Dr. Daniel Kalish

19449 Riverside Drive, Suite 207. • Sonoma, CA 95476
Phone: 800-616-7708 or 707-939-7960 • Fax: 707-939-7488
www.drkalish.com • office@drkalish.com

Dear Patient,

Welcome! And thank you for choosing Dr. Kalish as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:
During your initial consultation Dr. Kalish will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:
Once you have completed your lab tests, Dr. Kalish will explain the meaning of your test results to you in a follow up consultation. He will create an individualized therapeutic program for you, including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:
Subsequent consults are scheduled to monitor your progress. **Dr. Kalish will also design an on-going wellness program to be reviewed and updated with our staff at no charge every six months.**

We invite you to contact us via email or phone should you have any questions during the course of your treatment. We may be reached at 800-616-7708 (707-939-7960 outside the U.S.) and via email at office@drkalish.com. Office hours are Monday - Thursday 10:00 a.m. to 4:00 p.m. Pacific Time.

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

In health,

Dr. Kalish and Staff

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Please note: We must receive your completed paperwork at least 1 day prior to your phone consultation. Please fax your completed paperwork to 707-939-7488. Thank you!

New Patient Paperwork

Name:				Date:
Address:			Country:	
City:		State:	Zip/Postal Code:	
Home Phone:	Work Phone:		Fax:	
E-mail:			Cell Phone:	
Please mark your preference for occasional follow up communication from our office: _____Email _____Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:			Referred by:	
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize The Natural Path to release my personal medical information to me.

Patient's Signature: ____ Date: __________________________

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ **Height** _____ **Blood Pressure** (if known) __________ **% Body Fat** (if known) ________

1. Are you presently taking any medications, nutritional supplements or vitamins?______________
please list (attach sheet if necessary)

____

2. In the past, have you used birth control pills and/or antibiotics?____________________________

a. For how long?____

3. If you have fillings, please list material(s) used:____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average?_______________________________________

6. Do you have any food allergies, sensitivities or restrictions?_________________________________

____

7. Do you smoke, drink alcohol or use recreational drugs?____________________________________

a. How much, how often?____

b. How often do you drink caffeinated beverages?____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.)**:**______

____

9. Are there foods that you eat on a daily basis, almost daily basis?____________________________

a. Do you "miss" these foods if you do not eat them?___________________________________

10. Write briefly about your weight gain/loss history:____

____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity:______________________

12. What methods have you tried to lose/gain weight?____

____

13. How is your energy level?____

a. Are there times in the day that you feel best?___________________**worst?**___________________

14. Are you happy in your life right now?____

15. What are your main sources of stress?____

____

16. How do you deal with your stress?____

____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes_____ No_____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes_____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes_____ No_____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes____ No _____

e. Now and then I think I am a secret eater. Yes _____ No_____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes____No____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes_____No_____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No_____

i. I feel shaky if I don't eat on time or if I don't snack. Yes_____ No_____

j. I often find myself irritable or angry. Yes_____ No_____

18. Check off any of the following that have applied to you <u>within the last 30 days:</u>

______Do you feel nauseous?

______Do you have bloating?

______Do you get heartburn?

______Do you have constipation?

______Do you have gas?

______Do you belch following meals?

______Do you have abdominal/intestinal pain?

______Do you get bloated after meals?

______Do you have diarrhea?

______Do you travel outside of the U.S.?

______Are your stools compact/hard to pass?

______Do you have gurgles in your stomach?

______Do your bowel movements alternate between constipation and diarrhea?

24. In your estimation, how physically fit are you right now?

Unfit______ Below average______ Average ______ Above average______ Very fit______

25. How often do you exercise? ____

a. What is your regime?____

____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?____

____

27. What are your fitness goals? (Check all that apply)

______ General fitness endurance

______ Weight loss/maintain weight

______ Osteoporosis prevention

______ Specific sport enhancement

______ Flexibility

______ Muscle toning

______ Muscle strengthening

______ Muscular coordination/balance

______Other____

____

28. Surgeries, starting with most recent:____

____

29. Hospitalizations:____

30. Briefly describe where you have lived since childhood:________________________________

____

____

31. What is your heritage? (Irish, German, Spanish, etc.)

____

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:

Now	Past	**Satisfactory**
Now	Past	**Boring**
Now	Past	**Demanding**
Now	Past	**Unsatisfactory**

Do you worry over:

Now	Past	**Home life**
Now	Past	**Marriage**
Now	Past	**Children**
Now	Past	**Job**
Now	Past	**Income**
Now	Past	**Money problems**

Do you often:

Now	Past	**Feel depressed**
Now	Past	**Have anxiety**

Do you often:

Now	Past	**Have irrational fears**
Now	Past	**Feel upset**
Now	Past	**Feel things go wrong**
Now	Past	**Feel shy**
Now	Past	**Cry**
Now	Past	**Feel inferior**

Have you:

Now	Past	**Seriously considered suicide**
Now	Past	**Attempted suicide**

You are welcome to send Dr. Kalish a photo of yourself (from waist up if possible) via email to: office@drkalish.com

Or via mail to:
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POLICIES AND PROCEDURES
(please retain pgs. 7 & 8 for your records)

New Patients

Phone Appointment

Your first consultation will be 45 minutes – 1 hour ($295). During this time Dr. Kalish will determine the appropriate lab tests you should order to address your specific health concerns. If you would like your consult recorded, please make this request when you schedule your consultation.

Fee Schedule

New Patient consultation: $295 (45 minutes - 1 hour)
1 hour: $300
45 minutes: $225
30 minutes: $150
15 minutes: $75

Payment is due at time of consultation
Methods of payment are: Visa, MasterCard or American Express.
All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments

Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.
We encourage you to book your appointments 2 weeks in advance.
Dr. Kalish will call you at the time of your scheduled consultation. He strives to operate on a precise schedule, so please keep your phone line clear.
If paying by credit card, the card number is required to be on file with our office prior to the consultation.
As a courtesy to you will receive a reminder via email.

Lab Tests

The results of your lab test(s) will be sent to Dr. Kalish 2 to 4 weeks after mailing your specimens to the lab.

Dr. Kalish will evaluate the results. After evaluation you will be contacted to schedule a follow-up appointment.

Cancellations

If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Product Orders

You will be contacted regarding the cost of your program as prepared by Dr. Kalish and/or to schedule future appointments.
Orders are shipped within 24 hours of receipt unless otherwise stated. Saturdays, Sundays, and holidays not included.

Shipping

Normally orders are shipped by regular Ground UPS.
We cannot be responsible for lost packages if you request that we ship your order via USPS or via any other carrier.

Returned Products

PRE-APPROVAL is REQUIRED on ALL RETURNS!!
Refrigerated items CANNOT be returned
15% restock fee of purchase price less shipping and handling may be refunded on unopened and non-refrigerated items
No supplement returns will be accepted after 30 days on all regularly stocked items.
Special orders CANNOT be returned!
Prepaid tests can be returned for credit within one year of purchase.

Important Notes

Dr. Kalish is not a medical doctor; he does not service medical emergencies. **If you have a medical emergency, you must contact your primary care physician or dial 911!**
Please contact the office if you are not clear on any of our policies or procedures.

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I (*please print name*) ____**have read and understood Dr. Kalish Inc.'s Policies and Procedures.**

Date____

Signature____

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NOTICE OF PRIVACY PRACTICES
(please retain pgs. 10, 11 & 12 for your records)

Effective Date: April 14, 2003

Please Note: In order to comply with the numerous state, Federal, and local laws that govern medical information privacy, this document is provided. Dr. Kalish, Inc., its healthcare practitioners, and all associated personnel will do everything possible to maintain the privacy of your medical information as required by law. Under no circumstances will Dr. Kalish, Inc. disclose your personal or medical information to any outside parties.

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.

WHO WILL FOLLOW THIS NOTICE.

This notice describes Dr. Kalish Inc.'s practices and that of:
Any health care professional authorized to enter information into your patient chart.
All employees, staff and other clinic personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
• make sure that medical information that identifies you is kept private;
• give you this notice of our legal duties and privacy practices with respect to medical information about you; and
• follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nutritionists, technicians, or other clinic personnel who are involved in taking care of you at the clinic. Different departments of the clinic also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Health Care Operations. We may use and disclose medical information about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many clinic patients to decide what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nutritionists, technicians, and other clinic personnel for review and learning purposes. We may also combine the medical information we have with medical information from other clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment at the clinic.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under limited circumstances, we may use and disclose medical information about you for research purposes. Note: Under no circumstances will your name be associated with your medical data. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the clinic.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the clinic. To request an amendment, your request must be made in writing and submitted to the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the clinic; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the address below. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic, call 800-616-7708. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical

information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR RIGHT TO PRIVACY.

Dr. Kalish, Inc. protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. Dr. Kalish, Inc. will not disclose this information without your authorization, except as permitted by law.

Our **Notice of Privacy Practices** provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is **not** shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

____
Print name

____
Signature Date

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PAYMENT AUTHORIZATION

I, (print name)___________________________authorize Dr. Kalish, located at 19449 Riverside Drive, Suite 207, Sonoma, CA 95476 to bill my credit card as listed below.

Name on Credit Card ______________________________________

Credit Card Holder's Billing Address (Where your statement is mailed.)

____

____

Credit Card Details

Type of credit card (please check one): Visa MasterCard American Express

Card # ____Exp date ________

Last 3 digits (4 for Amex on front) on back of card _______________
(found on the back of your credit card on the signature panel)

Patient Information

Name: ____

Address: ____

City: ________________________ State: ___________ Zip: ___________

Authorization

_____________________________________ _________________________________
Card Holder's Signature Today's Date

_____________________________________ _________________________________
Patient's Signature Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: (Provider) ____Dr. Daniel Kalish____
(Name of Doctor, Clinic, Hospital, etc.)

Address: _**19449 Riverside Drive, Suite 207, Sonoma, CA 95476**________________________

I, *(please print name)* ____ request the following information:

Test results History Records Diagnosis
Treatment Reports Progress

concerning my: Accident Injury Illness

Other ____

To be released to: ____
(Name of Practitioner, Doctor, family member etc.)

Address: ____

Fax:____

For the purpose of: (Specify)____

____

According to Section 1795 of the California Health and Safety Code, these records must be provided within 15 days of receipt o this notice.

Signed: ____ Date: ____________________

Patient Spouse Parent Guardian