Heart to Heart Medical Center

Shiroko Sokitch, MD - Owner

Heart to Heart Medical Center
2200 Range Ave., Ste. 109
Santa Rosa, CA 95403
P: (707) 524-9640
F: (707) 524-9649
drshiroko@hthmc.com
www.hthmc.com

New Patient Orientation

Welcome to Heart to Heart Medical Center! We are delighted to be able to serve you. Our services include general medicine, acupuncture, and Chinese Medicine. Please view our office policies below.

- **If possible, please fill out these forms before your appointment.**

- **No Fragrances, Please:**
  The chemicals in fragrances give some people asthma, headaches, nausea or other symptoms.
  We ask that you don't wear any of the following scented products to your appointments:
  - Perfume
  - Cologne
  - Lotion
  - Laundry detergent
  - Or anything else with strong scents

- **Cancellation Policy:**
  - New patients will be charged 50% of their initial visit fee if we are given less than 2-business days cancellation notice from their scheduled appointment date.
  - Returning patients will be charged $75 if we are given less than 1-business day cancellation notice from their scheduled appointment date.

We look forward to seeing you at the office!

Dr. Shiroko Sokitch

Heart to Heart Medical Center

Shiroko Sokitch, MD - Owner

2013 Updated Billing Policy

As of February 1, 2013, there will be nominal fees added to the following services. This will enable us to enhance the quality of your medical care, and allow us to devote the necessary amount of time to your questions and requests.

We recognize the need for patient-care outside office appointments, and appreciate you understanding our fee adjustments to meet those needs.

Emails

- Emails That Require an In-Depth Response $20
- Prescription Renewal Requests $25 (To prevent this charge, please contact your pharmacy directly)
- Questions About Medication or Changes in Medication – Please schedule a phone or office appointment.

Phone Calls

- Prescription Renewal Requests $25 (To prevent this charge, please contact your pharmacy directly)
- In-Depth Phone Meeting (Substitute for Office Appointment) $105
- Questions About Medication or Changes in Medication – Please schedule a phone or office appointment.

Insurance

- Letters to Insurance Companies $25/page
- Insurance Pre-approval $50

Lab Results

- Standard Lab Results Appointment (15 minute consult) $125 (this price has not changed)
- In-Depth Lab Results Appointment (30 minute consult) $160

Medical Records

- You can go online to www.hthmc.com to download our medical records request form and fax it to (707) 524-9649.
- Medical Record Requests $.025 per page plus $10 minimum administration fee.

I have read Heart to Heart Medical Center's 2013 updated billing policy and consent to these charges.

Print name: ______________________________ Date: ______________

Signature: ____

Heart to Heart Medical Center

Shiroko Sokitch, MD - Owner

Patient Intake Form

Name: ______________________________ Today's Date: ______/______/__________

Address: ____________________ City: ____________________ Zip: ______________

Birth Date: ____________________ Age:____________________ Sex:______________

Home Phone: ______________________________ Work Phone: ______________________________

Employer: ______________________________ Occupation: ______________________________

Marital Status: ______________________________ Email Address: ______________________________

*** Emergency Contact: ______________________________ Relation to Patient: ______________________________**

*** Address: ______________________________ Phone: ______________________________**

Who referred you? ____

What goal (s) do you have for this visit?

____

____

We do not bill most insurance companies. Fill in below ONLY if we have agreed to bill your insurance company for you. * Please let us copy your insurance card*****

Ins. Co. Name: ____________________ Ins. Co. Phone: ______________________________

Address: ____________________ City: __________ State: ______ Zip: ______________

Policy/Claim #: ____________________ Policy Holder: ______________________________

Insured's Employer: ____

Attorney's Name (if any): ____________________ Phone: ______________________________

Primary or referring physician: ____________________ Phone: ______________________________

Date of Injury: ____

Heart to Heart Medical Center

Shiroko Sokitch, MD - Owner

Patient Medical History

Name ____

Please write a brief history of your most important health concerns:

List all the medication and supplements you are currently taking (Name, dose, and reason for taking). Bring supplements to your first visit.

Allergies to foods, medications, plants, or anything else:

Past surgeries and the approximate age they occurred:

Past accidents or injuries and the approximate age they occurred:

Past illnesses and approximate age they occurred:

Circle if any of the following have run in your family:

Allergies Cancer TB Diabetes Heart Disease Stroke

Please circle any additional physical symptoms or mental issues as described below.

Head and neck problems	Digestive symptoms
Heart and lungs	Muscles/Nerves/Joints
Memory Problems	Recurrent emotional/ mental issues

If you have menstrual issues:

Age of first period: ____________________ Age of menopause: ____________________

Problems with periods? (yes/no) ________ Number of pregnancies? ________________

Number of children? ___________________

Other symptoms or issues: ____

Heart to Heart Medical Center

Shiroko Sokitch, MD - Owner

Notice of Privacy Practices

This notice describes how health information about you may be used and how you can get access to your health information. This is required by the Privacy Regulations stated in the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Use and disclosure of health information:

1. To public health authorities that are authorized by law to collect information.
2. Lawsuits and other proceedings in response to a court or administrative order.
3. Required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of others.
5. If you are a member of US foreign military forces, vets as well, and if required by appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

Your rights regarding health information:

1) Communications: You can request that Shiroko Sokitch, MD communicate with you about your health in a particular manner or at a certain location. You may want us to contact you at home only.
2) You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. You have the right to request that we restrict our disclosure to only certain individuals, such as family members. We are not required to agree: however if we do, we are bound by our own agreement except when 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 such as medical records and billing records, but not psychotherapy notes. You must submit your request in writing, or complete request forms available in this office.
4) You may amend your health information if you believe it is incorrect or incomplete. To request copies or an amendment to your health information, please complete the required form in our office or request in writing and send to: Shiroko Sokitch, MD 2200 Range Avenue, Suite 109, Santa Rosa, CA 95403, attn.: medical records.
5) Right to copy of this notice: You are entitled to receive a copy of Notice of Privacy Practices. You may ask us for a copy of this notice at any time. Contact our front office or call us at (707) 524-9640.
6) Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice in writing or with the Secretary of the Department of Health and Human Services.
7) Our practice will obtain your written authorization for uses/disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice, or our health information privacy policies, please contact our office manager, privacy officer at (707) 524-9640.

I hereby acknowledge that I have read and reviewed this Privacy Notice.

Print name: ______________________________ Date: ______________

Signature: ____

Heart to Heart Medical Center

Shiroko Sokitch, MD - Owner

Treatment Agreement

Insurance: The Heart to Heart Medical Center does not bill insurance companies for your office visits with only *very few exceptions*. We accept checks, credit cards, ATM cards and cash at the time of service. We will provide you with information necessary to apply for reimbursement from your own insurance company.

Appointments: Follow-up appointment cancellations without 1-business day notification will be subject to a $75 charge. New patients require a 2-business day cancellation notification.

Payment Policy: All charges are the responsibility of the patient or the patient's guardian. I understand that charges for services are due at the time of service unless there is a prior agreement to bill my insurance company on my behalf. A credit card will be kept on file for the patient as a guarantee of payment and will be used for all PAST DUE PAYMENT BALANCES OVER 90 DAYS. It is the patient's responsibility to provide updated credit card information.

Emergency Services: A variety of health services are provided on an outpatient bases, but we do not admit patients to hospitals, or make hospital rounds.

Cancer: Dr. Sokitch is not an oncologist (cancer specialist) and does not treat cancer but she does provide supportive care for any treatment you may be receiving.

Dr. Sokitch is a primary care provider in that she does the following:

- Provide preventive care and teach healthy lifestyle choices
- Identify and treat common medical conditions
- Assess the urgency of your medical problems and direct you to the best place for that care
- Make referrals to medical specialists when necessary

She does not have hospital privileges and does not do annual pelvic exams anymore.

Payment Agreement (in the rare case of insurance billing)

I hereby authorize the processing of my medical insurance either by electronic or manual methods by the Heart to Heart Medical Center and/or its practitioners. My signature below authorizes payment to Dr. Sokitch for all medical benefits to which I am entitled.

I further authorize Dr. Sokitch to release all medical and/or insurance claims information necessary to secure payment. I recognize my financial obligation of any co-insurance, deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.

I further understand that Dr. Shiroko Sokitch has Opted-out of Medicare and will no longer bill Medicare. It is now the patient's responsibility to make payment at the time of services.

By signing below, I acknowledge that I have read the above Payment and Treatment Agreement, and understand my responsibilities to both.

Print name: ______________________________ Date: ______________

Signature: ____

Patient Informed Consent to Receive Treatment

Welcome to Heart to Heart Medical Center. Below is a consent form, intended to inform you of the way that Dr. Sokitch practices and the potential risks. We ask that you please sign that you understand and agree that there are some risks associated with any medical practice.

At Heart to Heart Medical Center each patient is treated as an individual and there is no "one size fits all" course of diagnosis or treatment. Dr. Sokitch uses a blend of Chinese and Western medicine modalities, possibly recommending one or more practices, diagnostics, or remedies.

The practices utilized may include one or more of the following: acupuncture; dietary supplements; bio-identical hormone treatment; herbal remedies; exercise; lifestyle counseling; medicinal use of nutrition; massage; stretching, physical manipulation, electrical muscle stimulation; mind-body techniques, such as meditation, prayer, and relaxation and art therapies.

As with any medical treatment, there MAY be risks with CAM therapies. Rigorous, well-designed clinical trials for many CAM therapies HAVE PRODUCED VARYING RESULTS; therefore, the safety and effectiveness of many CAM therapies are uncertain. Dr. Sokitch cannot be expected to be able to anticipate and explain all risks and complications. She will inform you of the choices of treatment available to you and inform you of the risks and controversies of the proposed treatments so that you will be able to make an informed decision regarding your care.

Of the treatments Dr. Sokitch uses, acupuncture and bio-identical hormone replacement are most common. There are potential risks and benefits of these procedures as described below:

Acupuncture is considered a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days; aggravation of pre-existing symptoms; discomfort; or pain. There have been rare instances reported in which a patient fainted, developed a scar or infection, experienced a spontaneous abortion, or sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung).

Contraindications for acupuncture treatment and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, an implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy.

Potential benefits of acupuncture treatment include: restoration of health and the body's maximal functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

Bio-identical hormone replacement therapy can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident, helping to reduce symptoms associated with low levels of these hormones. Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies.

Although the use of bio-identical hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with use bio-identical hormones.

Contraindications for Bio-Identical Hormone replacement include: family history of breast or prostate cancer, history of breast or prostate cancer in the past or currently undergoing treatment, other reproductive cancers such as uterine or ovarian, risk of blood clots, and, pregnancy.

Some dietary supplements may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. Also keep in mind that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions and other side effects to prescribed herbs and supplements.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Privacy: I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, or my representative, or unless it is required by law.

Patient Authorization and Consent for Treatment

I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by Dr. Sokitch, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.

I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of Bioidentical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with the prescribed CAM therapy.

Print Name____

Signature of Patient____
(or Person Authorized to Consent)

Date______________________

CONSENT TO TREAT A MINOR CHILD

I authorize Dr. Shiroko Sokitch to treat ____ (Name)

who is my _____________________ (Relationship).

Adult's Signature ____ Date ________________________________