Notice of Privacy, Office Policy, Consent and New Female Patient Intake Packet

We appreciate you taking the time to fill out these forms accurately and completely. Doing so will maximize the benefits of our visit together. Welcome to our practice!

8134 E. Cactus Rd., Suite 610
Scottsdale, AZ 85260
Phone: 480-451-1602
Fax: 480-614-1242

Dear Valued New Patient

Allow me to begin by welcoming you to my practice with open arms. I am happy and honored that you have chosen me as your healthcare provider, and I fully intend to do allthat is within in my power to help you achieve your healthcare goals.

Please be sure to read the following information, complete the intake forms accurately and thoroughly, **place your initials/signature where indicated** and bring them with you to your initial consult appointment along with any recent imaging and/or lab reports that may be relevant to your current health concern.

I along with my staff appreciate the confidence you are placing in us and look forward to meeting and working with you on your path to achieving and maintaining optimal health!

Sima Aidun, N.M.D.

Office Policy

Please read each line carefully and initial each section and ask for a completed & signed copy for your future reference. Office policy is subject to change without notice.

Payment

I agree to pay for naturopathic medical services rendered by Aidun Medical at the time of the visit via check, cash, Visa, or MasterCard payment. Payment via check is appreciated. Initials ___
Please note that starting January 1, 2024, payments made using an **American Express** credit card will be charged a 3% processing fee. Initials ___

Labs and Imaging: PPO plan

Aidun Medical is not able to determine insurance coverage. Coverage of lab and imaging studies such as mammogram, DEXA, MRI, etc. is to be determined by your insurance provider. Initials _____
Note: Most PPO plans include coverage of lab/imaging work with major providers (i.e., Sonora Quest, Lab Corp). Also, we do offer discounted labs which can be of some relief for patients under high-deductible plans.

Labs and Imaging: Medicare/ State Insurance/ HMO

Medicare/State does NOT cover any cost of lab and imaging studies ordered by naturopathic physicians. For our Medicare patients, we do offer discounted labs. HMO most likely will not cover lab expenses. Initials____

Insurance

Aidun Medical is not an in-network provider for any insurance companies. I understand that all billing is up to me and that no billing is provided by Aidun Medical. Initials____
Note: Aidun Medical will happily provide you with the information necessary for you to submit a claim.

Returned Checks

A $35.00 processing fee is applicable for each returned check. Initials_____

Cancellation/No Show (please read carefully)

We greatly value your time, and it is our goal to attend to your needs in a timely manner. We therefore do not overbook appointments and strive to maintain timeliness in patient scheduling. We recognize that cancellations/ reschedules at times become necessary, but we ask that a cancellation/reschedule notice be received by our office no later than **24 business hours prior to the appointment.** Though our office provides a courtesy reminder for each appointment, this may or may not happen within 24 hours of the appointment due to our office schedule. If for any reason you need to but do not cancel/reschedule your appointment in a timely manner, your physician becomes unable to provide the same quality service to another patient during your scheduled time slot. **Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you**. We thus reserve the right to charge:

$95.00 for late cancellation/reschedule of an **initial consultation appointment.**

$55.00 for late cancellation/reschedule of **established patient appointment.**

A NO SHOW for any type of appointment will be charged **the cost of the full office visit.**

We use your credit card information for the purpose of holding your appointment as well as enforcing this policy. **Your credit card will NOT be charged UNLESS you miss your appointment without a 24-business hour cancellation notice.** Initials_____
More than two late cancellations or no-show appointments may result in discharge from the practice. Initials_____

Late Arrival for Appointments

A patient arriving late for a scheduled appointment will be seen for the remaining time of the appointment only and will be charged 100% of the appointment fee**.** Initials_____
Being late for an appointment by 20 minutes or more will be considered a "no show", resulting in a charge per the Cancellation/No Show policy (see above). You will need to reschedule. Initials_____

Lab Orders

We do not order lab tests without first establishing the patient-physician relationship. Therefore, lab orders will only be issued after the initial consultation. Follow up appointments to review and discuss the results are necessary and will be made on the day of the office visit and scheduled based on anticipated time of results. Initials___

Prescriptions

In case of acute disease such as cold, flu, abdominal pain, vaginal infection, etc., we CANNOT prescribe any medication without an in-office evaluation. Initials___
Note: Same-day appointments are available to address acute concern in a timely manner.

Prescription Refills

Prescriptions will NOT be refilled if it has been 12 month or longer since the patient was last seen. Initials____

Packaged Services

I understand that I am responsible for payment for the full package at the time of initial visit. I also understand that packaged programs are nonrefundable, transferable, or exchangeable and that the package must be used within 2 months after purchase except for maintenance programs. Maintenance programs must be used within one year of purchasing package. Initials ___

Supplements

Supplements are non-refundable and non-exchangeable. Charges for phone/email orders are placed at the time the order is received. Initials___

Telephone and E-mail Access to the Doctor

We are committed to being available to you as a partner in achieving your health care goals. We welcome brief phone calls (5-10 minutes) and E-mails to clarify ongoing treatment plans (no diagnosis) at no charge. For more involved medical concerns beyond and above these, please contact our office and we will accommodate you with a phone/in office consultation appointment. Initials_____

Follow-up Appointments

We trust that you are as motivated as we are to achieve your health goals. In some instances, follow up visits become necessary and will only be scheduled accordingly**.** Therefore, it is important to adhere to any follow up recommendations in order to ensure effective treatment. Initials_____

Emergencies

In case of a medical emergency or serious medical concern you are to call 911 immediately. Initials_____

I have read the above office policies completely and I understand and agree with each item as demonstrated by my signature below.

Patient Name_____Signature_____Date_____

Notice of Privacy Practices

Per the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Our commitment to your privacy - Our practice is dedicated to maintaining your privacy and protecting your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information in certain special circumstances - The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response toa court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary, to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health data to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office. Note: *We must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to our office. You must provide us with a reason that supports your request for amendment. Note: *We must respond within 60 days.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our office.
6. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, *please feel free contact our office.*

Acknowledgment of Receipt of Notice of Privacy

By signing below, I,_____, acknowledge that I have received, read, understood, and accepted a copy of Dr. Sima Aidun's notice of privacy practices.

Do you wish to be contacted by electronic mail (Email) **Yes, I do** or **No, I do not** (circle one)

Patient or legally authorized individual signature/name_____Date_____

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of privacy practices, but acknowledgment could not be obtained because (please specify):

_____
_____
_____
_____

End of notice of privacy practices

Informed Consent & Request for Naturopathic Medicine

I understand that the evaluation, diagnosis, and treatment by a naturopathic physician and specifically by Dr. Sima Aidun N.M.D may include, but is not limited to:

• **Interview** (history taking)

• **Physical examination**

• **Common diagnostic procedures** (such as, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva, Pap Smears)

• **Dietary advice and therapeutic nutrition** (such as the therapeutic use of foods, diet plans, nutritional supplements, intravenous and intramuscular injections)

• **Acupuncture** (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body surface)

• **Botanical medicines and nutraceuticals** [also referred to as supplements] (such as the prescribing of various therapeutic substances including plant, and mineral). Substances may be given in the forms of pills, creams, powders, tinctures-which may contain alcohol, suppositories, topical creams , intramuscular and intravenous treatments.

• **Over the counter medications & Prescription medications** to be filled at a pharmacy

• **I understand and I am informed that in the practice of Naturopathic Medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:**

• **Potential risks**: pain, discomfort, minor bruising from acupuncture; allergic reaction to prescribed herbs, supplements, intramuscular, intravenous therapies, prescription medications; an aggravation of pre-existing symptoms.

• **Potential benefits:** restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.

• **Notice to pregnant women**: all female patients must alert the provider if they know or suspect that they are pregnant, since some of the therapies could present a risk to the pregnancy.

By signing below, I (print name),_____acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment.

Name_____Signature_____Date _____

Patient Demographic Information

(All of the below information is subject HIPPA confidentiality protection)

Name_____Birth Date__/__/__Age__Date_____Address_____

_____City, State_____Zip_____

Telephone, Home_____Work_____Mobile_____

Social Security #_____*E-mail_____Fax _____

*E– Mail addresses are for in office use only, we do not share or sell our patient 's E-mail addresses

Occupation_____Employer_____

Circle one: Single, Married, Divorced, Separated, Significant relationship.

Emergency Contact: _____

Name_____Relationship to you_____Phone_____

How did you hear about Dr. Aidun? _____

What is the main reason for today's office visit?_____

_____

Your pharmacy_____Phone Number _____

Heath Insurance (Please Circle): **PPO** **PPO High Deductible** **HMO** **Medicare** **None**

Record of Disclosure

Please choose Yes or No to the following and initial:

I authorize employees or physicians at Dr. Sima Aidun's office to leave a **detailed message** for me on a voice message device associated with the phone number listed below:

Laboratory reports_____Yes (initials_____) No (initials____)

Protected health information _____Yes (initials_____) No (initials____)

If your answer is **YES** to either of the above, please provide us with an acceptable phone number to leave this information

(_____)_____-_____

If your answer is NO to either of the above, the staff/ physicians at Dr. Sima Aidun's office will, as necessary leave a message indicating your need to call the clinic to retrieve any of your health-related information.

Print Name_____Signature_____Date _____

_____

(Office use only): Confidential #_____

Pharmacy:_____

Female Initial History/Pre-Consult Form

TODAYS DATE _____

Patient Name (on each page)_____DOB:_____AGE:_____

List, in order of importance, your goals for working with your physician, Dr. Aidun N.M.D:

1)_____ 2)_____

3)_____ 4)_____

Date of your recent: (please complete the information below to the best of your ability)

Mammogram_____ @ Imaging center: _____

Pap Smear _____ @ Office of Dr._____

Bone Density _____ @ Imaging center/Office of_____

Colonoscopy _____ @ imaging center/office of_____

Have you had a Hysterectomy? Y/N If yes, were your ovaries removed? _____

What was the reason for Hysterectomy?_____Date of Hysterectomy _____

Prescription Medicines & Nutrient Supplement/Herbs that you are taking (include dosage if known):

1)_____ 2)_____

4)_____ 5)_____

Present Medical Condition

Please list any medical conditions you are currently experiencing:

1._____2._____

3._____4._____

Past Medical History

Please list any medical conditions you did experience in the past:

1._____2._____

3._____4._____

Do you have any food or drug allergies? Y N

If Yes, what is the allergen?_____Reaction you experience:_____

List All Surgeries & Hospitalizations, including date occurred:

1) _____4)_____

2) _____5) _____

3) _____6) _____

Family History

	Father	Mother	Other immediate family (specify)
If deceased, cause of death			
Cancer type (if applicable)			
High Blood Pressure	Y N	Y N	Y N
Heart Attack and/or Stroke (please mark)	Y N	Y N	Y N
High cholesterol	Y N	Y N	Y N
Hypothyroidism	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N
Other:			
Other:			

Check appropriate column -Yes (Y), No (N) or Past (P)- regarding use of the following:

	Y	N	P	Comment(including the amount consumed)
Antacid				
Soda Pop				
Alcohol				
Water				
Coffee				
Smoking				
Recreational drugs				

SKIN			
Rash	Y N P	Color Change	Y N P
Hives	Y N P	Lump	Y N P
Psoriasis/eczema	Y N P	Itchy	Y N P
Dry	Y N P	Warts/moles	Y N P
Cancer	Y N P	Perspiration	Y N P
HEAD			
Headache:	Y N P	**Migraine:**	Y N P
Dandruff:	Y N P	**Head Injury:**	Y N P
Oil/dry hair:	Y N P	**Hair loss:**	Y N
NOSE			
Frequent Colds	Y N P	**Seasonal Allergy**	Y N P
Congestion	Y N P	**Post Nasal Drip**	Y N P
EYES			
Dry/Watery	Y N P	**Blurry Vision**	Y N P
Double Vision	Y N P	**Cataracts**	Y N P
Strain	Y N P	**Discharge**	Y N P
Itchy	Y N P	**Glaucoma**	Y N P

MOUTH/THROAT			
Canker sores	Y N P	**Cold sores**	Y N P
Sore Throat	Y N P	**Gum disease**	Y N P
Loss of taste	Y N P	**Hoarseness**	Y N P
NECK			
Stiffness	Y N P	**Swollen Glands**	Y N P
Full movement	Y N P	**Tension**	Y N P
RESPIRATORY			
Cough	Y N P	**TB**	Y N P
Shortness of breath w/ exertion	Y N P	**Bronchitis**	Y N P
Shortness of breath sitting	Y N P	**Pneumonia**	Y N P
Shortness of breath lying down	Y N P	**Asthma**	Y N P
Wheezing	Y N P	**Painful breathing**	Y N P
CARDIOVASCULAR			
High Blood Pressure	Y N P	**Palpitations**	Y N P
Low Blood Pressure	Y N P	**Chest Pain**	Y N P
Arrhythmias	Y N P	**Water Retention/Edema**	Y N P
URINARY TRACT			
Incontinence	Y N P	**Pain w/ Urination**	Y N P
Frequent Infections	Y N P	**Hesitancy**	Y N P
Urgency	Y N P	**Discharge/Blood:**	Y N P
GASTROINTESTINAL			
Indigestion	Y N P	**Recent Bowel Change**	Y N P
Bloating	Y N P	**Constipation**	Y N P
Nausea	Y N P	**Hemorrhoids**	Y N P
Vomiting	Y N P	**Gall Bladder Disease**	Y N P
Change in Appetite	Y N P	**Liver Disease**	Y N P
Diarrhea	Y N P	**Ulcer**	Y N P
Heartburn	Y N P	**Number of Bowel movements per day**	

Menstruation Cycle, Pregnancy and Menopause			
Age menstruation began		Children?	Y N P
How long menstruation lasts?		If you answered Y to children, list number	Y N P
How often menstruation occurs?		Miscarriage?	Y N P
Heavy menstrual bleeding	Y N P	If you answered Y or P to miscarriage, list number	Y N P
Menstrual cramping	Y N P	Abortion	
Date first day of your last menstrual cycle (important)		If you answered Y or P to abortion, list number	
Abnormal pap smear	Y N P		
Sexually active	Y N P		
Birth control	Y N P		
If you answered Y to birth control, list type			
If you answered Y to birth control, list age (s) used			
If menopausal, since what age?			
Use of hormones	Y N P		
If using hormones, what types?			

MUSCULOSKELETAL			
Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

Mental/Emotional			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization**	Y N P

Exercise

How often do you exercise?_____What type of exercise? _____
For how long? _____

_____
Typical Day's Diet:

Breakfast_____
Lunch_____
Dinner_____
Snacks_____

Present Weight:_____**Weight one year ago**: _____**Present Height**: _____

How committed are you towards making valuable changes for better health:

Little Moderately Very

Please provide us with your payment information below. Once the information is entered in a secured site, payment information on this page will be destroyed.

Please note that starting January 1, 2024, payments made using an **American Express** credit card will be charged a 3% processing fee.

Payment via check is appreciated.

CREDIT CARD (please mark one) ☐VISA ☐MASTER CARD

ACCOUNT NUMBER: _____ _____ _____ _____

EXP DATE: _____/_____ 3 DIGIT SECURITY NO: _____
(LOCATED ON THE BACK OF CARD)

CARD HOLDER NAME: _____
(Exactly as printed on card)

BILLING ADDRESS: _____

_____

_____

PHONE: (_____) _____ - _____ EMAIL: _____

SIGNATURE: _____ DATE: _____

End of Intake