Center for Holistic Medicine

Functional Medicine • Autism Spectrum Disorders • Medical Acupuncture

Dr. Katarzyna Ferraro M.D.

****THIS FORM MUST BE RECEIVED BY OUR OFFICE BEFORE YOU CAN MAKE AN APPOINTMENT****

Office Use Only: Date of Initial Evaliation:______________

HBOT QUESTIONNAIRE:

PERSONAL INFORMATION:

Patient Name: ________________________ Date of Birth: ___/___/_____ Male ☐ Female ☐

Home Address: ________________________ Phone Numbers: Home: ____________________

_____________________________________ Cell: ____________________

Email: _______________________________ Work: ____________________

Parent/Guardian Names (if patient is a minor): ____

PRIMARY PRACTITIONERS

NAME	PHONE NUMBER	CITY, STATE	LAST VISIT

SPECIALISTS

NAME	SPECIALTY	PHONE NUMBER	CITY, STATE	LAST VISIT

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Patient Name: ________________________

CHIEF COMPLAINT OR CURRENT ILLNESS

What are your major **CURRENT** health problems/concerns?

PROBLEM and BRIEF DESCRIPTION	DATE OF ONSET	FREQUENCY (daily, weekly, etc..)	SEVERITY (mild, moderate, or severe)

Is this problem a result of an injury? YES or NO (circle one)

If yes, please describe the injury in detail:

____

____

____

When did the injury occur? ______________________________

What therapies, medications, or other interventions have you tried and were the responses positive/negative/nonresponsive?

____

____

Reason for having a HBOT Evaluation: ______________________________

____

Please describe your HBOT history if you have done any sessions in the past (Hard/Soft chamber, where it was done, number of sessions, response, etc.) :

____

____

PAST MEDICAL HISTORY:

Include any chronic/recurring disorder or previously treated problems/disease which no longer affect you

CONDITION	PAST TREATMENTS	CURRENT TREAMENT	TREATMENT DATE(S)

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Smoker: YES □ NO □ Are you pregnant: YES □ NO □
If no, will you be trying in the next 6 months? YES □ NO □

Do you have a history of any of the following medical problems?

CONDITION	YES	NO	If YES, please explain
Epilepsy or seizure disorder			
Pneumothorax/Collapsed Lung			
Asthma or emphysema			
Cataracts			
Optic Neuritis			
Heart Failure			
Heart Problems			
Retinopathy of prematurity			
Dental Disease			

Have you ever had a concussion? YES □ NO □

If yes, please describe the trigger (sports injury, accident, etc.) and recovery (length of time, interventions, etc.): ______________________________

____

____

Please list any devices/hardware in your body: ______________________________

____

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REVIEW OF SYSTEMS AND OTHER HISTORY:

	CURRENT PROBLEM	PAST PROBLEM	NEVER A PROBLEM
Chills or Fever			
Fatigue			
Rashes			
Eye problems			
Headaches			
Ear Infections			
Sinus Infections			
Congestion			
Frequent colds			
Nosebleeds			
Cough			
Difficulty breathing			
Shortness of breath			
Abdominal pain			
Diarrhea			
Constipation			
Hypertension			
Chest pain			
Irregular heartbeat			
Leg pain after short walks			
Wounds that will not heal			
Painful urination			
Frequent urination			
Kidney stones			
Seizures			

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Continued...	**CURRENT PROBLEM**	**PAST PROBLEM**	**NEVER A PROBLEM**
Poor memory			
Depression			
Anxiety			
Numbness in a body part			
Mood Swings			
Irritability			
Insomnia			
Muscle Pain			
Fractures			
Joint pain or stiffness			
Claustrophobia			
Panic attacks			

Other (please describe any other problem you have in any organ system not mentioned above):

____

____

List any related labs, imaging studies, or evaluations (please include copies):

____

____

____

FAMILY HISTORY:

List any allergies, major illnesses, genetic diseases, or problems for each family member.
**If deceased, please list their age at death and the cause.

Father	
Mother	
Siblings	
Other pertinent family history	

Center for Holistic Medicine Practice Policies

Effective March 2017

Office Policy:

We require a credit card number to be put on file to schedule appointments. To be considered an active patient an on site visit must be made at least 1 time per calendar year. All follow ups must be done in person or by telephone (as recommended by your physician)

Cancellation Policy:

All services are provided by appointment only and this scheduled time is for your exclusive use. Cancellation policy differs by type of appointment as written below.

Initial functional medicine/Autism Spectrum consult:

All new patients are required to give a **1 week cancellation notice** due to the length of the appointment and time spent by the physician reviewing your records. Center for Holistic Medicine retains the deposit of 175.00 as non refundable. If you do not call or just do not show up for your appointment you will be billed for the remaining amount of 175.00 . (These appointments are very involved and time consuming)

Note: Appointments can be rescheduled at the physician's discretion.

Acupuncture:

All new patient appointments are required to give a **1 week cancellation notice** prior to your scheduled appointment. Center for Holistic Medicine retains the 75.00 deposit as non refundable if cancellation policy is broken.

Note: Appointments can be rescheduled at the physician's discretion.

Follow up appointment Cancellation:

We require 48 hours notice for follow up cancellations for Functional Medicine/Autism Spectrum management which includes office visits and telephone consults with the doctor. Center for Holistic Medicine retains the right to bill $100.00 of the standard fee for any consultation not cancelled with in 48 hours prior to the visit.

Cancellation for follow up for Medical Acupuncture treatment: We require a **48 hour notice** for cancellation of follow up acupuncture visits. Center for holistic medicine retains the right to bill 50.00 of the standard fee for any consultation not cancelled within 48 hours of scheduled visit.

Note: Any deposits made on an initial examination of any kind is non-refundable. We will hold these deposits to be applied toward your first exam for 6 months. Should you decide to cancel and not reschedule within that allotted time, the deposit will be applied as a cancellation fee and another deposit would be required for scheduling.

Signature________________________________ **Date**____________________

Center for Holistic Medicine Practice Policies

Email Policies:

As a part of our effort to provide you with the very best medical care, our clinicians use emails as a form of communications with patients.

Note: Email is not HIPPA compliant and is not 100% secure.

Email Guidelines:

- Email communications is viewed as billable time, as in an office visit or telephone consultations.
- Any Email that requires at least 15 minutes of clinician time will be billed as per the clinician's discretion.
- Brief emails will not be billed individually, but frequent emails will be cumulative and left to the clinician's sole discretion when billing time is necessary.

Please note that if you choose to submit our invoices to your insurance company for reimbursement, telephone consults are not generally covered by insurance and email correspondence is not covered by insurance. You should not submit invoices for email correspondence to your insurance provider.

If you have any questions regarding any of these policies, please call us at 717-243-0616

Thank you,

If the patient is a child both parents/guardians must sign below.

I, ______________________________ have read and understand the above outlined policies regarding email. I also understand that email is NOT 100% secure.

Patient Name: ______________________________

Patient Signature: ______________________________ **Date:** ____________

Parent/Guardian Signature: ______________________________ **Date:** ____________

Parent/Guardian Signature: ______________________________ **Date:** ____________

Center for Holistic Medicine
9 Brookwood Avenue Carlisle, PA 17015
(717)243-0616 FAX: (717)245-2351

Name: ______________________________ Phone: __________________

DOB: _______________________________

Center for Holistic Medicine

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Acknowledgement of receipt of Privacy Practices Notice:

I, __________________________ acknowledge that I have received a Privacy Practices Notice from the Center Holistic Medicine.

Patient Signature: _____________________ Date:_____________

- I give authorization to release information to the following people:
  ____________________________ Relationship: ____________________
  ____________________________ Relationship: ____________________

- May we leave a message on an answering machine or with your spouse? Y/N
- May we use Email to communicate with other medical professionals? Y/N

If a personal representative on behalf of the individual signs this authorization, please complete the following:

Personal Representative's Name: ________________________________

Relationship to Individual: ______________________________________

Signature Office Representative (office use only):

I attest that the above information is correct.

Signature:____________________________ Date:_________________________

Print Name: ___________________________ Title: _________________________

Center for Holistic Medicine
9 Brookwood Avenue
Carlisle, PA 17015
P) 717-245-2351

Mild Hyperbaric Therapy Consent Form

You are about to begin your mild hyperbaric treatment. This technology has been reported to have beneficial effects for a wide range of conditions. Nevertheless, as with many treatments, there are areas of concern which you should be aware. It is important that you take a few minutes to read the following information.

OTIC BAROTRAUMA: This is a condition of injury to the eardrum, and is extremely unlikely to occur in the mild hyperbaric chamber. However, severe ear discomfort can be caused if you cannot equalize the pressure in your ears. As the chamber is pressurized, (at the beginning of your session) you must be able to equalize the pressure in your ears to acclimate to the pressure changes. You do this by "popping" your ears. This is normal, and you can help the "popping" effect by yawning, chewing or swallowing. A more effective method is to hold your nose, close your mouth and blow. Continue to do this each time you feel pressure build up in your ears, while the chamber is being inflated or deflated. When the chamber reaches its full pressure or is near completion of depressurization you will not have these symptoms.

If one or both of your ears do not acclimate normally (by the "popping"), you will begin to experience discomfort in your ear canals. This can be caused by ear and/or throat congestion, or by prior trauma to the ears. You should not endure any ear discomfort during your session. We/you will adjust the pressure to a level of comfort for you and slowly try again to see at what level you are able to equalize the pressure in your ears. If you are unable to equalize the pressure in your ears, the session will have to be discontinued.

PAIN FROM SINUS, HEAD COLDS OR VIRUSES: You should not use the chamber if you are suffering from any of these conditions. Discomfort from these conditions is less frequent, but may occur in people with chronic and acute sinus infections or allergic rhinitis. If you experience discomfort from any of those conditions during pressurization you must suspend the treatment.

PULMONARY HYPEREXPANSION: This condition is very rare under mild hyperbaric treatments. However, to be overly cautious, holding your breath during decompression must be avoided as it could lead to expansion of the air in your lungs and damage to the lung tissues.

I/We________________________ read and fully understand and consent to treatments in the hyperbaric chamber and I/we agree to hold The Center for Holistic Medicine harmless from any blame I may associate with treatments in the hyperbaric chamber.______________ (initials, both parents/guardians)

Although mild HBOT has been reported to be beneficial for a wide range of conditions, this treatment is not meant as a cure for any condition or disease, and no therapeutic outcomes can be guaranteed.

Mild HBOT may be considered an alternative therapy for you or your child's condition. By signing below, you understand that we may be recommending mild HBOT for an off-label use.

We do not in any way recommend mild HBOT as a substitute for any medical treatments prescribed or suggested by any medical physician. We do not make any guarantees to any results that an individual may experience.

Patient Name:________________________________

Signature:___________________________________
(Patient or Parent/Guardian)

Signature:___________________________________
(Parent/Guardian)

Witness:____________________________________

Date:____________

Adapted from Center for Autism and Integrative Health, LLC Wilton, CT