ARVAN INTEGRATIVE HEALTH CARE LLC
NEW PATIENT REGISTRATION FORM

Patient Name: _____

Address: _____ Zip:_____

Sex: Male Female **Birth Date:** _____/_____/_____ **Age:** _____ **Marital:** S/M/D/W

Primary Phone: _____-_____-_____ **Alt Phone:** _____-_____-_____

Pharmacy & Phone: _____

Who is financially responsible for payment for these services?

____Self ___Spouse ____ Parent/Guardian ____ Other _____

May we leave personal medical/billing information on your telephone answering machine …at home or cellphone? _____YES _____NO **…at work?** _____YES _____ NO

Do you give our office permission to discuss your personal/medical/billing information with family members? ____ YES _____ NO (If yes, please provide their names and phone numbers below.) (If yes is marked and the names are left blank, the approval is invalid.)

1. Name: _____ Relationship: _____

Phone Number(s): _____

2. Name: _____ Relationship: _____

Phone Number(s): _____

Emergency Contact: _____Relationship: _____

Phone Number(s): _____

Please present your photo ID, the receptionist will make a copy and return it to you.

I hereby acknowledge I have received, read and understand, and agree to Arvan Integrative Health Care LLC's: (If this form is completed prior to your appointment, please do not initial or sign until you arrive at our office.)

Notice of Privacy Practices _____ (initials);

Patient Review of Medical History _____ (initials);

Financial and Services Policy Agreement _____ (initials);

Communications Policy Agreement _____ (initials); and

(applicable only for Medicare beneficiaries) **Private Contract for Medicare Opt-Out** _____ (initials).

Digital signatures/initials are not accepted.

_____ _____

Patient or Parent or Guardian Signature **Date**

ARVAN INTEGRATIVE HEALTH CARE LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requires all medical records and other individually personally identifiable health information used or disclosed by Arvan Integrative Health Care LLC ("Practice") in any form, whether electronically, on paper, or orally are kept confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, the Practice is providing this notice of how the Practice maintains your PHI confidentiality and how the Practice may disclose your personal information.

Practice may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services.
- Payment means such activities as obtaining compensation for services, billing or collections activities, and utilization review.
- Health Care Operations include business aspects of operating the Practice.
- Practice may also disclose PHI pursuant to valid order of a court of law.

The Practice may contact you, by phone or in writing, to provide appointment reminders or other Services-related information. You have the right to "opt out" from receiving certain communications from Practice. Your authorizations and rights related to Practice communications are found in the Communications Policy Agreement.

You may revoke any authorization for PHI disclosure in writing to the Practice, except to the extent that Practice has already taken action and made disclosures in the past relying on your prior authorization.

You may have the following rights with respect to your PHI:

- Request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, or any other person identified by you. This restriction may be subject to limitations.
- Receive confidential PHI communications by reasonable alternative means or locations.
- Inspect and copy your PHI.
- Amend your PHI.
- Receive an accounting of disclosures of your PHI.
- Obtain a paper copy of this notice from us upon request.
- Be advised if your unprotected PHI is intentionally or unintentionally disclosed.

In the event of a breach of confidential PHI, the Practice will notify all affected patients within sixty (60) days of discovery of the breach by the Practice, in accordance with the breach notification requirements mandated by law.

This notice is effective as of November 5, 2019. Practice reserves the right to revise the terms of this Notice of Privacy Practices and to make such revised provisions effective for all Practice PHI. The Practice will post a copy of the effective Notice of Privacy Practices. You may request a written copy of the effective Notice of Privacy Practices using the contact information provided at the end of this Notice.

You may have recourse under the law, if you feel that your PHI protections have been violated by the Practice. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. Practice does not retaliate for filing a complaint. Feel free to contact the Physician Andrea Arvan, acting as Practice compliance officer, at 913-742-0864 for more information or in writing to Arvan Integrative Health Care LLC, 7410 Switzer Road, Shawnee, Kansas 66203.

ARVAN INTEGRATIVE HEALTH CARE LLC

FINANCIAL AND SERVICES POLICY AGREEMENT

1. **Notice**: This Financial Policy and affiliated agreements ("Policy") for Arvan Integrative Health Care LLC ("Practice") does not constitute insurance, nor is it a medical plan that provides health insurance coverage. This Policy covers only limited, routine Services, as provided in this Policy.

2. **Services**: Services means those medical services that Andrea Arvan, MD ("Physician") provides through the Practice, which are medical services that Physician is authorized to provide under the laws of the State of Kansas and that are consistent with Physician's training and expertise.

3. **Insurance - Out of Network**: Practice is a direct pay practice and Practice and Physician do NOT participate with ANY insurance or government healthcare program. Your initials acknowledge your understanding and agreement that Practice and Physician are considered out of network for all government and commercial insurance plans and thus, do not participate in any HMO, Medicare, Medicaid, Medigap, or Tricare, or any commercial primary, secondary, or tertiary insurance plans.
Patient Initials: _____

4. **Reimbursement - Out of Network Coverage**: Your Insurance company may reimburse you for out-of-network coverage, depending on your specific insurance. It is your responsibility to understand your plan's out of network coverage and reimbursement options. Practice does not make any representations regarding the potential for you to be reimbursed for Services. If you have questions, you should speak directly with your insurance company or benefits manager.

2. **Payment**: Patient agrees by initialing in this section below to pay for their care at the time of service. Payment in full is required for all services before you leave the Practice office. Practice is a direct pay practice and does NOT participate with ANY insurance or government healthcare program. Cash, checks, all major credit cards, and Care Credit are accepted. If Patient's account is not paid when due, and Practice should retain an attorney or collection agency for collection, Patient agrees by initialing in this section below to pay all costs of collection including reasonable interest, reasonable attorneys' fees and reasonable collection agency fees.
Patient Initials: _____

3. **Fees**: Practice is a fee-for-service Patients are billed for Practice visits based on time spent with the Physician according to the following fee schedule:

PRACTICE FEE SCHEDULE	FEE
15 minutes or less; or simple one-matter follow up visit	$80.00
30 minutes or less; or complex follow up visit	$165.00
60 minutes or less; or complete physical visit	$325.00
Optional: 90 minutes or less; or new patient initial visit* Includes 2 visits.	$450.00
30-minute acupuncture only	$85.00

7. **Laboratory Work**: In the event you require laboratory work or specimen analysis, such laboratory work or specimen analysis will be done by the third-party laboratory service provider. You will be billed separately by the third-party laboratory service provider. Patient is responsible for all costs associated with laboratory work or specimen analysis. Complex laboratory follow up with Physician requires a complex follow up visit to Practice.

*All new patients must have an initial visit charged at the $450.00 rate for their first Practice visit.

8. **Medicare**: If you are enrolled in Medicare, Medicare requires that you sign a one-page private contract with your health care provider indicating that you have been informed that medical services will not be covered by Medicare. Before receiving Services, Medicare enrollee Patients must acknowledge their choice to receive Services not covered by Medicare on Practice's Medicare Opt-Out Agreement.

10. **Minor Children**: All children less than eighteen (18) years of age must be accompanied by a parent or legal guardian for any Practice visit. Payment in full is still required at the time of service.

11. **Hours of Operation and Appointment Cancellations/No-Show**: Normal hours to schedule an appointment are Monday through Friday from 9:00A.M. to 5:00P.M. C.S.T. Your scheduled appointment date and time are reserved exclusively for you. If you must cancel an appointment, please provide Practice with advance notice not less one full business day before your scheduled appointment. Cancellations less than one full business day are considered "no-shows" and Patient will be charged a $50.00 fee. Practice does not schedule new appointments until all unpaid, due and owing fees are paid.

12. **Physician Absence**: From time to time, Physician may be temporarily unavailable to provide Services. In the event of the Physician's absence normal Practice hours of operation, Patients will be given the name and telephone number of an appropriate provider for the Patient to contact.

12. **Returned Check/Credit Card Fees**: Practice will assess a $35.00 fee for any check returned to Practice due to insufficient funds or for any other reason, or for any charge-back fee for any credit card transaction. Practice and Physician reserve the right to discharge from the Practice any patient who does not pay in full at the time of service.

13. **Miscellaneous**: A. Jurisdiction. This Policy is governed and construed under the laws of Kansas.
B. Venue. Practice, Physician, and Patient agree venue is proper in Johnson County, Kansas.
C. Legal Significance. This Policy is a legal agreement. You are entitled to consult an attorney and seek legal advice. Your signature below signifies your agreement with and an acknowledgment of your understanding of the terms of this Policy.
D. Waiver. Practice's choice to not enforce any term of this Policy does not constitute a waiver.
E. Amendment. Practice may amend this Policy without notice subject to your subsequent agreement.

I, _____, ("Patient," "you" or Patient's Guardian) hereby agree to be bound by the terms of this Policy and acknowledge my understanding of the terms contained in this Policy.[1] I acknowledge and agree Services provided to me as Patient by Practice, Arvan Integrative Health Care LLC, and Physician, Andrea Arvan, MD, shall be governed by this Policy.

_____ _____
Signature of Patient, Parent or Guardian Date

[1] Policy and terms as revised and enacted by Arvan Integrative Health Care LLC on November 5, 2019.

ARVAN INTEGRATIVE HEALTH CARE LLC

COMMUNICATIONS POLICY AGREEMENT

This Communications Policy Agreement ("Communications Policy") for Arvan Integrative Health Care LLC ("Practice") establishes the rights and obligations of Practice and you, _____ ("you" or "Patient"), with respect to Communications regarding your Services from the Practice and Andrea Arvan, M.D. ("Physician").

1. **HIPAA**: You acknowledge that you received the Practice's Notice of Privacy Practices establishing Patient's Health Insurance Portability & Accountability Act of 1996 ("HIPAA") right to control Patient's protected health information ("PHI").
Patient Initials: _____

2. **Communications Policy Qualifies HIPAA Rights**: Your instruction to Practice in this Communications Policy to communicate by certain methods of Communications may qualify or affect your HIPAA rights and the protections described in the Notice of Privacy Practices. Practice complies with HIPAA and protects Patient PHI, unless Patient directs otherwise, as specified in this Communications Policy. YOU ACKNOWLEDGE THAT BY AGREEING TO COMMUNICATE WITH PRACTICE BY CERTAIN MEANS OF COMMUNICATION THAT YOU MAY WAIVE CERTAIN HIPAA PROTECTIONS.
Patient Initials: _____

3. **Certain Communications Not Secure**: Patient acknowledges that Communications with the Physician using electronic mail (email), voice cellular phone, cellular phone text message and other forms of electronic communication are not necessarily secure or confidential methods of communications.
Patient Initials: _____

4. **Methods of Communication**: Patient expressly waives the Practice's obligation to guarantee confidentiality of PHI by choosing to communicate with Practice and Physician by any of the following means of Communication. Please indicate by initialing the means of communication by which you authorize Practice and Physician to communicate with you. You understand and agree that even if you do not initial the following but communicate with Physician or Practice by one of these means of communication, anyway, that you waive Practice's obligation to guarantee confidentiality of PHI and authorize communication by that method. Please communicate with me by:

Electronic Mail (email). _____ (initials)
Cellular phone voice communications. _____ (initials)
Cellular phone text message. _____ (initials)
Video chat. _____ (initials)

5. **Email and Text Message**: Email and Text Message are not necessarily secure mediums for sending or receiving PHI. Physician and Practice make reasonable efforts to keep Email text message communication confidential and secure. However, neither Practice nor Physician can assure or guarantee absolute confidentiality of email or text message communications. You understand and agree that email and text message are not appropriate means of communication in an emergency or for time-sensitive problems. In an emergency, you must call 911. Neither Practice nor the Physician will be liable for any loss, injury, or expense arising from a delay in responding to Patient, when that delay is caused by technical failure, including but not limited to (i) failures caused by an internet service provider, (ii) failure of electronic messaging software, or email provider (iii) failure of the Practice's computers or computer network, or (vi) Patient failure to comply with the guidelines for use of e-mail described in this Agreement.

6. **Physician and Clinic Follow-Up Communications**: Physician and Practice may make themselves available to Patient by authorized means of communication during normal business hours: Monday through Friday, 9:00 A.M. through 5:00 P.M. CST.

a. The Physician checks email, text messages, and voicemails frequently on weekdays, during normal business hours. However, Physician routinely sees patients during normal business hours and may not be available to immediately respond to you. If you do not receive a response by the next business day, you agree that you will contact the Physician and Practice by telephone or other means.

b. Patient may have access to telephone Communication with the Physician outside normal business hours. Patient may be given a phone number where Patient may reach the Physician when medical questions arise unexpectedly outside normal business hours. In the event of an emergency, you must call 911.

7. **Communications Part of the Medical Record**: Patient acknowledges that all Communications may become a part of his or her medical record.

8. **Miscellaneous**: A. Jurisdiction. Communications Policy is governed under Kansas law.
B. Venue. Clinic, Physician, and Patient agree venue is proper in Johnson County, Kansas.
C. Legal Significance. This Policy is a legal agreement. You are entitled to consult an attorney and seek legal advice. Your signature below signifies your agreement with and an acknowledgment of your understanding of the terms of this Policy.
D. Waiver. Clinic's choice to not enforce any term of this Policy does not constitute a waiver.
E. Amendment. Clinic may amend this Policy without notice subject to your subsequent agreement.

I, _____, ("Patient," "you" or Patient's Guardian) hereby agree to be bound by the terms of this Communications Policy and acknowledge my understanding of the terms and my Communications choices and authorizations contained in this Policy.[1] I acknowledge and agree my Communications and those provided to me as Patient by Practice, Arvan Integrative Health Care LLC, and Physician, Andrea Arvan, MD, shall be governed by this Policy.

_____ _____
Signature of Patient, Parent or Guardian Date

[1] Communications Policy and terms as revised and enacted by Arvan Integrative Health Care LLC on November 5, 2019.

Andrea Arvan, M.D.
913.742.0864

Date: _____

Patient Information

Name: _____
(last) (first) (middle)

How would you like to be called: Mr. / Mrs. / Ms. _____

Date of birth: _____/_____/_____ Birthplace: _____

Street Address: _____
(street name and number)

_____ House / Condo / Apt / Senior / Other
(city) (state) (zip)

Do you live alone: Yes / No Who lives with you: _____

Preferred Telephone: (_____) _____-_____ (cell / home)

Secondary telephone: (_____) _____-_____ (cell / home)

Work telephone: (_____) _____-_____

E-mail address: _____@_____
(do not provide e-mail address if you do not want any correspondence through e-mail)

Single: Yes / No Married: Yes / No Living Partner: Yes / No

Widow(er): Yes / No Divorced: Yes / No Single Parent: Yes / No

Occupation and position: _____

Employed by: _____

Pharmacy: _____
(name) (phone)

In Emergency, notify: _____ Phone: (_____) _____-_____
(name and relation)

Physicians in your care

Where do you see them?

Allergist: _____

Cardiologist: _____

Dentist: _____

Dermatologist: _____

Endocrinologist: _____

ENT: _____

Gastroenterologist: _____

Neurologist: _____

Neurosurgeon: _____

Ob/GYN: _____

Oncologist: _____

Ophthalmologist: _____

Orthopedist: _____

Physiatrist (PMR): _____

Psychologist: _____

Pulmonologist: _____

Rheumatologist: _____

Urologist: _____

Preferred Hospital: _____

Have you been hospitalized? Yes / No

Where/Why: _____

_____

_____

_____

_____

_____

_____

_____

Social History

Tobacco Use:

Do you smoke: Never / Yes / Quit when: _____ Cigarettes / Cigars / Pipe

How many years: _____

Packs per day: _____

Do you Vape: Never / Yes / Quit when: _____

Do you chew: Never / Yes / Quit when: _____

Marijuana Never / Yes / Quit when: _____

Alcohol Use: Never / Yes / Quit when: _____

If Yes:

What do you prefer to drink: beer / wine / spirits

How many drinks per week: _____

Have you previously quit drinking: _____

If yes: when/how long: _____

Rehab/AA: Yes / No _____

Drug Use: Never / Yes / Quit when: _____

If Yes:

What type of drug: _____

How often: _____

Rehab: Yes / No _____

Coffee/Soda/Energy Drinks: Never / Yes / Quit when: _____

If Yes:

How many cups/sodas per day: _____

How often: _____

What time is your last cup of coffee or soda: _____

Do you feel coffee or soda affects your sleep: Yes / No

Exercise: Never / Yes / Used to when: _____

What kind, how often, how long?

_____Walk/TM/Run: _____

_____Sports: _____

_____Gym/weights: _____

_____Fitmess classes/Tai Chi/Yoga: _____

Education:

Years in High School: _____ Years in College: _____ Years Post Grad: _____

Degrees: _____

_____

_____

General Assesment:

Weight: current _____ lbs Max weight: _____ when: _____

Are you comfortable with your weight: Yes / No

Height: _____feet _____inches Has your height changed: Yes / No

Hair Color: _____ Do you dye your hair: Yes / No

Eye Color: _____ Do you wear contacts / glasses

Dominant hand: Right / Left / Ambidextrous Dyslexia: Yes / No

Do you vaccinate: Yes / No

Last Vaccines: Influenza _____ Pneumovax _____ Shingles _____

Tetanus _____ Hepatitis A / B _____ Childhood vaccines completed: Y / N

Past Illnesses

Chicken Pox: Yes / No Measles: Yes / No German Measles: Yes / No

German Measles: Yes / No Mumps: Yes / No Mononucleosis: Yes / No

Hepatitis A: Yes / No Hepatitis B: Yes / No Hepatitis C: Yes / No

Polio: Yes / No residual injury: _____ Post-polio syndrome: Yes / No

Other: _____ _____

Are you prone to viral infections/colds: Yes / No

Do you feel healthy: Yes / No
If not, why: _____

Do you feel safe at home: Yes / No
If not, why: _____

Reason for Visit today

_____ to get established. I have no active concerns.

_____ I have a new worry. Please state: _____

_____

_____

_____ I have chronic medical issues to manage. The one that worries me the most is:

_____

_____

_____ I have a worrisome family history and want a preventive medicine plan. In particular:

_____

_____

_____

_____

Medical History

Medical Problem: How many years:

Surgical History

Have you had:

Operation:	When:	Operation:	When:
Tonsillectomy	_____	Appendectomy	_____
Gall Bladder	_____	Hernia	_____
Hysterectomy	_____	Mastectomy	_____

Procedure:	When:	Procedure:	When:
Colonoscopy	_____	EKG	_____
Chest X-Ray	_____	Mammogram	_____
EGD	_____	Cardiac test	_____

Other Operations : Date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Tests : Date:

MRI scan:	When:		When:
Brain	_____	Neck	_____
Abdomen	_____	Spine	_____
_____	_____	_____	_____

CAT scan:	When:		When:
Brain	_____	Chest	_____
Abdomen	_____	Pelvis	_____
_____	_____	_____	_____

Allergies

Drug / food / Other:

Reaction:

Environmental Allergies

Allergen:

Reaction:

Prescribed Medications (supplements listed below)

Medication Name and dose:

Medical problem:

Supplements you are taking now

(include medications such as laxatives, aspirin, Tylenol, eye drops, nose sprays, fiber supplements. Anything you take no matter how insignificant.)

Supplement Name and dose:

Why did you start this:

Supplements you have stopped:

Supplement Name and dose:

Why did you stop this:

Alternative Treatments you have tried:

Treatment:	Good or Bad response:

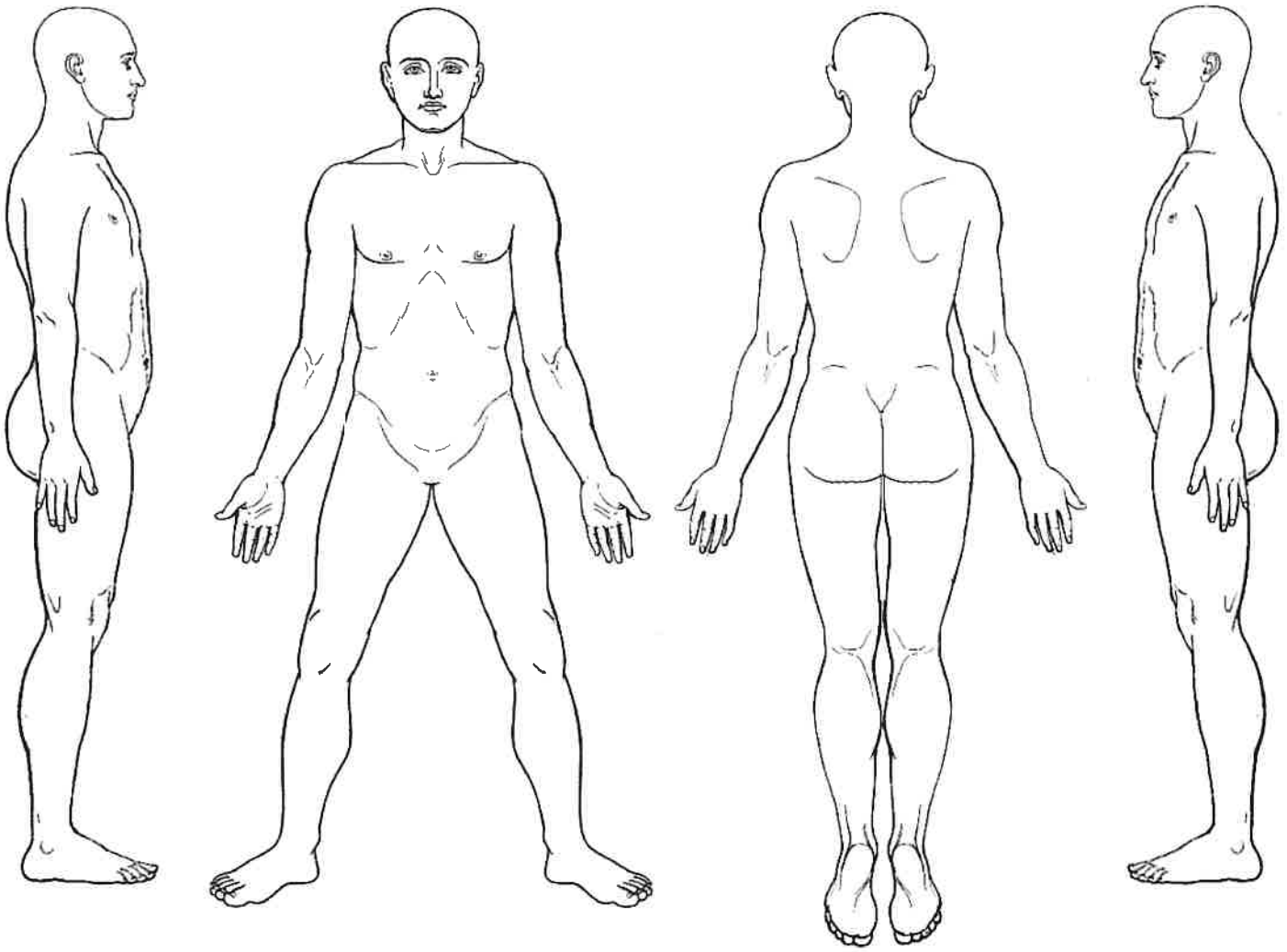
How do you tolerate:

Antibiotics: _____

Steroids: _____

Pain

Please mark where you feel discomfort with a number from worst to least in severity:



How often:

Type of discomfort:

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

Family History

Family Member	Current Age	Health Issues	(Age deceased)	(Cause of death)
Father				
Mother				
Brother				
Sister				
Spouse				
Son				
Daughter				

History of family illnesses:

Alcoholism _____
Allergies _____
Anemia _____
Arthritis _____
Asthma _____
Cancer _____
_____
Cholesterol _____
Convulsions _____
COPD _____
Depression _____

Diabetes _____
_____
Gall Bladder_____
Headaches _____
Heart _____
_____
Hepatitis _____
Hysterectomy_____
IBS _____
Menstrual _____
Migraines _____

Miscarriage _____
Obesity _____
_____
Parkinson's _____
Prostate _____
Psychology _____
Stroke _____
Suicide _____
Tuberculosis _____
Ulcers _____
Varicose Vn _____

Concerns/Questions/Comments that you wish to list:

Arvan Integrative Health Care LLC

Request for an Individual's Health Information
(Please Print Clearly)

Patient Information:
Last Name: _____ First: _____ Middle: _____

Other Names Used: _____ Date of Birth: _____ SS# _____

Address: _____

Primary Phone: _____ Work Phone: _____

The undersigned authorizes hereby authorizes the release of Patient's health information as follows:

____ Most Recent Progress Notes
____ Pathology/Lab Reports
____ X-Ray Reports
____ Mental Health
____ Entire health Record
____ Other: _____
____ Medication List

Records Released From:
Name: _____
Address: _____
_____
Phone: _____

Fax: _____

Records Released To:
Name: Dr. Andrea Arvan, MD, Arvan Integrative Health Care LLC
Address: 7410 Switzer Road
Shawnee, KS 66203
Phone: 913.742.0864

Fax: 816.931.4257

Notice:

- I may revoke this authorization at any time, in writing. Revocation will not apply to information already retained, used or disclosed under this authorization. Unless revoked, this authorization automatically expires one year from date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, Arvan Integrative Health Care LLC may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to disclosure by the recipient and no longer protected by federal privacy regulations.

Your Rights:

- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

This authorization is binding:

- The statements made in this authorization are binding and controlling. I understand and acknowledge this authorization take precedence over statements made in Arvan Integrative Health Care LLC's Notice of Privacy Practices.

This completed form may be mailed (_____), faxed (_____), hand delivered, or emailed (_____). Incomplete forms and digital signatures are not accepted.

_____ _____
Signature of Patient, Parent, or Guardian | Relationship to Patient

_____ _____
Print Patient Full Name | Date