New Health Institute, Inc
180 Newport Center Drive Suite 120
Newport Beach, CA 92660
Phone 949.644.6969 Fax 949.644.6959

Name:_____Today's Date: _____

Drivers License #_____ Social Security#____-____-____

Sex: _____ Birth Date: _____/_____/_____ Age: _____

Mailing Address: _____

City: _____ State: _____Zip: _____

Email Address: _____

Home Phone: _____Cell phone: _____Fax:_____

Employer Name: _____Telephone: _____

Occupation: _____

Spouse's Name: _____ Telephone: _____

Who may we thank for referring you to our office? _____

Whom may we contact in the case of an emergency?

Name: _____Relationship:_____ Phone: _____

Who is your primary care physician?

Name: _____Phone:_____

If you are a minor or dependent, please provide us with your parent/guardian information:

Name of Parent/Guardian: _____ Phone: _____

Who is financially responsible for your bill? _____

I will be paying today with: Cash_____Check_____Credit Card_____

Name of your insurance carrier: _____ Policy number: _____

Name of insured on this policy: _____

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the payment of all balances due for any professional/medical services or treatments rendered to me. I certify this information is true and correct to the best of my knowledge. I agree to notify New Health Institute of any changes in my status and the above information.

Signature: _____ Date: _____

Parent Signature (if minor):_____Date:_____

Patient Name:_____ Date: _____

YOUR CURRENT CONDITION

1. PLEASE DESCRIBE YOUR MAJOR PROBLEMS OR SYMPTOMS.
   If none, please tell us the reason for seeking this consultation. Please be clear and concise. Include when the symptoms first appeared.

2. HAVE YOU SEEN OTHER PHYSICIANS FOR THESE PROBLEMS?
   Please indicate the results of their evaluation.

3. WHAT HABITS, ACTIVITIES, OR ATTITUDES DO YOU THINK HAVE CONTRIBUTED TO YOUR CURRENT CONDITION/AILMENT?

Reviewed By: _____ _____
Svetlana R. Stivi, M.D Date

PATIENT MEDICAL QUESTIONNAIRE Patient Name:_____ Date: _____

MEDICATION STRENGTH AND DOSAGE:

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

NUTRITIONAL SUPPLEMENTS:

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

ALLERGIES TO MEDICATIONS, FOOD, ETC. (PLEASE DESCRIBE THE REACTION/S):

1._____ 4._____

2._____ 5._____

3._____ 6._____

HOSPITALIZATIONS/SURGERIES:

Date Reason

1. _____ _____

2. _____ _____

3._____ _____

4. _____ _____

5. _____ _____

6. _____ _____

MAJOR ILLNESSES:

Date Reason

1. _____ _____

2. _____ _____

3._____ _____

4. _____ _____

5. _____ _____

6. _____ _____

Reviewed By: _____ _____

Svetlana R. Stivi, M.D Date

Patient Name:_____ Date: _____

PATIENT MEDICAL QUESTIONNAIRE

FAMILY HEALTH HISTORY

Please list any significant illnesses in your immediate family.

Relationship	Age if Living	Age if dead	State of health or cause of death
Mother			
Father			
Siblings			
Spouse			
Children			

CHILDHOOD HISTORY

Did your mother have problems during pregnancy with you? (Stress, illness, smoking, medication, alcohol) _____

Bottle Fed_____ Breast Fed_____ How Long_____

CHILDHOOD ILLNESSES

- ☐ Colic
- ☐ Allergies
- ☐ Rheumatic Fever
- ☐ German measles
- ☐ Eczema
- ☐ Bronchitis
- ☐ Recurrent Colds
- ☐ Bed Wetting
- ☐ Asthma
- ☐ Pneumonia
- ☐ Ear Infections
- ☐ Urinary Track Infection
- ☐ Polio
- ☐ Meningitis
- ☐ Thrush
- ☐ Persistent Diaper Rashes
- ☐ Hyperactivity
- ☐ Tonsillectomy
- ☐ Mumps
- ☐ Learning Disability
- ☐ Additional comments:

_____

_____

_____

_____

HOME LIFE AS A CHILD

- ☐ Loving
- ☐ Abusive
- ☐ Argumentative
- ☐ Friendly
- ☐ Supportive
- ☐ Peaceful
- ☐ Educational
- ☐ Single-parent
- ☐ Stressful
- ☐ Loud
- ☐ Fearful
- ☐ Lonely
- ☐ Additional Comments

_____

_____

_____

_____

Reviewed By: _____ _____

Svetlana R. Stivi, M.D Date

Patient Name:_____ Date: _____

PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYSTEMS

(Please check current or recent symptoms/problems from the following list)

GENERAL:
- ☐ Weakness
- ☐ Fatigue
- ☐ Weight Change
- ☐ Night Sweats
- ☐ Fever
- ☐ Sensitivity to heat or cold

SKIN:
- ☐ Rashes
- ☐ Itching
- ☐ Changes in hair or nails
- ☐ Changes in color or pigmentation

HEAD:
- ☐ Headache
- ☐ History of head trauma

EYES:
- ☐ Pain
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Inflammation or Discharge
- ☐ Glasses
- ☐ Surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinopathy

EARS:
- ☐ Loss of Hearing
- ☐ Ringing
- ☐ Pain
- ☐ Discharge
- ☐ Bleeding
- ☐ Postnasal Drip

MOUTH/THROAT:
- ☐ Sores
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Dentures
- ☐ Change in taste

BREAST:
- ☐ Lumps
- ☐ Pain
- ☐ History of Cancer
- ☐ Nipple Discharge

RESPIRATORY:
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing Blood
- ☐ Phlegm Production
- ☐ Trouble breathing when lying down
- ☐ Waking up suddenly due to cessation of breathing
- ☐ Shortness of breath at rest or on exertion
- ☐ Blueness of skin
- ☐ Leg/Arm swelling
- ☐ Hypertension
- ☐ Leg pain when walking
- ☐ Heart Murmurs
- ☐ History of Rheumatic Fever

GASTROINTESTINAL:
- ☐ Change in appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Abdominal Pain
- ☐ Bleaching
- ☐ Excess Gas
- ☐ Abdominal Enlargement
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Black Stools
- ☐ Constipation
- ☐ Jaundice
- ☐ Nausea
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Need for Laxatives
- ☐ History of Hepatitis B or C
- ☐ Vomiting Blood

GENITOURINARY:
- ☐ Urinary frequency or urgency
- ☐ Nighttime need to urinate
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Impotence
- ☐ Loss of Libido
- ☐ Pain with Intercourse
- ☐ Testicular Pain or Swelling
- ☐ Gonorrhea, Syphilis
- ☐ Contraception
- ☐ Genital Herpes
- ☐ Recurrent Urinary Tract Infections

Reviewed By: _____ _____

Svetlana R. Stivi, M.D — Date

Patient Name:_____ Date: _____

PATIENT MEDICAL QUESTIONNAIRE

REVIEW OF SYSTEMS

(Please check current or recent symptoms/problems from the following list)

ENDOCRINE:

- ☐ Goiter
- ☐ Prednisone treatment
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

BLOOD/LYMPHATIC:

- ☐ Anemia,
- ☐ Transfusions,
- ☐ Bleeding Tendency,
- ☐ Clotting Problems,
- ☐ Lymph Node Enlargement/Pain

JOINTS/MUSCLE:

- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Joints Pain
- ☐ Swollen Joints
- ☐ Deformity of Joints

NEUROLOGIC:

- ☐ Fainting
- ☐ Abnormal Gait
- ☐ Seizures
- ☐ Speech impairment
- ☐ Loss of sensation
- ☐ Paralysis
- ☐ Memory Loss
- ☐ Depression
- ☐ Dizziness

ALLERGIC HISTORY:

- ☐ Sensitivity to foods
- ☐ Pollen
- ☐ Weeds
- ☐ Animals
- ☐ Chemicals
- ☐ Drugs or vaccines
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Hives

IMMUNE SYSTEM:

- ☐ Frequent colds
- ☐ Recurrent mouth sores
- ☐ Recurrent skin infections
- ☐ Shingles (Herpes Zoster)
- ☐ HIV (+)
- ☐ Frequent/prolong use of antibiotics

GYNECOLOGIC HISTORY:

- ☐ Pregnancies # _____,
- ☐ Deliveries # _____,
- ☐ Miscarriage # _____,
- ☐ Abortions # _____,
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ PMS
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Hormone Replacement Therapy
- ☐ Abnormal Mammogram test
- ☐ Abnormal PAP Smear Test
- ☐ Abnormal Bone Density test
- ☐ Date Last Period Began _____

SCREENING TESTS:

Procedure	Date	Results
Colonoscopy		
Sigmoidoscopy		
CXR		
Pap smear Test		
Mammogram Test		
Bone Density		
Stress Test		
EKG		
All body CT-scan		
Angiography		
Other		

Reviewed By: _____ _____

Svetlana R. Stivi, M.D — Date

Patient Name:_____ Date: _____

LIFESTYLE QUESTIONNAIRE

NUTRITION:

1. How many meals do you eat each day?_____
2. Do you usually eat breakfast? YES _____ NO _____
3. How many times per week do you eat out at restaurants? _____
4. How many sweets do you consume each day? _____
5. How many cups of coffee/black tea/caffeinated soft drinks per day do you drink? _____
6. How many glasses, bottles of water do you drink per day? _____
7. How many serving of fruits/vegetables do you eat per day? _____
8. Have you ever been diagnosed with Anorexia Nervosa or Bulimia? YES_____ NO_____
9. What percentage of your food consumption is organic?_____

EXPOSURES:

1. Have you ever smoked? YES____ NO____ How much? ____ How Long? ____
   When did you quit? _____
2. Do you live or work closely with a smoker? YES____ NO____
3. Have you been exposed to industrial chemicals, pesticides, or other toxins? YES___ NO ____
4. Approximately how many Mercury amalgam fillings do you have in your teeth? _____
5. Do you drink alcohol? YES_____NO _____
   What kind? _____ How much? _____ How Often? _____
6. Do you use street drugs? YES _____NO _____ What type? _____ How often? _____

EXERCISES:

1. Do you exercise? YES ____ NO ____
2. What type of exercise do you do?_____
3. How often do you exercise each week and for how long is each session? _____

SLEEP:

1. How many hours of sleep do you get each night? _____
2. Do you have trouble falling asleep? YES ____ NO _____
3. Do you awaken frequently during the night? YES _____ NO ____
4. Do you wake up feeling refreshed in the morning? YES ____ NO ____
5. Do you snore or hold your breath at night? YES ____ NO _____
6. Do your legs feel restless at night? YES _____ NO _____

STRESS:

1. Do you often feel that there is not enough time to accomplish your daily tasks? YES ____ NO ____
2. Do you feel frustrated or angry by existing personal or work circumstances? YES _____ NO ____
3. What level of stress do you consider yourself to be: LOW _____ MEDIUM _____ HIGH _____
4. Please describe ways that you cope with stress in your life: _____

HOBBIES AND INTERESTS:

1. What are your hobbies or life interests? _____
2. Do you allow time to enjoy your hobbies and/or life interests? YES _____ NO _____

Reviewed By: _____ _____
Svetlana R. Stivi, M.D Date

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an Arbitration Agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement, you are changing the place where your claim would be presented. You can still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Furthermore, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide excellent medical care in such a way as to avoid any such dispute. We know that most problems begin with a lack of communication. Therefore, if you have any questions about your care or treatment plan, please ask us.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court processes except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, and other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedures Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedures. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provisions in this arbitration agreement are held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement and acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical records.

By: _____
Physician or Authorized Representatives Signature.

By: _____
Patient's or Patient Representative's Signature Date

Svetlana R. Stivi M.D.
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
(949) 644-6969

By: _____
Print Patient's Name Date

New Health Institute, Inc
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
Phone 949-644-6969 Fax 949-644-6959

STATEMENT OF PATIENT AWARENESS AND RESPONSIBILITY

Please be advised that our services are intended to compliment those provided by your primary care physician; therefore all patients are urged to maintain their relationship with their primary care provider. As an Integrative Medicine consultant, Dr. Stivi is in the office by appointment only, and is not available to handle urgent or emergency situations. In the event of sudden illness or emergency, patients are expected to contact their primary care physician and/or go to the nearest emergency room.

1. I am aware that any therapy, no matter how well designed and carried out, may fail to alleviate my symptoms or have a direct improvement on my health.

2. I agree to make every effort to pursue the program mutually agreed upon with my physician.

3. I expect to be informed of those therapies most relevant to my condition, both conventional and alternative, realizing that I have the choice to accept, refuse, or terminate them at any point.

4. I understand that unforeseen difficulties may arise in the course of treatment.

5. I am responsible for seeking professional medical attention from Dr. Stivi or another facility for any worsening of my condition, including consideration of hospitalization, invasive procedures or treatment in the emergency room.

6. I am aware that many medical conditions require additional treatment and that follow-up visits are often necessary.

7. I understand that I may be referred to another physician for treatment. Full medical care is available to me, and I am aware that I will not be told to avoid seeing other physicians.

8. I consent to medical evaluation and treatment by the New Health Institute, Inc. I Understand that the New Health Institute, Inc. may recommend various methods to help me regain my health and those methods will be discussed with me.

9. There is no Doctor or nurse on call after hours, on weekends, or Holidays. Patients are expected to contact their primary care physicians or go to the nearest emergency room in case of emergency.

MY SIGNATURE BELOW CONSTITUTES CONSENT TO MEDICAL SERVICES:

Print Name: _____

Signature: _____ Date: _____

New Health Institute, Inc
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
Phone 949-644-6969 Fax 949-644-6959

PATIENT FINANCIAL POLICY

(Please read carefully before signing)

1. There will be a $35 charge for all returned checks. No third party checks are accepted.

2. Phone consultations payment is required at the time of the scheduled appointment.

3. Dr. Stivi may recommend laboratory work that will be performed by outside laboratories. If your visit includes lab tests, x-rays/scans, you will receive separate billing from the company performing the processing and evaluation of those tests; e.g., Hoag Hospital, Newport Imaging, Newport Diagnostics, Westcliff Labs, etc.

4. Please remember that your are financially responsible for all services rendered to you at the New Health Institute. You may wish to contact your insurance company directly should you have any concerns regarding insurance coverage for medical services rendered by an out of network provider. We will be happy to provide you a pro-form Super Bill if necessary.

5. To better serve all patients, our office requires at least one business day, at least 24 hours (exclusive of weekends and holidays) notice to cancel any follow-up office visit. New patient appointment cancellations require a 72 hours notice (exclusive of weekends and holidays); otherwise your credit card will billed for the full amount of the initial consultation. This charge is directly payable by you and will not be submitted to your insurance company. It may by necessary to reschedule your appointment if you are late more than 20 minutes.

6. Payment for all supplements, IV's, treatments, and diagnostics is due at time of service. Most insurance companies do not cover these services. You have the right to refuse any service. Mail order supplements are sent via U.S. mail or UPS. Payment must be received before any items can be shipped to you.

7. There will be a minimum charge of $30 for all letters that require review of medical records and/or typing on official letterhead (fees may vary depending on the time required).

8. There will be a minimum charge of $30 for all medical records copied (fees may vary depending on the amount of files and the time needed to copy them).

By signing below, you acknowledge that you have read, understand and agree to the above policies.

Print Name: _____

Signature: _____ Date: _____

New Health Institute, Inc
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
Phone 949-644-6969 Fax 949-644-6959

PATIENT REQUEST FOR CONFIDENTIAL CHANNELS OF COMMUNICATION

Patient Name: _____ Date of Birth: _____

I understand that when Dr. Stivi must contact me regarding my appointment or for any other reason, she will contact me by telephone or by mail.

I hereby request to receive communications as follows:

1. By Telephone (please check all that apply)

☐ At Home Telephone Number_____
☐ At Work Telephone Number_____
☐ Cell Phone Telephone Number_____
☐ Other Telephone Number_____

When providing information by telephone, I hereby consent to the following:

☐ Leave message on my voicemail/answering machine for appointment reminder.
☐ Leave message on my voicemail/answering machine to call office back.
☐ Leave message on my voicemail/answering machine providing test/procedure information or results.
☐ Leave message with another person at this number for appointment reminder.
☐ Leave message with another person at this number to call office back.
☐ Leave message with the following person(s) providing test/procedure information or results.

Name of person and relationship to patient.

1._____
2._____
3._____

2. by Mail

☐ At my home address: _____
☐ At my business address: _____
☐ Other address: _____

By Fax

☐ Fax Number_____

I certify that I am the patient or patient's personal representative and am authorized to sign this form.

Print Name: _____ Signature:_____

Date: _____ Relationship to Patient: _____

If patients personal representative, attach a copy of legal authority.

New Health Institute, Inc. Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully.

New Health Institute Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully.

Uses and Disclosures of your medical information:

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example results of laboratory test and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information maybe used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from a credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operation. Your health information may be used as necessary to support the day–to-day activities and management of New Health Institute, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality

Law-Enforcement . Your health information may be disclosed to Law enforcement agencies, without your permission, to support government audit and inspections, facilitate law-enforcement investigators, and with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the stat's public health department. Other uses and disclosures require your authorizations. Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. Additional uses of information include:

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information maybe used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights. You have certain right under the federal privacy standards.These include:

The right to request restrictions on the use and disclosure of your protected health information

The right to receive confidential communications concerning your medical condition and treatment

The right to inspect and copy your protected health information

The right to amend or submit corrections to your protected health information

The right to receive an accounting of how and to whom your protected health information has been disclosed

The right to receive printed copy of this notice

New Health Institute, Inc. Duties: We are required by law to maintain the privacy of you health information and to provide you with this notice of privacy practices. We also are to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by the law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices maybe required by changes in federal and state laws and regulations. What ever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised polices and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information: As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting New Health Institute, Inc.

Complaints: If you would like to submit a comment or complaint about our practices, you can do so by sending letter outlining your concerns to: New Health Institute, Inc, 180 Newport Center Dr Suite 120, Newport Beach, CA 92660. Telephone (949) 644-6969

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You can contact Svetlana R. Stivi, M.D, for further information concerning our privacy practices.

Effective Date: This Notice is effective on or after May, 15 2006

_____	_____	_____
Print Patient Name	Patient Signature	Date

New Health Institute, Inc
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
Phone 949-644-6969 Fax 949-644-6959

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices.

Print Name: _____

Signature _____ Date:_____

If not signed by the patient, please indicate relationship to patient bellow:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Name of Patient: _____

New Health Institute, Inc
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
Phone 949-644-6969 Fax 949-644-6959

AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release and disclose the health information of the above named patient as described below to:

Svetlana R. Stivi, M.D.
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660

I understand that the health information to be released, as described below, may include information concerning drug or alcohol abuse, mental health or HIV test results; and I specifically consent to the release and disclosure of any such information relating to drug or alcohol abuse, mental health, and HIV test results. I understand that this authorization does not apply to psychotherapy notes.

Health information to be released [Check all that apply]

- ☐ Entire Medical Record
- ☐ Medical History
- ☐ Diagnostic test results/reports
- ☐ Surgical/Operative Reports
- ☐ Other _____

This information may be used and disclosed for the following purposes:

_____

This authorization is effective immediately and shall remain in effect until _____
I understand that I have the right to revoke this authorization at any time. I further understand that if I revoke this authorization, it will apply to information that has already been released pursuant to this authorization.

I understand that treatment, payment, enrollment or eligibility for benefits cannot be conditioned on my signing this authorization.

I understand that once information is released and disclosed pursuant to this authorization, unless protected under California law, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I have a right to receive a copy of this authorization form after it is signed.

I certify that I am the patient or the patient's personal representative and am authorized to sign this form.

Print Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

If patients personal representative, attach a copy of legal authority.

New Health Institute, Inc
180 Newport Center Drive, Suite 120
Newport Beach, CA 92660
Phone 949-644-6969 Fax 949-644-6959

CONSENT TO DISCLOSE PATIENT HEALTH INFORMATION TO FAMILY AND FRIENDS INVOLVED IN PATIENT CARE

Patient Name: _____ Date of Birth: _____ SSN#: _____

I understand that Dr. Stivi will NOT disclose my protected health information to my family, friends or relatives except in emergency situations.

I understand that Dr. Stivi may disclose my protected health information to my family, friends or relatives that I identify who is directly involved in my care or payment of my care provided that I have an opportunity to agree or object to such disclosure.

The individual(s) named bellow is/are directly involved in my care and I would like these individual(s) to give and receive information from Dr. Stivi regarding my medical condition and treatment. Therefore, I hereby consent, agree and authorize Dr. Stivi to disclose my protected health information to the following individual(s) who is/are involved in my care or in the payment of my care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that by consenting to the disclosure of my protected health information to the individual(s) named above, all my personal information relevant to my care and treatment may be disclosed including, but not limited to, my medical history, my medical condition, diagnostic tests performed and their results, laboratory results, surgical procedures and other personal information given to, or discussed with, my physician.

This consent to disclose my protected health information applies to: (check the appropriate box)

Health information to be released [Check all that apply]

- ☐ This visit only
- ☐ All visits at which the individual(s) named above is/are present
- ☐ All communications with the individual(s) named above including information provided in person, by e- mail, by telephone, or by mail.

This consent is effective immediately and shall remain in effect until I revoke it. I understand that I have the right to revoke this consent at any time by providing written notice to Dr. Stivi. I further understand that I am NOT required to sign this form in order to receive treatment, and that I am voluntarily requesting and consenting to Dr. Stivi to disclose my protected information to the individual(s) named above.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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A MESSAGE TO OUR PATIENTS ABOUT OUR CANCELLATION POLICY

At New Health Institute we try to provide our clients with prompt appointments and accessible hours. Because of this goal, we ask that you kindly give our office 24 hours notice prior to canceling a scheduled appointment. Please be aware that we are instituting $ 110 service charge for failure to provide adequate notice of cancellation. This service will be automatically billed to your account or credit card.

Our office strives to provide the best personalized care available for our clients. Thank you for your understanding and feel free to refer any questions to our competent staff members.

I hereby agree to and will abide by the New Health Institute cancellation policy.

Patient Name: _____

Signature:_____Date:_____

Office Signature:_____Date:_____

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http://www.newhealthinstitute.com

AUTHORIZATION TO BILL CREDIT CARD

It is the practice of this office to require payment in full at the time of service. We are requesting that our patients give us the permission to process their credit card for the services rendered. (Co-pays, deductibles, products, treatments)

By signing below, you acknowledge that you have given us authorization to process your credit card for any outstanding balances.

Last four Digits: ___ ___ ___ ___

Your Signature: _____ Today's Date: _____