Dushyant Viswanathan, MD, ABIM, ABOIM, AACE
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						

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

Habits

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?	

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

Exercise

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_______________

Dushyant Viswanathan, MD, ABIM, ABIHM

CCIM CONSENT FORM

Name: DOB:

DATE:

I HEREBY CONSENT TO:

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

Diagnostic Functional & Physiologic testing

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

Consultation: Office or Tele-Health (Phone / Video) Consult

Treatment strategies, when indicated and appropriate, such as:

- Yogatherapy
- Essential Oil Therapy, Pranaroma, and Aromatouch Therapy
- Compounded medical therapy
- Nutraceutical Therapy (natural medicines)
- Bioidentical Compounded Hormone Therapy
- Pharmaceutical Medication, and I accept risks of them which include causing any symptoms at any time.
- CCIM Proprietary Programs
- IV therapies
- Home-based nurse visits
- 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. I understand that CCIM specializes in microbiome evaluation & treatment, endocrinology, integrative internal medicine, yogatherapy, and prolotherapy. I understand that CCIM does not replace my local PCP and acute care centers (hospital, urgent care)

X____
date

Dushyant Viswanathan, MD, ABIM, ABIHM

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT
including Prolotherapy AND Yogatherapy

Name ___________________________

DOB

DATE

I understand that as a patient of The Columbia Center for Integrative Medicine (CCIM) I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with Dr Dushyant Viswanathan. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks**. Please Note: If you No Show or Cancel your appointment with less than 24 hours notice, there will be a charge assessed of $50.**

I understand that all information shared with the clinicians at CCIM is confidential and no information will be released without my consent. While written authorization will be requested, prior to any discussion with other providers. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality.

I understand that while prolotherapy and/or medication, may provide significant benefits, it may also pose risks. Prolotherapy like any injection may be accompanied by some bleeding, bruising and the risk of infection. Medications may have unwanted side effects. Please inform the office and/or Dr Viswanathan as soon as you notice any unusual bleeding, discoloration or signs of infection.

I understand furthermore that yogatherapy, while safe overall, may pose the risk of fall or emotional release. Please inform the office and/or Dr Viswanathan with any concerns you may have.

If I have any questions regarding this consent form or about the services offered at CCIM, I may discuss them with Dr Dushyant Viswanathan. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by UCC. I understand that I may stop treatment at any time.

____ _____________________________

Signature Date

Dushyant Viswanathan, MD, ABIM, ABIHM

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.

Dushyant Viswanathan, MD, ABIM, ABIHM

10320 Little Patuxent Pkwy Ste. 200 Columbia, MD 21044

CCIM POLICIES

CCIM APPOINTMENT CANCELLATION POLICY:

- CCIM will charge a fee:
  - $150 for any cancellation of medical appointments within 24 hours of the appointment.

CCIM Credit Card merchant service fee

- CCIM will charge a fee of 3.5% of the total transaction for credit card & Paypal 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: _______________________________________

Dushyant Viswanathan, MD, ABIM, ABIHM

ccimhealth.com

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

The CCIM Member program aims to use proactive and comprehensive methods of communication and healthcare delivery to improve your health and quality of experience.

The purpose of the integrative medicine service is to offer diagnostic and therapeutic strategies which lead to strengthening, optimization, and reinforcement of the patient's healthy physiology. This approach, in conjunction with standard medical/surgical care, will improve patient outcomes[1].

The purpose of the integrative alchemy service is to offer proactive psychospiritual and experiential yogatherapeutic strategies to optimize alignment in every aspect of life.

Key points of CCIM Concierge Membership (*customized to you*)

- Unfettered, unlimited access to Dr DV and Elaina
- HIPPA-compliant texting service (via TigerText application)
- Access to compounding pharmacy and customized medications and therapies
- Access to professional-grade holistic medicines and services
- Real-time communication with your various providers
- Customized wellness plans
- Meal Planning & Nutritional Assessments
- Cooking classes
- Healthcare patient advocacy (in your interactions with other providers)
- Office visit fees (net savings of $150-300 per office visit)
- Skype Consultations (net savings of $150-300 per consult)
- Phone Consultations (net savings of $150-300 per consult)
- Includes test kit fees ($50 savings per kit)
- Immediate troubleshooting of any symptoms or medical concerns
- Clinical Yogatherapy strategies (*Elaina will explain more about this*)
- Integrative Alchemy therapeutic strategies (*Elaina will explain more about this*)
- Hospital-based consultation (in select geographical areas)

Costs: $599/mo plus 3.5% credit card svc charge (or $5 check processing fee)

About CCIM Member Program: https://www.youtube.com/watch?v=mhPbOWrVFqU

[1] http://www.bravewell.org/content/pdf/IntegrativeMedicine2.pdf