Important Notice

The consultation with your clinic doctor regarding your child to discuss the issues of biomedical treatment is very detailed. This form is to alert you to the various things our office recommends if your initial appointment is an office visit.

- It is highly recommended that you bring a sitter to watch your child after their examination by the doctor. Typically your child will only need to be seen by the doctor for 10 to 15 minutes. This is to allow you as the parent or caregiver an opportunity to have your full undivided attention during your consultation.

- The doctor will be covering various aspects of biomedical medicine regarding autism-spectrum disorders in great detail. If you prefer to bring your own audio or video recording device this is allowed. Otherwise, the doctor will attempt to record your initial consultation at your request.

- We recommend that you plan for at least 1-1/2 to 2 hours of office time. This includes the time spent with the doctor, and 30 to 45 minutes for pre & post office staff consultation (this is especially important if our office staff needs to explain laboratory test collections, billing and/or paperwork procedures).

- Our office staff will assist you with regards to questions about laboratory testing procedures, billing, and/or office paperwork procedures. <u>However, the office staff does not do laboratory test analysis, nor do they attempt to interpret why a particular test or therapy has been ordered or recommended by the doctor</u>. **Also, you are responsible for reading ALL laboratory test kit instructions. Please take the time to read the test instructions prior to test collection.**

- Our office staff is here to assist you, but if they feel that your questions go beyond their scope of knowledge they may require that you schedule more time with your doctor.

- **PLEASE NOTE: Our office staff cannot provide child care. Your child must be observed and handled by a sitter or other parent at all times. No child can be left in our office unattended.**

- <u>**Please NO Food or Drink inside the office suite.**</u>

- Please bring your original signed paperwork to your initial appointment.

Stillpoint Center
Integrative Medicine

Dear Parent,

Thank you for choosing Stillpoint Center for Integrative Medicine (SCIM) as your healthcare provider. Our staff is dedicated to making your experience a most satisfying one. SCIM's team of healthcare practitioners will assure that you receive care that is specifically tailored to your health needs.

The enclosed information is necessary in order for us to complete your in office file and for our participation in your health care. You are encouraged to make copies of these documents for your records. **NOTE: The following forms must be completed, signed, and received by our office prior to scheduling an appointment.** We apologize for any inconvenience this may cause, but we need to accommodate other patients waiting to be scheduled. **You may fax these forms; the originals must be delivered to the center.**

- **Patient Information Form** *(return to office)*
- **Office Policies and Procedures** *(return to office)*
- **Autism-Spectrum Health Questionnaire** *(return to office)*
- **Universal Health Association Membership Application** *(return to office)*
- **Credit Card Authorization** *(return to office)*
- **Patient Consent Form** *(return to office)*
- **Important Document – Must Read and Sign** *(return to office)*

If your initial appointment is at our clinic, please bring an adult to look after your child or children as your clinic doctor will need your full attention for much of the consultation. If this is a consult by phone, we appreciate that you send along a photograph of your child or children for their chart. This helps us put a face to the child (parent) we are speaking with over the phone.

If you have copies of recent medical and laboratory reports, please provide them to our office at least one day prior to your appointment. If you cannot provide them prior to your appointment, you may bring them with you.

Please don't hesitate to contact us should you have any questions. We look forward to assisting you.

Appointment Date ______________________________ Time_______________ (PST)

Stillpoint Center for Integrative Medicine
41660 Ivy Street, Suite A
Murrieta, CA. 92562
(951) 461-4800 - phone
(951) 461-4560 – fax

Revised 8/08

Stillpoint Center
Integrative Medicine

(Office Policies and Procedures)

Hours:

- Monday & Fridays: 9AM–4PM (PST)
- Tuesday through Thursday: 9AM–5PM (PST)
- Office visits are by appointment only.

Consultation Fees, Test Kits, and In-Office Therapies:

We offer a 15% cash discount to patients paying in full. We accept check, mastercard, and visa. For patients needing a payment plan we accept CareCredit (see below).

CareCredit:

CareCredit (www.carecredit.com) is a medical financing service available through our office that you can put towards office consultations, laboratory testing, and in-office therapies. Our practice is listed as ***Universal Health Association*** under ***General Medicine*** on the ***CareCredit*** website.

Appointments:

- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, CareCredit, and check. No cash please.
- First appointment: All initial paperwork must be completed, signed, and received by office before your appointment will be scheduled. You may fax these forms, but the originals will need to be delivered to the center on the day of your appointment.
- First appointment: If paying by check for a phone consultation, include the check with your mailed paperwork.
- **Follow-up consults may be scheduled as *brief/focused*, *detailed*, and *comprehensive/complex* depending on your child's particular situation.**
- Patients who forget their appointment or cancel less than 2 business days prior to their appointment will be required to pay for the missed visit. Please understand that a missed appointment could have gone to a patient on the waiting list. The 48-hour reminder call from SCIM is a courtesy reminder only and not a guaranteed affirmation of your appointment.
- Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
- Scheduled consultations that include review of lab tests require that laboratory test results be received at least 24 hours prior to appointment.

Medical Letters, Narrative Reports, Chart Note Copying, etc.

Medical letters to schools, insurance companies, disability, as well as narrative reports and chart note copying for insurance purposes, etc. are a billable service. If your insurance company requires additional information we will attempt to bill them prior to sending the requested information. Unfortunately, some insurance companies feel that paying for this service is not an allowable. If this occurs than any fees will be your responsibility.

Office Consultations:

- Please check in 15 minutes before your scheduled appointment.
- Patients who are late may lose part of their time, and may be billed at the rate of the scheduled appointment.
- **Please do not wear any scented products, as many of our patients are chemically sensitive. These include lotions, cologne, perfume, hair spray, etc.**

Phone Consultations:

- **There is no price difference for phone consultations.** **Each phone consultation is treated like any other consultation – the time spent with your doctor is the same whether it is in person (in the office) or over the phone. The phone consultation is for the patient's convenience. If you would rather have an office consultation then let the office staff know your preference.**
- Your doctor will call you at the time of your scheduled consultation.
- All appointments are scheduled for the Pacific Standard Time zone.
- We require patients outside of the USA to call the office at the time of their scheduled phone consultation. If this is not possible, than phone consultation phone bill charge will be billed to the patient.

Cancellations:

- As a courtesy, our office will call you to confirm your appointment 2 business days in advance.
- If you cannot keep a scheduled appointment, you must notify us a minimum of 2 business days prior to your scheduled time, or you will be charged for the missed appointment.
- If your appointment is on Monday, please notify our office no later than noon on the previous Thursday.

Prescription Request:

- Prescriptions originating from a consultation are processed at no charge. However, refills of these original prescriptions requested by you that are approved by your doctor without consultation may incur a processing charge per prescription.
- Requests for a new prescription or a change in prescription type or transfer to a different pharmacy or multiple refills may incur a prescription processing charge.

Questions and Follow-up:

- Please direct e-mails, faxes or letters regarding you or your child's care to the Center's administrative assistants (info@mystillpoint.com). Questions must be brief and concise. The office staff and/or clinic physicians will determine if a phone or office consult is needed to answer your question(s). Otherwise, a member of our office staff will respond to your inquiry. When leaving a voice mail message, please be brief and concise and always include your name and phone number, including the area code.

- Please Note: We try to accommodate questions regarding treatment clarification at no charge. Simply put, if you have a quick question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, then by all means contact us. However, if the response to a question you submit requires doctor research and/or review, you may be billed for the time involved at the doctor's hourly rate.

Follow-up Consultations:

- We generally recommend that all patients minimally have an office consultation with their respective clinic doctor every 3 months to 6 months.
- If prescription medication is being provided by your clinic doctor for yourself or your child than a office consultation is required in the following manner:
  - **Every 3 to 6 months – Southern California region**
  - **Every 6 to 12 months – Central and N. California, Out of State.**
- The reason for these office visits is for the doctor to physically see you or your child and provide a physical examination.

Payment:

- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, CareCredit, and check. No cash please.
- If paying by check for a phone consultation, include the check with your mailed paperwork.
- If you are unable to pay by credit card, a check must be provided prior to your appointment in the amount due for the scheduled time. In the event that your consultation exceeds or falls short of the scheduled time, adjustment to payment will be made on the same day via Electronic Funds Transfer (EFT).

Insurance:

- For patients that have seen the medical director, a "Superbill" receipt (form detailing diagnostic codes and fees) can be provided to you after each visit. This receipt can be submitted to your insurance carrier for reimbursement. Some services may not be covered by certain health insurance plans. It is your responsibility to know what your insurance plan covers. We are not responsible for unpaid claims by your insurance company for services we provide. SCIM does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

- SCIM healthcare practitioners are **non-participating** Medicare, Medi-Cal, Champus, and Tri-Care providers. They can treat these patients who privately contract outside of these programs on a cash basis only. Standard receipts can be provided. However, diagnostic code receipts called "Superbills" cannot be provided as these organizations will not allow for patient reimbursement. **There is a waiver on the last page of this document titled "Patient Private Contract" that must be completed if you are a member with the above insurance plans.**

Acceptance of Policies and Procedures

By completing the following you agree to the policies and procedures detailed above.

Patient (please print):_______________________________________ Date: ___________________

Signature (patient or responsible party): ____

If signed by party other than patient, print name: __________________________________

Patient Private Contract
(Medicare/MediCal/Tricare)

____

(Patient Name or Legal Guardian)

With:

Kurt N. Woeller, D.O.
41660 Ivy Street, Suite A
Murrieta, CA 92562

Under Code 1128 of the Social Security Act,
Dr. Woeller has requested exclusion from participation in the Medicare Program

I have voluntarily decided to privately contract outside the Medicare Part B program for the professional services of osteopathic medicine, even if such items and services would otherwise be covered by **Medicare/MediCal/TriCare**. Neither my family nor heirs nor estate will file any Medicare Part B forms for these services nor require Dr. Kurt Woeller, D.O. or his office staff to do so.
I hereby waive my entitlement to Medicare Part B benefits for these services.

By signing this contract, I also agree that:

I am responsible for payment of office fees for services.
Medicare will make no reimbursements for any items or services.

No Medicare payment limits are applicable.

Medigap plans and other supplemental plans **will not make payments** for these items and services since Medicare will make no payment.

I may have such services provided by another physician for which Medicare payment would be made.

Osteopathic Manipulative Medicine is a covered Medicare service and other participating physicians may choose to bill Medicare for these osteopathic services.

I acknowledge that a legal representative or I signed this agreement at a time when I was not facing any medical emergency or urgent healthcare situation.

____________________________ ____________________
Patient or Legal Guardian Date

____________________________ ____________________
Kurt N. Woeller, D.O. Date

Stillpoint Center
Integrative Medicine

Patient Contact Information

(PLEASE PRINT CLEARLY)

Patient Name ____
Last First Middle initial

Home address ______________________________ Birth date ____/____/____

City __________________ State ________ Zip ________

Driver's License # ________________________ State _____

Primary phone: Daytime (   ) ______________ Evening (   ) ___________

Cell phone (   ) ___________________ Fax (   ) ___________________

Email address ____________________________________(please print clearly)

Employed by _____________________________

Occupation _____________________________

What name do you prefer to be called?

____

Who referred you to our office?

____

In case of emergency contact:

Name _____________________________ Relationship ______________

Address ____

City ____________________________State ______ Zip ______________

Home phone (   ) _____________ Work phone (   ) ________________

For children under 18 years of age:

Mother's full name ____

Father's full name ____

School attending ___________________________ City ______________

____

For office use only:

The Universal
Health Association

Universal Health Association
41660 Ivy Street, Suite A
Murrieta, CA. 92562
*951-461-4800 * 951-461-4560 (fax)*
www.universalhealthassociation.org

The purpose of the Universal Health Association (UHA) is to protect the rights of patients to obtain and the rights of health practitioners to provide a wide array of cutting-edge healthcare services, therapies and diagnostics at a reasonable price, while protecting patient's healthcare practitioners from frivolous legal actions by those who do not appreciate the unique diagnostic and therapeutic options that we provide.

In addition to conventional medical care, Stillpoint Center for Integrative Medicine offers its discerning clientele access to cutting-edge diagnostic testing and therapies. To offer these services while protecting doctors and other health care practitioners from unreasonable liability, it would be necessary to carry very costly medical liability insurance. This cost typically would be passed on to patients in the form of substantially increased fees. The UHA offers a solution to this potential cost spiral.

A growing segment of the American population (and others around the world) demand access to both conventional, as well as cutting-edge healthcare services. However, a doctor may be found "negligent" for utilizing diagnostic procedures and/or treatments that are not considered to be conventional: those defined as "standard" and "customary" within his/her community.

Members of the UHA (which includes all patients, staff members, doctors, and other health care practitioners), through their by-laws, agree to limit the scope and extent of legal remedies against fellow members of the Association. All complaints against other members, including healthcare practitioners, must be initiated with the UHA. By becoming a member of the UHA you agree to the Association's by-laws, including its grievance procedures as set forth in Article XXVII (Grievances). For convenience, your healthcare provider has agreed to pay your $5 lifetime membership fee to the UHA. UHA by-laws are provided on the internet at www.universalhealthassociation.org and are available in printed form at Stillpoint Center for Integrative Medicine.

MEMBERSHIP APPLICATION

Name:______________________________
Business Address:______________________________
Business Phone:______________________________
Home Address:______________________________
Home Phone:______________________________
e-mail:______________________________

MEMBERSHIP CERTIFICATION

I, (print name) ______________________________, have been informed of the benefits and responsibilities of the membership in the ***Universal Health Association.*** I have been informed of the by-laws under which the Association operates and understand the nature of those by-laws, that include but are not limited to, the use of administrative remedies and Arbitration to resolve disputes. In consideration for the benefits of membership, I agree to join the ***Universal Health Association*** as of the date below. I also agree to abide by all of the Association's by-laws, rules and regulations as they exist now and as they may be amended in the future.

Executed on (date) ____________________ **at (City and State)**____________________

Name (print): ______________________________

Signature: ______________________________

Note: Membership information is held in confidence and not provided, leased, or resold to any third party or entity, unless otherwise required by law. Its use is solely for Association business and communicating to members.

Stillpoint Center
Integrative Medicine

(Credit Card Authorization)

I, (print name)____authorize Stillpoint Center for Integrative Medicine (SCIM) , located at 41160 Ivy Street, A - Murrieta, California to bill my credit card as listed below.

Name on Credit Card _____________________________________

Credit Card Details

Visa Card # ____Exp date _______________

MasterCard Card # ____Exp date _______________

Discover Card # ____Exp date_______________

Driver's License # ______________________ State: _______

Patient Information

Name: ____

Address: ____

City: _____________________________ State:____________Zip: ______________

Phone (include area code): ____

Authorization

______________________________________ ___________________________
Card Holder's Signature Today's Date

______________________________________ ___________________________
Patient's Signature Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

Stillpoint Center
Integrative Medicine

THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR RIGHT TO PRIVACY.

Stillpoint Center for Integrative Medicine (SCIM) protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. SCIM will not disclose this information without your authorization, except as permitted by law.

Our **Notice of Privacy Practices** provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is **not** shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

____
Print name

____
Signature Date

Stillpoint Center
Integrative Medicine

Effective Date: June 1, 2005

Please Note: In order to comply with the numerous state, Federal, and local laws that govern medical information privacy, this document is provided. Stillpoint Center for Integrative Medicine (SCIM), its healthcare practitioners, and all associated personnel will do everything possible to maintain the privacy of your medical information as required by law. Under no circumstances will SCIM disclose your personal or medical information to any outside parties.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE.

This notice describes SCIM practices and that of:

- Any health care professional authorized to enter information into your patient chart.
- All employees, staff and other clinic personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other clinic personnel who are involved in taking care of you at the clinic. Different departments of the clinic also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Health Care Operations. We may use and disclose medical information about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and service about many clinic patients to decide what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective.

We may also disclose information to doctors, nurses, technicians, medical students, and other clinic personnel for review and learning purposes. We may also combine the medical information we have with medical information from other clinics to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. s and to evaluate the performance of our staff in caring for you. We may also combine medical information

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the clinic.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under limited circumstances, we may use and disclose medical information about you for research purposes. Note: Under no circumstances will your name be associated with your medical data. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the clinic.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

SPECIAL SITUATIONS

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the clinic. To request an amendment, your request must be made in writing and submitted to the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the clinic; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the address below. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic, call 800-831-8798. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Stillpoint Center
Integrative Medicine

Autism-Spectrum Health Questionnaire
(includes children without an official diagnosis)

Child's Name______________________________
Child's Age_______ Date of Birth: ____________
Sex: ____ Male: ____ Female: ____ Weight: _____

Age of Autistic Spectrum Disorder (ASD) Diagnosis? ________ Official Diagnosis __________________________
Is child classified as Mild ASD ___ Moderate ___ Severe ___
Symptoms became apparent at what age? ______
What signs and symptoms first became noticeable that alarmed you as a parent? (Please list as many initial developmental problems as possible, ie. poor eye contact, aggressive behavior, etc.):

What developmental issues does child suffer with currently if different from above?

Other Health Issues:
Does your child suffer with other health problems: ___Allergies ___Asthma ___Constipation ___Diarrhea ___Eczema___ Kidney Problems ___Lung Disease ___ Diabetes ___Thyroid Disease ___Heart Disease ___ Seizures___ Repeated Infections ___Other, please explain____________________________________
Did your child's condition change following an illness, infection and/or seizure disorder (such as a febrile seizure) ___No ___Yes, please explain____

Digestive Health:
Does child have periodic loose stools/diarrhea___ Yes ___ No
Offensive Gas ___Yes ___No Undigested Food Stuff in Stools ___Yes ___No
Is you child potty trained ___Yes ___No Does your child suffer with reflux/heartburn ___Yes ___No
Is your child currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___Yes ___ No
Did occurrence of digestive problems occur following a particular vaccine ___Yes ___No ___ Unsure
Does your child produce formed stools ___Yes ___ No
Have they ever produced formed stools ___Yes ___ No

Antibiotic History:
How many courses of antibiotics has your child received in lifetime (approx): ___ 0 ___ 1-5 ___5-10 ___10-15 ___15-20 ___20+
Main reason for antibiotic use: ___Ear Infections ___Bronchitis ___Pneumonia ___Sinus Infection ___Intestinal Infection ___Other (please explain)____
Was your child ever treated for a yeast infection following antibiotic use ____________________________

Drug Allergies: ____No/Unknown ____Yes (explain)____

Home Environment:
How old is your current home____ Has your child lived in a home that had lead-based paint___Yes ___No
Is your flooring carpet ___ hardwood ___ tile___ Do you have carpeting in the bathrooms _____________
Has there ever been any exposure in the home to molds ___Yes ___No, explain______________________
Do you use commercial cleaners in the home ___Yes ___No
Has your child used or sleep in fire retardant clothing or bedding ___Yes ___No
Is child exposed to outside pesticides, fungicides, etc. ___Yes ___No
Please list pets and/or farm animals your child is exposed to _____________________________________

Mothers Pregnancy and Labor:
Did Mom have any complications during pregnancy, ie. ___High Blood Pressure___ Seizures ___ Diabetes
___Infections that antibiotic treatment ___Viral Infections (Flu, Mono) ___________________________
Does Mom know her Rh status ___ (+ or -) Blood Type ___
Did Mom receive Rhogam during pregnancy ___Yes ___No
Did Mom receive any vaccinations during pregnancy ___Yes ___No, which ones ____________________
Did Mom receive any vaccinations after pregnancy while breastfeeding ___Yes ___No
Was your child delivered vaginal___ or C-section___
Forceps and/or suction devices used __________ Was there any concern for birth trauma __________

Mother's Medical History:
___Low Thyroid ___ Thyroid Cancer ___ Parathyroid problems ___ Nightblindness (difficulty seeing at night)
___Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid)
Mercury Fillings in Mouth ___ Dental work that contains Nickel ___
Other, please explain____
Did Mom have any dental work done during pregnancy ___Yes ___No
Did mom have mercury fillings removed while breastfeeding child ___Yes ___No

Family History:
Is there a family history of Developmental Disorders, i.e. Autism, PDD? Please explain:

Is there a family history of other Neurological Disorders, i.e. Multiple Sclerosis, etc.

Is there a family history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis, etc.)?

Is there a family history of Clotting or Blood Disorders, Strokes, Hemophilia, Platelet Disorders?

Is there a family history of Psychiatric Disorders, i.e. Depression, Schizophrenia, etc.?

Is there a family history of Genetic disorders?

Is there a family history of Seizures, Vaccine Reactions?

Is there a family history of Celiac Disease, or Gluten Intolerance?

Vaccination Status:
Has child received all the recommended vaccinations for their age? ____ Yes ____ No
Has your child received: ___DTP ___ DTaP ___ MMR ___Hib ___Hep B ___OPV ___IPV
___Pneumonia ___Chicken Pox ___Flu ___Others (please list)__________________________________
Do you feel your child's behavior change after a particular vaccination? ____Yes _____No. If yes, please indicate which vaccine(s) ____
How long after the above vaccine(s) did child become symptomatic? (ex:: Minutes, days, etc. ____________

Did your child receive any vaccinations when they were sick ___Yes ___No, please explain_____________

Did your child suffer any vaccine reactions ___Fever ___ Inconsolable screaming ___Excessive lethargy___
___Rashes ___Vomiting ___Seizures ___Other____

Medication Usage:
Has child taken steroid medication ___Yes ___No. If Yes, which kind ___Inhaled ___oral
Has child taken medication for yeast/candida infection ___No ___Yes, please list____________________

Is child currently taking medication for yeast ___Yes ___No
Are they taking supplements for yeast ___Yes ___No, please list__________________________________
Please list other medication child is currently taking:

Supplements:
Please list all supplements child is currently taking, including nutritional oils, i.e. Cod Liver, Flax, etc:

Diet:
Is child on a Gluten Free Diet ___Yes ___No
Is child on a Casein Free Diet ___Yes ___No
Has child benefited by being on a GF/CF diet:____
Is child on a Specific Carbohydrate Diet _____ Is child on a Low Oxalate Diet _____

DAN! Therapies:
Has child received Secretin ___Yes ___No. If yes, have they benefited____________________________
Is child receiving Cod Liver Oil ___Yes ___No. Any benefits?____________________________________
Is your child receiving Bethanocol Treatment ___Yes ___No. Any benefits?_________________________
Has child received IVIG (Intravenous Immunoglobulins) ___Yes ___No. Any benefits?_______________
Is child currently receiving IVIG therapy ___Yes ___No
Does child currently have Mercury/Amalgam/Silver Fillings? ___Yes ___No
Has child received Mercury Chelation w/DMSA ___Yes ___No DMPS ___Yes ___No EDTA ___Yes ___No
Any benefits from chelation therapy?____
Has child received Chelation Therapy for other Heavy Metals besides Mercury?
____
Has your child taken antifungals in the past, i.e. Nystatin,? ___Yes ___No Diflucan ___Yes ___No
Is child taking Transfer Factor? ___Yes ___No Colostrum ___Yes ___No
Valtrex ____Yes ____No Low Dose Naltrexone (LDN) ____ Yes ____No Actos ____ Yes ____ No
Spironolactone ____Yes ___ No
Other Biomedical Therapies____

Attended a "Defeat Autism Now!" seminar ___Yes ____ No Other biomedical Autism Conferences ___Yes ___No

TACA seminars or classes ___Yes ___No Other biomedical autism support groups ___Yes ___No

What autism-related books have you read ____

Internet articles or websites ____

What biomedical therapies are you interested in? ____

Other Important Information: If pertinent, please take the time to tell us more about the medical history of your child in relation to their autism diagnosis. If more space is needed you may use the back of this document.

IMPORTANT DOCUMENT – PLEASE READ & SIGN

(This document must be read and signed prior to your appointment.)

This document is a brief overview of what you can expect from your first consultation in our office in Murrieta, CA. Much of the information that relates to therapy prioritization and testing recommendations applies mostly to parents new to the biomedical approach for their autism-spectrum child. It is impossible to discuss all potential scenarios with regards to every child in this document, but if you are new to biomedicine for autism, have not implemented biomedical therapies, or proceeded with biomedical testing in the past please read carefully.

Initial Consultation:

- When you arrive at our office an office staff member will take a polaroid photograph of you and your child for you child's chart. This is important so that we can put a face to you and your child's name in the future.
- Please bring a babysitter, family member, etc. to watch your child once your doctor has finished their examination. This is so you can have your full undivided attention with your clinic doctor.
- Please be aware that we have a small waiting area. If your child is unable to sit or play quietly than an adjacent exam room can be used or your child can be taken outside (large courtyard fountain area) or to a nearby park facility (inquire with an office staff member about park locations).
- Please NO FOOD OR DRINKS in the office. If your child must eat or drink they can do so outside of the office building.
- Please allow at least 1-1/2 to 2 hours in our office (consultation time + an additional 30 to 60 minutes after your appointment to settle payment and/or go over test recommendations, etc. with the office staff.
- Please be sure to show up on time for your appointment. The doctors are very prompt in their scheduling and very rarely run over.

Therapy Recommendations:

- For most children (teenagers and/or adults) starting out with biomedical we will likely recommend Methyl-B12 therapy. It will benefit you to read Dr. Woeller's article about this therapy prior to your consultation. This article can be downloaded from our website resource center at www.stillpointhealth.com. Click on the 'handouts' link and look for the handout called "Methylcobolamin Handout." The complete title of this article is "**The Use of Methylcobolamin (B12) Injections to Support Methylation Problems in Autistic-Spectrum Children**."

- Your doctor will discuss with you the various options for treatment, supplements, and testing for your child. Please understand that each child is different and will ultimately require different therapies to help optimize their potential. However, for most kids on the autistic-spectrum the application of foundational therapies such as nutritional support, methyl-B12, and dietary support is critical in the early stages.

- If your child is not on any supplements your doctor will still most likely recommend methyl-B12 therapy first before proceeding with supplements. However, each case is different and they will discuss their particular recommendations for your child at your initial consultation.

Laboratory Testing:

- Laboratory testing is an essential part of any biomedical program. In our office we try to streamline testing recommendations that will help clarify problem areas.

- Many of the tests that we use are not available from regular doctors/pediatricians offices, local hospitals or standard labs such as LabCorp, Unilab, Quest, etc. Some tests will likely be an out-of-pocket expense. This does not mean testing is not insurance reimbursable. Reimbursement solely depends on your particular insurance carrier. Please check with your own insurance carrier if you are unsure.

NOTE: CareCredit is available (www.carecredit.com) ***through our office as way to help finance consultation and laboratory fees.***

- **Great Plains Laboratory** (www.greatplainslaboratory.com) does have a contract with Blue Cross & Blue Shield PPO, and other PPO insurances. You can check with them to determine whether they accept your particular type of Blue Cross insurance, or other insurance. Labs such as Neuroscience/Neuroimmunology can also bill some insurance providers. Other labs that we many times use for testing are paid directly to our office: **Doctors Data and BioHealth Diagnostics.** Please ask one of the office staff members the best way to ascertain insurance reimbursement from these particular companies lab tests. These laboratory companies provide high quality and specialized testing panels that are necessary for the specific needs of autistic children.

- Many times we will need to use a standard lab for blood testing: Unilab, LabCorp, Quest, Westcliff or your local hospital, etc. (if available). ***These labs do their own billing that does not involve our office.*** Your particular type of insurance will determine what payment is allowable. **Charges for blood draws will be payable directly to the facility providing this service.**

Laboratory Testing Panels:

- Each doctor is seeking the most complete information on your child as possible. Many children on the autism-spectrum need evaluation for mineral and vitamin imbalances, heavy metal exposure, immune imbalances, digestion problems and yeast overgrowth, etc.

- An extensive and **advanced** comprehensive laboratory work-up through our office that is applicable for many children can run $1500 to 2500. This is the cash price. This price does not calculate what your particular insurance company will pay back to you for reimbursement. However, some people choose to begin with a less expensive profile that incorporates fewer tests (for more information please read Dr. Woeller's handout titled *"Dr. Woeller's Recommended Diagnostic Testing Approach for Children with Autism-Spectrum Disorders"* at www.mystillpoint.com). For example, performing an Organic Acid Test and Comprehensive Stool Analysis which costs approximately $600.

- **The average (comprehensive) initial laboratory work-up is approximately $1800-2200**

- Listed below are the common tests that are often recommended to ***initially*** evaluate a child (as well as teenagers and/or adults) on the autism-spectrum:

- **Non-Blood**
  - **Organic Acid Test** – ***urine*** (Great Plains Laboratory) – used to evaluate yeast and bacteria toxins, metabolic problems.
  - **Urinary Peptide** – ***urine*** (Great Plains Laboratory) – used to evaluate digestive proteins from gluten and casein *(may not be necessary if child already on a strict gluten and casein-free diet)*
  - **Comprehensive Stool Analysis + Parasites –** ***stool*** (Doctor's Data or Great Plains Laboratory) – used to evaluate for digestive imbalances, inflammation, parasites, bacteria, and yeast.
  - **Hair Analysis –** ***hair*** (Doctor's Data or Great Plains Laboratory) – used to screen for heavy metals and certain mineral imbalances.
  - **Porphyrin Profile –** ***urine*** (Great Plains Laboratory) – used to evaluate metabolic makers for oxidative stress, neurological inflammation and heavy metal toxicity.

- **Blood**
  - **Comprehensive Food Profile** (Great Plains Laboratory) – used to evaluate immune food sensitivities.
  - **Whole Blood Glutathione** (Great Plains, NeuroImmunology) – used to access levels of the antioxidant glutathione.
  - **Whole or Red Blood Cell Analysis** (Doctor's Data or Great Plains Laboratory) – used to assess mineral levels. Absolutely needs to be done before proceeding with traditional heavy metal detoxification therapy such as DMPS or DMSA.
  - **Dr. Woeller Neuroimmunology Panel - including viruses, myelin, neurofilament, and blood brain barrier antibodies, etc.** (NeuroImmunology) – used to assess viral markers, autoantibody reactions to nerve tissue, etc. that can indicate chronic exposure and infection.
  - **Plasma Amino Acid** (Doctors Data or Great Plains) **– if applicable**
  - **Comprehensive Blood Chemistry** including liver & kidney function, electrolytes (potassium, sodium), thyroid, complete blood count, iron and anemia profile, vitamin D (and at times – immunoglobulins, IgG, IgM, IgA for immunity, measles marker, anti-strep makers), measles IgG, testosterone, DHEA, etc. *This panel is generally paid by you directly to the laboratory (and not our office) providing the blood draw service for the other test kits, i.e. LabCorp, Unilab, West Cliff. We have figured the approximate cost (approximately $375-450) into the total cost for all labs listed below, but realize that depending on your insurance carrier this test panel can be billed through your insurance company.*

- This comprehensive work-up is a common testing panel, but is not an absolute to begin treatment in our office. The above listed tests are done to quickly get children to the point of maintenance therapy, whether this is detoxification for heavy metals, anti-fungal or anti-viral treatment, or a combination of treatments. <u>However, please be advised that your child's particular situation may dictate some changes to this profile</u>.

- Your doctor will explore these issues with you during the initial consultation. Additional tests may be recommended based on your child's particular needs. Sometimes this includes more advanced testing for immune disorders, neurotransmitter analysis, Lymes disease, mold exposure and others.

- **It is very important to remember that the above listed testing does not have to be done all at the same time.** We have many children who start with basic dietary changes (gluten/casein-free), supplements and/or methyl-B12 therapy without doing any initial testing. Other parents decide to focus on yeast (candida) issues first and perform a simple urine and stool test to check for this potential problem. This is perfectly acceptable. There are many options.

- With regards to blood testing we do recommend trying to do as many blood tests at one time to reduce the stress on your child. If blood tests are required than this will be our recommendation.

Costs and Finances:

- We understand having an autistic child can be expensive with all the therapy and special programs your child needs. Adding biomedical assessment, supplements, and consultations is adding to this expense. However, in our experience the application of many biomedical therapies helps some children so much that their need for other non-biomedical therapies is often reduced. An example is the methyl-B12 therapy which is inexpensive. A one month supply on average is approximately $40 to $50 (not including shipping). In many cases this is equal to or less than a particular vitamin and the upsides of benefit for your child can be tremendous.

- People are concerned about long-term costs of any biomedical program. This is understandable. Most of the costs for comprehensive testing (if you choose) will be in the beginning of biomedical assessment for most children. Further testing down the road may be required, but it rarely is thousands of dollars at a time. The same can be said of consultations. You can expect an initial visit for one hour and in most cases if comprehensive testing is performed a one hour follow-up appointment for test review. However, after these beginning consultations things become more spread out. You may be only speaking with your clinic doctor once every 4 to 8 weeks generally for 15 to 30 minutes at a time. There are always exceptions, but most of the time this is the common pattern you can expect.

- Each doctor's goal is to get your child to their maintenance treatment program ASAP. We want to see the majority of your resources going towards treatment of your child, and not ineffective or useless testing, etc. However, we do understand the complex nature of autism from a biomedical standpoint and that some testing and consultation is absolutely necessary to help you and your child proceed down this chosen path.

If you have any questions about the content of this document please contact one of the office staff members. They will be happy to answer your questions and help you through the process of working with our office. Our goal is to make this process efficient and cost effective for you. We look forward to working with you in regards to optimizing your child's health potential.

Name (Mother, Father or Legal Guardian): ***Please sign and date***

***Mother** ____
***Father** ____
***Legal Guardian** ______________________________________

Date: ____