidative therapy, and/or preventive medicine. Although I will not be reimbursed for the above medical services, I agree to said services and agree to pay for these services. I understand **payment is due at the time of service unless specific arrangements were made in advance,** that credit can be obtained by using Mastercard™ or Visa™ and that any outstanding balance owed to Bio Health Center will be **subject to a 1.5% monthly interest charge.**

Federal Health Insurance Portability and Accountability Act (HIPAA) and General Authorization for Release of Medical Information - Acknowledgement

David A. Edwards, MD, HMD, Ltd does **NOT transmit ANY health care claims information electronically.** Therefore, we do **NOT** "qualify" as a "covered entity" under the provisions of the federal Health Insurance Portability Act of 1996 (HIPAA or PL104-191). However, we do agree with protecting the absolute privacy of **ALL** personal-private health information in our custody, and we do fulfill **ALL** mandated federal requirements of HIPAA in our handling and care of **ALL** personal-private health information. An outline of HIPAA mandates is provided on the reverse side of this form. I authorize the release of any and all medical information to my insurance/health plan administrator, any and all physicians(s) I may be referred to and/or any person(s) legally designated by me.

I have read, understand and acknowledge **ALL** of the above:

Signature (Patient/Guardian if minor) _____ Date_____

Notice to Patients Regarding the Destruction of Health Care Records

(a) Pursuant to the provisions of subsection 7 of NRS 629.051;

(1) The health care records of a person who is less than 23 years of age may not be destroyed; and

(2) The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and

(b) Except as otherwise provided in subsection 7 of NRS 629.051 and unless a longer period is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

I have read and understand the above statutory requirements for the maintenance of my health care records.

Signed_____ Date_____

DAVID A. EDWARDS©, M.D., H.M.D. Ltd.
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INFORMED CONSENT FOR THE CLINICAL SERVICES OF JEAN MALIK, ADVANCED PRACTITIONER OF HOMEOPATHY

HOMEOPATHIC ADVANCED PRACTITIONER ACKNOWLEDGEMENT:

I have been informed and understand that Jean Malik, Advanced Practitioner of Homeopathy (AHP) is **NOT** a Nevada licensed Homeopathic physician, but a Nevada State certified Advanced Practitioner of Homeopathy. I understand that Jean Malik, AHP is certified by and functions under the regulatory authority of the Nevada State Board of Homeopathic Medical Examiners and practices homeopathic, nutritional, orthomolecular, neural therapeutic, neuro-muscular integrative and herbal therapy, including preventive homeopathic medical services, under the supervision of Nevada law (Nevada Revised Statutes or NRS630A). Certified Advanced Practitioners of Homeopathy are **PROHIBITED** from practicing allopathic medicine, and that their allopathic prescribing authority is **LIMITED** to methods approved under the Homeopathic Statutes of NRS 630A.040. I have been informed and understand that homeopathic methods of practice are currently **NOT** available at any Nevada hospital. I have been informed and understand that due to this Jean Malik, AHP does **NOT** practice at any area hospital including emergency care. I have been informed and understand that homeopathy, electro-dermal screening, herbal therapy, nutrition, neuro-muscular integration, chelation therapy, bio-oxidation therapies and some homeopathic methods of diagnostic testing may not be "recognized" or "accepted" by insurance companies, the FDA and/or the AMA as reimbursable medical services. I understand that I am responsible for payment for any and all services determined by any "third party payer" to be "non-covered" under the terms of my health/medical insurance and/or health plan contract.

FEDERAL ANTI-FRAUD NOTICE: ACKNOWLEDGEMENT

I have been informed and understand that the determination as to whether any and all homeopathic medical/health services are "covered" by my private insurance/health plan will be made by my insurance/health plan administrator or their designee **after** these services have been provided. I understand that I am fully responsible for payment for any and all homeopathic medical services provided. I understand that I will be asked to sign an attestation to this each visit in order to prevent any possible appearance of "insurance fraud." I understand that payment is due at the time of homeopathic service **unless specific** arrangements were made **in advance** and that credit can be obtained by using Mastercard™ or Visa.™ I understand that any outstanding balance owed to Jean Malik, AHP not processed thru Mastercard™ or Visa™ will be **subject to a 1.5% monthly interest charge.**

NOTICE TO ALL MEDICARE™ PATIENTS: ACKNOWLEDGEMENT

I have been informed that **Medicare™** does **NOT** cover any expenses for services and/or procedures performed by Jean Malik, AHP. **Medicare™** does **NOT** cover preventive services, nutritional therapy, orthomolecular therapy, neural-therapy, neuro-muscular integrative therapies, electro-dermal screening, chelation therapy, bio-oxidative therapy and/or homotoxicology. Although I will not be reimbursed for these services performed by Jean Malik, AHP I agree to pay for thee services. I understand that payment is due at the time of the homeopathic service unless **specific** arrangements were made **in advance** and that credit can be obtained by using Mastercard™ or Visa.™ I understand that should any outstanding balance be owed to Jean Malik, AHP not processed thru Mastercard™ or Visa™ it will be **subject to a 1.5% monthly interest charge.**

I have read, understand and agree with **ALL** of the above.

Signature (Patient/Guardian if minor) _____ Date _____

Medical Data

Mark an X next to any of the following which you have had or now have (notes of explanations are helpful).

- ☐ Anemia
- ☐ Allergies
- ☐ Asthmas
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Attention Def. Disorder
- ☐ Acne
- ☐ Alcohol Problem
- ☐ Appendicitis
- ☐ Bronchitis
- ☐ Back Pain
- ☐ Baldness
- ☐ Bladder Infection
- ☐ Bleeding Tendency
- ☐ Bloating/Excess Gas
- ☐ Boils
- ☐ Bowel Condition
- ☐ Blood Transfusion
- ☐ Cirrhosis (Liver)
- ☐ Colds - Recurrent
- ☐ Colitis - Irritable Bowel, Spastic
- ☐ Constipation
- ☐ Chronic Fatigue
- ☐ Concussion
- ☐ Cancer _____
- ☐ Convulsions/Seizures
- ☐ Candid/Yeast Infection
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Dandruff
- ☐ Dyslexia
- ☐ Depression
- ☐ Dental Problems
- ☐ Diarrhea - Chronic
- ☐ Digestion Problems
- ☐ Deafness/Hearing Problems
- ☐ Diverticulitis/osis
- ☐ Diabetes Mellitus
- ☐ Eating Problem
- ☐ Emphysema
- ☐ Epstein Barr Virus
- ☐ Ear Infections
- ☐ Eye Problems
- ☐ Eczema
- ☐ Endocrine/Gladular
- ☐ Epilepsy
- ☐ Fistula/Fissures
- ☐ Gall bladder Disease
- ☐ German Measles (Rubella)
- ☐ Gout
- ☐ Goiter
- ☐ Hyperactivity
- ☐ High Blood Pressure (HT)
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Condition
- ☐ Hernia - Location
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Headaches
- ☐ Heart Disease
- ☐ Head Injury
- ☐ Herpes - Location
- ☐ Hair Loss
- ☐ Hay Fever
- ☐ Hypoglycemia
- ☐ Blood Cholesterol/Fats
- ☐ Impetigo
- ☐ Injuries, serious
- ☐ Jaundice, Yellowing
- ☐ Kidney/Bladder Disease
- ☐ Leg Pain with Walking
- ☐ Liver Trouble
- ☐ Meningitis
- ☐ Menstrual Cramps
- ☐ Migraines
- ☐ Mouth Sores
- ☐ Measles (Rubella)
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Neck Strain
- ☐ Nose Bleeds
- ☐ Neuralgia/Neuritis
- ☐ Obesity
- ☐ Palpitations
- ☐ Prostate Problems
- ☐ Parasites (Worms)
- ☐ Pain - Chest, Sciatic, Muscular, Abdomen, Headache
- ☐ Polyps - Site
- ☐ Pancreatitis
- ☐ Psoriasis
- ☐ Phlebitis
- ☐ Polio/Paralysis
- ☐ Pneumonia
- ☐ Pheumatic Fever
- ☐ Ringworm
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Sexual Dysfunction
- ☐ Shingles
- ☐ Sinusitis
- ☐ Skin Infections
- ☐ Sore Throat/Voice Problems
- ☐ Styes
- ☐ Suicide Attempt
- ☐ Scarlet Fever
- ☐ Thyroid Problem_____
- ☐ Tuberculosis
- ☐ Toxic Chemical Poisoning/Exposure
- ☐ Tumors
- ☐ Venereal Disease
- ☐ Warts
- ☐ Weight Loss/Gain
- ☐ Whooping Cough

ENERGETIC HISTORY PLEASE CHECK OR CIRCLE

A. Your favorite:

1. FLAVOR	2. SEASON	3. COLOR
Sour	Spring	Green
Bitter	Summer	Blue
Sweet	Indian Summer	Red
Spicy	Fall/Autumn	Yellow
Salty	Winter	White
		Black

ALLERGIC HISTORY

Do you suffer from any of the following symtoms:

- ☐ asthma ☐ fatigue ☐ trouble with: __ perfumes
- ☐ rashes ☐ headache __ gasoline fumes
- ☐ hives ☐ itchy eyes __ paints, chemicals
- ☐ hay fever ☐ nasal congestion __ smoke
- ☐ arthritis ☐ sinusitis ☐ trouble with weight

What makes your symptoms better?_____

worse?_____

What is your energy level?

1 2 3 4 5

worst best

Do weather changes affect you?_____

How_____

At what time of day do you feel worse _____?

better_____?

Do you prefer to be inside _____ or outside _____?

Do you sleep well _____ yes _____no

MEDICAL DATA

CHIEF COMPLAINT AND MAJOR PROBLEMS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PREVIOUS DIAGNOSIS

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

Have you consulted another Doctor about these problems? _____

If yes, Doctor's name and diagnosis: _____

_____

_____

List of previous illnesses/hospitalizations or surgeries

	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

List any current medicines, homeopathics, vitamins, minerals or herbs you are taking below:

Medicine/Supplement	Dosage	Year

ADDITIONAL DATA

Occupation _____ Education _____

Test Year

1. _____ Complete physical exam
2. _____ Chest X-ray
3. _____ Kidney X-ray
4. _____ G.I. X-ray
5. _____ Colon X-ray
6. _____ Gallbladder X-ray
7. _____ Electrocardiogram
8. _____ TB test
9. _____ Sigmoidoscopy
10. _____ CAT/NMR scan
11. _____ Heart catheterization

year Immunizations (Adult)

1. _____ Tetanus
2. _____ Influenza
3. _____ DPT
4. _____ Other

Family History

	HEALTH			AGE AT DEATH AND CAUSE	MEDICAL PROBLEMS
	GOOD	POOR	DECEASED		
1. Yourself					
2. Father					
3. Mother					
4. Brothers & Sisters					
5. Spouse					
6. Children					

DAVID A. EDWARDS©, M.D., H.M.D. Ltd.
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David A. Edwards, MD, HMD **Jean Malik, AHP**

ELECTRODERMAL RESPONSE SCREENING (EDRS) INFORMED CONSENT

BACKGROUND: It is generally accepted that there is a relationship between both conscious and subconscious stress and electrical resistance of the skin. Therefore, procedures that monitor skin resistance and changes in skin resistance are considered to provide useful indications of stress. The EDRS biofeedback is considered to provide useful indications of stress. The EDRS biofeedback testing procedure system is designed to help identify particular agents associated with various types of stress reactions and other agents which reduce those reactions. EDRS is currently classified as " investigational " by the U.S.F.D.A. and as such, it use requires a specific informed consent. Since the procedure is investigational there is no fee for testing.

PROCEDURE: The procedure is totally non-invasive (the skin is not pierced). A metal probe is touched to the skin at various acupuncture points (primarily on your hands and feet) in order to measure the electrical resistance of the skin.

RISK/DISCOMFORT: The procedure is extremely safe because it measures only changes in the electrical properties of the skin with a sensitive meter. The only discomfort that can be reasonably anticipated is the minimal discomfort of the pressure of the probe pressed against the skin.

RESULTS/BENEFITS: Using the additional information provided by this procedure, the doctor may reduce the time, cost, and risk associate with the process required to arrive at a correct course of homeopathic therapy.

QUESTIONS: Your doctor will answer any question(s) you may have. Please do not hesitate to ask any question concerning any area of your diagnosis or treatment.

FREE TO DECLINE: You are free to decline participation or to withdraw consent and to discontinue participation at any time without prejudice to yourself.

I Have Read and Understand the above Information and Hereby Consent to the Use of the Electrodermal Response Screening. I Consent to the Use of Clinical Reports and Results of My Case for Study and for the Purpose of Advancing Medical Knowledge and for Research and Scientific Purposes Provided That My Identity Is Kept Confidential.

Name:_____

Last **First** **Middle** **Date**

Signature_____**(Parent/Guardian)**

FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA/PL104-191) became effective on April 14, 2001. Included the federal law is a "Health/Medical Information Privacy" section. This law applies to any "**ENTITY**" that use computers to transmit health claims information. "**ENTITY**" is defined as a "Health Plan" (HMO's, insurers, group health plans, employee benefit plans), Health Care Clearinghouse (an entity that processes health information going from a health care provider to a payer and ***certain*** Health Care Providers (those who use computers to transmit health claims information). Covered **health care providers *must*** generally obtain the patient's consent prior to using or disclosing protected health information to carry out treatment, payment or health care operations. However, providers ***may condition*** treatment on patient's providing consent form. Covered entities must also make reasonable efforts to limit protected health information to the ***minimum necessary*** to accomplish the intended purpose of use, disclosure or request for health information from another. This standard ***does not apply*** to treatment.

Individuals have a right to see and obtain a copy of their own health information, including documentation of who has had access to this information, but there are also limited exceptions to when a patient can access their own information, such as when such access would endanger the life or safety of any individual. Individuals also have the right to request amendment or correction of health information that is incorrect or incomplete. Health plans and covered health care providers are required to provide written notice of their privacy practices, including a description of an individual's rights with respect to protected health information (such as the right to inspect and obtain a copy of health records) and the anticipated uses and disclosures of this information that may be made without the patient's written authorization. A covered entity may not condition the provision of services or payment on the receipt of the authorization.

Health information may be disclosed for a number of purposes without any patient authorization including, but not limited to: public health activities, research, and fraud investigations. For all other purposes (other than those listed), patient authorization is required. Covered entities can disclose protected health information without a patient's authorization only to researchers whose protocol has been reviewed and approved by an Institutional Review Board (IRB) or a "privacy board."

Only the use and disclosure of "protected health information" is covered. In order to be considered "protected health information" under the regulations, information must: (1) Relate to a person's physical or mental health, the provision of health care, or the payment of health care; (2) Identify, or could be used to identify, the person who is the subject of the information; (3) Be created or received by a covered entity; and (4) Which is transmitted or maintained in *any* form or medium. Covered entities may create and use "*de-identified information*," health information which has been stripped of elements that could be used to identify individual subjects.

Access to any and all personal health information by all employees of David A. Edwards, MD, HMD Ltd. is restricted to employees that are certified to practice Homeopathic medicine or are in training to certify. We **DO NOT** and **WILLNOT** disclose any non-public health information to any entity, except as permitted or required by law without your signed consent.