Dushyant Viswanathan, MD, ABIM, ABIHM
10320 Little Patuxent Pkwy Ste. 200 Columbia, MD 21044
1-888-250-CCIM
1-844-233-7639
ether@ccimhealth.com
ccimhealth.com

Patient Information

Name	DOB

Address	Gender

Home phone	Mobile phone

Email address

Emergency Contact

Name	Relationship to you	Phone

Have you ever seen a doctor that practices natural or integrative medicine? Y / N
If so, what type of natural medicine oriented clinicians have you visited?

__ Naturopathic Doctor __Holistic MD/DO __Acupuncturist __Chiropractor _____other

How did you find us? ___Doctor Referral __Patient Referral __ Web Search
If you were referred, please let us know by whom:

What are your health goals?

Do you have health insurance? Y/N
If yes, HMO or PPO?

Insurance_____ Name of Card Holder_____

Relationship to Patient_____ Date of Birth of card holder _____

ID #_____ Group Number_____

Copay_____

Please list other health care providers you are currently working with:

Name	Specialty	Contact Info

Current Health Concerns

Please list by order of importance to you.	How long has this been a problem?	Have you sought diagnosis or treatment for this issue before? If yes, please describe:
1.		
2.		
3.		
4.		
5.		
6.		

Personal & Family Health History

(Please place a check next to any of these conditions that you have or have had in the past)

Date of last physical exam?	Date of last Dexa Scan (Bone Density Scan)?
Date of most recent blood work?	Date of last colonoscopy?
Mother : ☐ Living ☐ Deceased Age:_____ Cause if deceased:	

Father : ☐ Living ☐ Deceased Age:_____ Cause if deceased:	Sibling: Y/N Number living: Number deceased: Gender: Age: Cause(s) if deceased: 1. 2. 3. 4.
Cardiac: __Hypertension __Heart Attack __Pacemaker __Irregular Heart beat __Other: Specify_____	Musculoskeletal: __Osteoarthritis __Rheumatoid Arthritis __Broken bones __Other: Specify_____
Respiratory: __COPD __Asthma __Shortness of breath __Shortness of breath with activity __ Other: Specify_____	Behavioral Health: __Alzheimer __Chronic Anxiety __Depression __Memory Problems __Other: Specify_____
Neurological: __Stroke __Seizures __Dizziness __Other: Specify_____	Cancer ☐ Yes ☐ No If yes, what type:_____ Are you diabetic ☐ Yes ☐ No

What is your preferred pharmacy?

Name: _____ Address: _____

Phone number: _____ Fax number_____

Prescribed Medications and over the counter medications- attach a separate list if necessary

Medication Name:	Dose	Frequency per day	Why?
1.			
2.			
3.			
4.			
5.			

Drug Allergies?

Any known medication allergies Y/N?

If yes, which medications:

What allergic reaction symptoms do you experience?

Supplements-please list all vitamins/botanicals, homeopathic, etc.

Medication Name:	Dose	Frequency per day	Why?	Where did you get them?
1.				
2.				
3.				
4.				
5.				

Have you had your Vitamin D levels checked in the past 3 months? **Y/ N**	
If your doctor offered an advanced, high quality line of supplements, would you consider purchasing them? **Y / N**	
If this practice offered a comprehensive weight loss/management program, would you consider it? **Y / N**	
If this practice offered a nutrition education program to improve your dietary habits, would you consider it? By appointment with a member of our staff? **Y /N** By a class exclusively for our patients? **Y / N**	

Lifestyle & Social History

Diet

Do you follow any special diet type or restrictions?	Are there foods you crave strongly?
What foods make you feel poorly? Explain:	What foods make you feel the best? Explain:
How would you describe your relationship with food?	

Please list typical foods consumed daily –specify typical times of day for each:

Breakfast		
Lunch		
Dinner		
Snacks		
Sweets		
Water	How much?	Tap, Filtered, Bottled?

Please check the appropriate box below to indicate the frequency of consumption:

	Daily	Weekly	Monthly	Occasionally	Rarely	Never
Sugar						
Artificial Sweeteners						
Fast food						
Fried food						
Processed food						
Flour/baked goods						
Caffeine						
Soda						
Alcohol						

Habits

Do you smoke cigarettes? Y/N	Packs per day?	Duration of habit?
	Past use?	If so, how long ago did you quit?

Do you use recreation drugs? Y/N	If Y, what type?
	How often?

Have you ever been treated for drug/alcohol addiction? Y/N	If Y, describe:	How long ago?

Sleep

How many hours of sleep do you get regularly each night?		Time you go to bed?
Do you fall asleep easily? Y/N	Do you sleep soundly? Y/N	Time you get up?

Do you wake rested? Y/N	What is your AM mood like?

Exercise

Do you exercise regularly? Y/N	How Often?	For how long?
What type of exercise(s) do you do?		

Spiritual Practices

Do you have any spiritual practices? Y/N	If yes, what kind?

Occupation

What is your occupation?	Do you like your work? Y/N
Number of hours worked per week:	Do you like your work environment? Y/N If No, please explain:

Stress Level

Rate 1-10 (1= very low , 10= high)	Source(s) of stress:
What do you do to cope with stress?	

Signature_____ Date_____

COLUMBIA CENTER
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CCIM CONSENT FORM

Name: DOB:

DATE:

I HEREBY CONSENT TO:

Integrative Internal Medicine Consultation: Enteroimmunology & Endocrinology office consultation

Communication with CCIM staff via secured and protected electronic and digital systems including, but not limited to, text message, email, phone, fax, video conferencing

Diagnostic Functional & Physiologic testing

Labs: Genova, Labrix, Doctors Data, Labcorp, Quicksilver

Treatment strategies, when indicated and appropriate, such as:

- Compounded medical therapy
- Nutraceutical Therapy (naturopathic medicines)
- Bioidentical Compounded Hormone Therapy via cream, pill, troche
- Injection Hormone Therapy: IGF1, HCG, Ghrelin
- Injection Micronutrient Therapy: B12, MIC/B/C/Glutathione
- Pharmaceutical Medication, and I accept risks of them which include causing any symptoms at any time.
- GI Detox & Restoration program featuring nutritional meal planning
- Yogatherapy & Integrative Alchemy
- Essential Oil Therapy and Aromatouch Therapy
- CCIM Proprietary Programs
- Prolotherapy & PRP, and I accept risks of injection therapy, including bleeding, swelling, pain, bruising, and the theoretical possibility of infection

I hereby consent to CCIM services, programs, methods, therapies, consultation. I understand the purpose, risk, and benefit of each therapy and service which will be customized to my medical needs.

X_____ date _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPPA CONSENT FOR RELEASE AND TRANSFER OF MEDICAL RECORDS)

1. Name: 2. Date of birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

_____

Name (client, provider, or other)

5. Information to be released:

□ Other (describe information in detail):_____

6. Purpose of Disclosure: The reason I am authorizing release is:

□ My request

□ Other (describe): _____

7. Person(s) Authorized to Make the Disclosure:

8. Persons(s) Authorized to Receive the Disclosure:

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient: _____

Signature of Personal Representative: _____

(relationship-) Date:

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to provider at the following address: 21900 Burbank Blvd. #300 Woodland Hills, CA 91367

2. You may refuse to sign this authorization. You refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

3. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at the point your information may no longer be protected by HIPAA.

4. If this office initiated this authorization, you must receive a copy of the signed authorization.

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CCIM POLICIES

CCIM APPOINTMENT CANCELLATION POLICY:

- CCIM will charge a fee $150 for any same day cancellation
- CCIM will charge a fee $50 for any cancellation of appointments 1-2 days prior to the appointment

CCIM Credit Card merchant service fee

- CCIM will charge a fee of 3.5% of the total transaction for credit card purchases and a $5 check processing fee.

CCIM RETURNED CHECK FEE:

- CCIM will charge a $35 fee for any checks that are returned

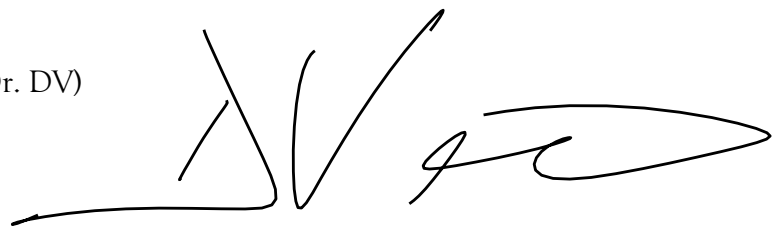
CCIM POLICY FOR PRINTING AND COPYING CHARTS:

- Please note that there is a standard service charge of $20 for printing, copying, and mailing charts

CCIM LATENESS POLICY:

- Please be advised that if you are more than 10 minutes late to your scheduled appointment, we may not be able to accommodate you for your appointment. We will reschedule your appointment for another time. If you are more than 10 minutes late that will be considered a missed appointment.

Patient signature: _____



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Integrative Medicine services NOT covered by insurance

Covered by CCIM Integrative copays and out-of-pocket charges

Access to naturopathic therapies
Food & nutritional intake, history and assessment and meal plan
Psychospiritual & emotional intake, history, assessment, and recommendations
Extensive time spent with physician
Multi-system based specialization offered by physician (*endocrinology, gastroenterology, functional medicine, mind-body medicine*, etc)
Regular secured email access
Opportunity for secured texting access
Integrative Alchemy and Clinical Yogatherapy services
Access to Wellness services
Information packets, printouts, background information
Facilitation of Genova Lab diagnostic services
Test kit fees
Access to rapid-fire communication between physician & pharmacist
Access to customized compounded & naturopathic therapies
Access to telemedicine services (phone / Skype consultations)
Customized protocols & assessment letters
Minimal to no wait time
Boutique experience of the office visit
Access to contracted practitioners (trainers, nutritionists, holistic practitioners)
Access to home-based IV therapies
Access to CCIM trademarked programs
Access to Membership program
Access to cutting edge therapies unavailable to the community outside of CCIM patients

CCIM MEMBERSHIP PROGRAM

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Cost: $599/mo

- Take advantage of a special 10% discount on the first 3 months of your CCIM Memberhsip today.
- Call 888 250 2246 and mention code **XV67H** to receive discount!

Services:

- Integrative Internal Medicine consultation
- Enteroimmunology Program (healing the immune system using your microbiome)
- Endocrinology Program (hormone balancing)
- Integrative Alchemy Program (customized holistic care)
- Custom Compounding Services (In partnership with Hunt Valley Pharmacy)
- Customized care and patient advocacy

https://www.youtube.com/watch?v=mhPbOWrVFqU

Increase your vitality by healing your microbiome, balancing hormones, and creating high quality self-care programs today!