Your path to well-being and longevity

Tumesh for Optimal Health
4920 Barranca Parkway, Suite D
Irvine, CA 92604
Tel: 949-387-8422
Fax: 949-387-8423
www.tumesh.com

REGISTRATION FORM

Today's date:	PCP: Tamara T. Kurmanalieva, MD

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Sin Mar Sep Div Wid Minor

E-mail address	Birth date:	Age:	Sex: ❑ M ❑ F

Street address:	Apt:	City:	State:	Zip:

S.S.:	Home phone:	Cell phone:	Work:

Guardian Name:

Street address:	Apt:	City:	State: CA	Zip:

Referred to Clinic by:	☐ Family	☐ Friend	☐ Online	☐ Other

NOTICE OF PRIVACY PRACTICES

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care and to enable us to meet your professional and legal obligations to operate this medical practice properly. We are required by law to maintain this privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. A copy of this notice may be provided to you which describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer, Idris Kurmanaliev, at 949-387-8422.

_____ I hereby acknowledge that I have read and understood the Notice of Privacy Practices of Tumesh for Optimal Health before filling out all required forms. I further acknowledge that a copy of any amended Notice of Privacy practices will be available at each appointment at the front desk and online at www.tumesh.com

_____ I voluntarily decline to receive a copy of the Notice of Privacy Practices of Tumesh for Optimal Health.

IN CASE OF EMERGENCY

Name of local friend or relative not living with you:	Relationship to patient:	Home phone:	Cell phone:

Address of emergency contact:

_____ _____

Patient's/Guardian's Signature: ***Date:***

Tumesh for Optimal Health

MEDICAL HISTORY INFORMATION

Name of Patient: _____ Date of Visit: _____

Reason for the Visit: _____

Health goals: 1. _____

2. _____

3. _____

Are you allergic to any medications? ❑No ❑Yes If yes, list medications and reactions:

Medication	Reaction

Do you take any medications daily? ❑No ❑Yes if yes, please list medications and dosage:

Medication	Dosage	Nutritional Supplements	Dosage

HEALTH HISTORY List all your known medical conditions:

Have you ever had chicken pox? ❑ No ❑ Yes If yes, approximately what year? _____

SURGERY/INJURY List previous surgeries or injuries and approximate year

Surgery	Year	Injury (Trauma or Fractures)	Year

FAMILY HISTORY List family member and approximate age of onset:

Disease	Family Member	Age of Onset
Thyroid Disease		
Strokes		
Seizures		
Osteoporosis		
High Cholesterol		
High Blood Pressure		
Heart Disease/ Heart Attacks		
Diabetes/ Adult or Juvenile Onset?		
Depression		
Cancer/ What type?		
Blood Disorder		
Others		

SOCIAL HISTORY

Name of Patient: _____ Date of visit: _____

Are you married? ❑ Yes ❑ No # of children _____ Boys: _____ Girls: _____

Are you sexually active? _____ Problems: _____

Circle if you are: heterosexual, bisexual, or homosexual

Are you in an abusive relationship? _____ Have you been sexually abused? _____

Tobacco use Current or Past_____ Quantity/day_____

Alcohol: Current or Past_____ Approximate amount/week_____

Illegal drugs: Current or Past_____ What type_____

Caffeine: ❑ Yes ❑ No Cups/day _____

HIV/AIDS Risks: _____ □ check if not sure

Do you have Advance Directive? ❑ Yes ❑ No

Advance Directive is used to direct your health care in case your health condition worsens and you are no longer able to make a decision for your own healthcare needs.

HEALTH MAINTENANCE

IMMUNIZATIONS

Type	Date
Tetanus Shot	
Pneumonia Shot	

Date of last physical exam? _____

Female Patients

Date of last menstrual period: _____

Are your periods regular? _____ Heavy? _____

Length of cycle _____

Total # of pregnancies: _____ Living children: _____

#vaginal _____ # c/s_____

Current method of birth control: _____

Methods used in past: _____

Date of last PAP: _____

Past abnormalities: _____

Date of last Mammogram: _____

Past abnormalities: _____

Male Patients

Date of last Prostate exam: _____

Past abnormalities: _____

Date of last PSA: _____

Past abnormalities: _____

Screenings (if applicable)

Date of last: Eye exam: _____ Results: _____

Colonoscopy/Flex sigmoidoscopy:_____ Results:_____

Cholesterol: _____ Results: _____

Bone density scan: _____ Results:_____

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PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Tamara Kurmanalieva MD
Tamara Kurmanalieva, M.D.

Patient Signature _____ Date _____ Physician's or Authorized Representative's Signature

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DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____ , understand I have the right to request a restriction as to how Protected
Patient/ Guardian
Health Information (PHI) is used / disclosed to carry out treatment, payment, or healthcare operations of Tumesh for Optimal Health. Tumesh for Optimal Health is not required to agree to any restrictions I may request. However, if Tumesh for Optimal Health agrees to any such restrictions, the restriction is binding on Tumesh.

My PHI means health information including demographic information collected from me and created or received by my physician, another health care provider, a health plan or my employer. This PHI relates to my past, present or future physical or mental health or condition and identifies me or there's reasonable basis to believe the information may identify me.

I understand that Tumesh for Optimal Health can communicate with me regarding my PHI through fax, email, phone, regular mail and from protected patient portal on www.tumesh.com. I understand that Tumesh for Optimal Health cannot and does not guarantee the privacy or security of any messages being sent over the Internet.

I voluntarily authorize **Tumesh for Optimal Health** to communicate with me through:

- ❑ Fax: _____
- ❑ Email: _____
- ❑ Regular mail: _____
- ❑ Patient portal: _____
- ❑ Phone Number: _____ _____
  Home Phone Cell Phone

Tumesh for Optimal Health may leave voicemail or send a message regarding my:

- ❑ Appointments only
- ❑ Appointments and other health information

I hereby give **Tumesh for Optimal Health** permission to disclose my PHI to:

_____ _____
Name of Friend/ Relative Relationship to the Patient

_____
Address Phone Number

❑ I DO NOT Authorize **Tumesh for Optimal Health** to:

_____ _____ _____
Please list

Date:_____ _____
Print Name

_____
Patient/Guardian Signature

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL RECORDS

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding the treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

Patient's Name: _____ Date of Birth: _____

Address: _____
STREET CITY STATE ZIP

Phone: _____

I hereby voluntarily authorize and direct: _____
NAME OF PROVIDER

Located at

_____
STREET CITY STATE ZIP

_____/_____
PHONE FAX

To provide a copy of my medical records as indicated below by checkmarks. The release of medical data includes re-disclosure of medical information obtained from other Providers in accordance with my wishes to ***Tumesh for Optimal Health*** at the above address or fax number.

INFORMATION TO BE RELEASED

- ❑ Dates of Service _____
- ❑ All records
- ❑ Face sheet
- ❑ Consultation Report
- ❑ Lab/Pathology Report
- ❑ Immunizations
- ❑ Operative Report
- ❑ _____

REASON FOR RELEASE OF RECORDS: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: medical history, diagnosis, and/or treatment of tobacco, drug or alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), billing information, correspondence, and records from other health care providers that the above – named health care facility may hold.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Print name of Patient or Legally Authorized Representative

_____
Relationship to Patient

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Cancellation/Broken Appointment/No-Show Policy

At Tumesh for Optimal Health, we greatly value your time and ours. Our office is a ***private practice*** and not a family "clinic."

Where appropriate, we prefer to schedule longer appointments so that we can complete as much needed care as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your path to wellbeing and longevity. If you have a medical emergency that needs immediate attention, we will always offer to see you as soon as possible.

When you make an appointment, please be sure that you will be able to keep it. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

If you cannot make an appointment as scheduled, please notify our office immediately.

A patient will be charged half (50%) of the original appointment fee for a "No Show Appointment" and for appointments which, absent a compelling reason, are canceled with less than 48 hours notice. This policy applies to all patients and all appointments.

I have read, understood, and agree to all of the above policies, terms and conditions stated above.

Patient Signature: _____ Date:_____

Print Name: _____

Witness Signature: _____ Date: _____

Witness Name: _____

Consent Form for the Purpose of Treatment at Tumesh for Optimal Health

I_____, hereby request and consent to the performance of medical treatment and other procedures, within the scope of practice afforded by the licensed healthcare professionals and other clinical staff members of Tumesh for Optimal Health, on me or for whom I am legally responsible.

I understand that any recommendations and care received at Tumesh for Optimal Health is supportive only, and do not substitute for regular medical care. I understand that I must continue to see my regular treating healthcare providers as directed by them and take my regular medications as prescribed.

_____I understand that the methods of treatment provided by Tumesh for Optimal Health include, but are not limited to, evaluation and management of acute and chronic medical problems, gender specific annual well exams, Bio-identical hormone restoration, acupuncture, electrical stimulation, Oriental and homeopathic medicine, weight loss, detoxification, nutritional restoration (IV or supplements), PK protocol, various types of oxidation therapy, various types of cosmetic procedures, and dietary and life style counseling.

_____I understand that some of the herbs and supplements recommended by Tumesh for Optimal Health may have occasional side effects. I will immediately notify Tumesh for Optimal Health of any side effects associated with my use of these herbs and/or supplements.

_____I understand that method(s) of treatment may involve insertion of various sized needles into different areas of my body, along with stimulation of these needles, either by hand or with an approved electrical device, and that there may be some discomfort and/or bruising during or following the treatment(s).

_____I understand that I have the right to question any therapy proposed and/or provided by Tumesh for Optimal Health and that all of my questions will be answered prior to receiving such treatment. I understand that I have **not** been and will not be given a guarantee of beneficial or specific results.

_____ I understand that Tumesh for Optimal Health does not accept any insurance. I will pay the amount presented to me at the time of my visit or procedure.

_____I am at least 18 years of age and I have provided a full and accurate medical history to the Physician. I am aware that I cannot hold the Physician responsible for damage, loss or liability that may result due to my failure to provide any information I did not provide prior to treatment. I understand that the Physician will rely on my documented medical history, as well as other information provided by me, my immediate family or others having information about me, in determining whether to perform or recommend certain procedures or treatment. Throughout the course of my treatment I agree to provide accurate, updated and thorough information regarding my medical history and any condition(s) or events which may impact medical decision-making.

I have carefully considered all of the relevant information provided to me regarding the foregoing medical treatment and other procedures, within the scope of practice offered by the licensed healthcare professionals and other clinical staff members of Tumesh for Optimal Health, and have determined, on my own free will, that I desire to proceed with the necessary treatment(s)/procedure(s) within the scope of Tumesh for Optimal Health. I am of sound mind and am capable of making this decision on my own behalf.

_____ _____

Signature of Patient or Person legally empowered to execute this Consent for a patient who is minor or physically or mentally incompetent

Date

_____ _____

Printed Name of Patient or Person legally empowered To Execute this Consent for a patient who is a minor or physically or mentally incompetent

Tumesh for Optimal Health Representative