Wellness Architecture
Dr. Samia McCully

New Patient Office Policy

Wellness Architecture is a cash office and payment is expected at time of service. Payment methods include check (preferable), Visa, Mastercard, or cash. If you have an insurance policy that will reimburse you for naturopathic medicine visits we will provide you with a superbill with appropriate diagnostic and billing codes that you can submit to the insurance company for reimbursement of your visit. We suggest that you make a copy of the superbill prior to submission because of consistent insurance clerical error. Our office will not interact with insurance companies on your behalf.

Cancellation Policy

We have a 48 hour cancellation/reschedule policy. If you do not call our office 48 hours prior to your scheduled appointment, you will be charged the full office visit fee.

We require a credit card number for our records to schedule your first appointment. Your credit card will not be charged unless you do not provide adequate cancellation notice and will be kept on file for missed appointments or appointments will inadequate cancellation notice.

By signing below, I agree that I have read and understood the policy. I guarantee payment of all charges incurred as a patient of Wellness Architecture.

Signed:____Date: ___________________

Printed Name: ____Date: ___________________

Parent or Guardian (minor): ______________________________Date: ___________________

841 El Camino Real • Menlo Park, CA 94025 • Phone: 650-233-7327
www.wellnessarchitecture.com

Notice of Privacy Practices

To our patients: 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. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

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

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a 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 prevent the threat.
5. If you are a member of the 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 information to only certain individuals involved in your care or the payment for your care, such as family member 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 Wellness Architecture, 841 El Camino Real, Menlo Park, CA 94025.

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 and submitted to Wellness Architecture, 841 El Camino, Menlo Park, CA 94025.

Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

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 the front desk receptionist.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. McCully at Wellness Architecture. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. 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 out health information privacy policies, please contact Dr. McCully at Wellness Architecture.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _________________, hereby acknowledge that Wellness Architecture has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Samia McCully
650-233-7327

I also understand that I am entitled to receive updates upon request if Wellness Architecture amends or changes its Notice of Privacy Practices in a material way.

________________________________ ________________________________

Signature

Relationship to Patient, if signed by someone other than patient.

____

Date

THIS SECTION IS TO BE COMPLETED BY WELLNESS ARCHITECTURE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): ____

____ ________________________

Name and title of employee

Date

Pre-Cleanse Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them in the comments section. The completed form will greatly assist us in providing a thorough evaluation of your health.

Confidential Patient Profile

Name:______________________________________ Age: _________ Date of Birth: ________________ Sex: ___

Address: ____________________________________ City: ________________ State: _________ Zip Code: _____

Phone: Home ( ) __________________________ Work ( ) ______________________

Cell: _____________________________ Email: ____

Occupation: _________________________________ How did you hear about us? ___________________________

Emergency Contact: __________________________ Relationship: __________ Day Phone: ( ) ___________

In this section please list in order of importance your health current concerns.

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Current Medication List: In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Are you allergic to any medications? Yes _______ No ___________

If "Yes", please list: ____

What happens when you have an allergy attack to medication? ______________________________

Hospitalizations: Include reason, year and duration: ______________________________

____

____

Current Supplement List: In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Describe your current energy level on a scale of 1-10: Morning _________ Afternoon: ___________ Evening: _______

Describe your sleep pattern (e.g., restful, interrupted etc.): ____

Food or Environmental Allergies: List any known allergens here:

1. ____ 5.______________________________________
2. ____ 6.______________________________________
3. ____ 7.______________________________________
4. ____ 8.______________________________________

Review of Systems (Check each symptom experienced within the last three months). Beside each symptom you have checked, mark the frequency indicated by:
Current = C
Past = P
Never = N

Digestive Tract		**Energy and Activity**	
Diarrhea		Fatigue	
Constipation		Sluggishness	
Bloated feeling		Apathy	
Belching		Hyperactivity	
Passing gas		Restlessness	
Stomach pains		Lethargy	
Ears		**Eyes**	
Itchy ears		Watery eyes	
Ear aches		Itchy eyes	
Ear infections		Swollen eyelids	
Drainage from ear		Sticky eyelids	
Ringing in ears		Dark circles	
Hearing loss		Blurred vision	
Joints and Muscles		**Skin**	
Pain in joints		Acne	
Arthritis		Hives and rashes	
Stiffness		Hair loss	
Limitation of movement		Flushing/hot flashes	
Aches in muscles		Excessive sweating	
Feeling of weakness			
Mouth and Throat		**Nose**	
Chronic coughing		Stuffy nose	
Gagging		Sinus problems	
Often clear throat		Hay fever	
Sore throat		Sneezing attacks	
Swollen tongue or lips		Excessive mucous	
Canker sores			

Head		**Lungs**	
Headaches		Chest congestion	
Faintness		Asthma, bronchitis	
Dizziness		Shortness of breath	
Insomnia		Difficulty breathing	
Mind		**Emotions**	
Poor memory		Mood swings	
Confusion		Anxiety/fear	
Poor concentration		Irritability/anger	
Stuttering/stammering		Depression	
		Aggressiveness	
Weight		**Other**	
Binge eating		Irregular heartbeat	
Cravings		Rapid heart	
Excessive weight		Chest pains	
Compulsive eating		Frequent illness	
Water retention		Urgent urination	
Underweight		Genital itch	

My goals for this cleanse are:

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

Questions or Comments:

____
____
____
____
____
____
____
____

OFFICE USE:

Pre-Cleanse (Date:__________)
Weight: __________
BMI: ____________
Body Fat: ________
BP: _____________

Post-Cleanse (Date:_________)
Weight: __________
BMI: ____________
Body Fat: ________
BP: _____________