Medicine for Your Soul

Dr. Nicole D. Barreda, N.M.D.
Natural Medicine for your Mind, Body, and Soul

17470 N. Pacesetter Way
Scottsdale, AZ 85255
Office: 480-281-1797
Fax: 480-281-1798
Email: DrBarreda@aol.com
www.MedicineForYourSoul.com

Directions

We are located at 17470 N. Pacesetter Way in North Scottsdale near Highway 101 and Princess Dr. When you arrive, please park in any uncovered parking space and enter through the main double door. If you need help with directions, please call and speak with one of the receptionists.

Follow these directions if you are traveling from the South or East Valley:

Take the Hwy 101 North
Exit at Princess Dr. / Pima Rd. (after of Frank-Lloyd Wright Blvd)
Take a Left (West) on Princess Dr.
Travel approximately 0.4 miles
Take a Right on N. Pacesetter Way (after Perimeter)
Take immediate Left into the parking lot
Park in any uncovered parking space and enter into the main double door entrance

If you are traveling from the West Valley:

Take the Hwy 101 East
Exit at Princess Dr. / Pima Rd. (after of Hayden Rd.)
Take a Right (West) on Princess Dr.
Travel approximately 0.4 miles
Take a Right on N. Pacesetter Way (after Perimeter)
Take immediate Left into the parking lot
Park in any uncovered parking space and enter into the main double door entrance

At www.maps.google.com you can enter our address for detailed driving directions and even pictures of the area and our building by clicking on the person logo.

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Confidential Patient Information

Name(Last, First Middle)			Date
How did you hear about Dr. Barreda?			Social Security Number
Date of Birth	Male / Female	Marital Status	Email Address
Address	City		State, Zip Code
Home Phone	Work Phone		Cell Phone
Employer			
Address			
Name of Spouse (or Parent if minor)			Telephone
Address			City, State, Zip Code
Emergency Contact	Relationship to You		Telephone
Address	City, State		Zip Code

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES. I WILL BE PAYING TODAY BY:

CASH _____ CHECK _____ VISA _____ MASTERCARD _____

At time of payment, you will be given a copy of your superbill from our office. This will show the diagnosis, services, and charges for that day. You can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office with any possible follow-up inquiries from your insurance company regarding your claims.

Insurance Company Name			Telephone
Address		City, State, Zip Code	
Subscriber's Name		Subscriber's Employer	
Group Number	Policy Number	Effective Date	Relationship to Insured

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I stop or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Furthermore, any charges, fees, or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed (i.e. minor surgery, etc.)

Signed _____ Date _____

Parent or Guardian (if minor) _____ Date _____

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DATE _____

NAME _____ AGE _____

Reason for office visit: _____

ALLERGIES: ☐ None
☐ Medications: _____ ☐ Foods: _____

CURRENT PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS: ☐ None
Please list name, dose, and how often you take it

CURRENT NUTRITIONAL SUPPLEMENTATION AND HERBS: ☐ None
Please list name, dose, and how often you take it

CURRENT OR CHRONIC MEDICAL CONDITIONS: ☐ None

PAST MEDICAL PROBLEMS (year or age): ☐ None

Have you ever had any of the following:
☐Chicken Pox ☐Polio ☐Mumps
☐Measles (Rubella) ☐German Measles (Rubeola) ☐Rheumatic Fever
☐Scarlet Fever ☐Tuberculosis ☐Herpes
☐Contact with Blood or Body Fluids ☐HIV / AIDS

SURGERIES (year or age): ☐ None

WHEN WAS YOUR LAST YEARLY MEDICAL EXAM? _____

Medical History - Page 3

MEDICAL HISTORY:

☐Decreased Hearing
☐Ringing in Ear
☐Ear Infections - frequent
☐Dizzy Spells
☐Failing Vision ☐Eye Pain
☐Double or Blurred Vision
☐Eye Infections - frequent
☐Nose Bleeds - recurrent
☐Sinus Trouble
☐Sore Throats - frequent
☐Hayfever / Allergies
☐Hoarseness - prolonged
☐Pneumonia / Pleurisy
☐Bronchitis / Chronic Cough
☐Asthma / Wheezing
☐Shortness of Breath:
☐On Exertion ☐Lying Flat
☐Chest Pain
☐High Blood Pressure
☐Heart Murmur
☐Irregular Pulse
☐Palpitations
☐Swollen Ankles
☐Fainting Spells
☐Leg Pain - walking
☐Varicose Veins / Phlebitis

☐Loss of Appetite
☐Difficulty Swallowing
☐Indigestion or Heartburn
☐Persistent Nausea / Vomiting
☐Peptic Ulcers
☐Abdominal Pain - Chronic
☐Gall Bladder Problems ☐Removed
☐Jaundice / Hepatitis
☐Change in Bowel Habits
☐Diarrhea ☐Constipation
☐Diverticulosis
☐Chrohn's / Colitis
☐Bloody or Tarry Stools
☐Hemorrhoids
☐Hernia
☐Urine Infections - frequent
☐Blood in Urine
Urination:
☐Overnight, more than twice
☐Painful ☐Loss of Control
☐Decrease in Force / Flow
☐Kidney Stones
☐Venereal Disease
☐Urethral Discharge
☐Chronic Fatigue
☐Weight Loss - recent

☐Cancer
☐Diabetes
☐Thyroid Disease
☐Anemia ☐Bruise Easily
☐Convulsions / Seizures
☐Stroke
☐Tremor / Hands Shaking
☐Muscle Weakness
☐Numbness / Tingling Sensations
☐Headaches - frequent
☐Arthritis / Rheumatism
☐Back Pain - recurrent
☐Bone Fracture / Joint Injury
☐Gout
☐Osteoporosis
☐Foot Pain
☐Cold Numb Feet
☐Rashes ☐Hives
☐Psoriasis ☐Eczema
☐Sleeping - difficulty
☐Nervousness
☐Depression
☐Memory Loss
☐Moodiness - excessive
☐Phobias
☐Mental Illness

FAMILY HISTORY: ☐No knowledge of family medical history

Relation	Age	Health Status	If Deceased: Cause/Age at Death
Father			
Mother			
Siblings			
Children			

Please indicate all conditions which apply to members of your family (brother, sister, father, mother, aunt, uncle, grandparent) and note relationship or additional concerns below:

☐Asthma / Allergiesr
☐Arthritis
☐High Blood Pressure
☐High Cholesterol
☐Diabetes
☐Heart Disease
☐Bleeding / Clotting Disorder

☐Headaches
☐Seizures / Epilepsy
☐Stroke
☐Thyroid Disorder
☐Tuberculosis
☐Chronic Lung Disease
☐Ulcers

☐Gallbladder
☐Liver Disease
☐Kidney
☐Breast Disease (Benign)
☐Breast Disease (Cancer)
☐Alcoholism / Substance Abuse
☐Mental Illness

FEMALES:

MENSTRUAL FLOW: ☐Regular ☐Irregular ☐Pain / Cramps - On a scale of 1-10 _____
_____ Days of Flow _____ Length of Cycle
Date of 1st day of last period _____

_____ Pregnancies _____ Live Births
_____ Miscarriages _____ Abortions
Birth Control Method _____
☐Flushing / Menopause
Date of last PAP Test _____ ☐Normal ☐Abnormal
Date of last Mammogram _____ ☐Normal ☐Abnormal

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Medical History - Page 4

DATE _____

NAME _____ AGE _____

SOCIAL HISTORY :

MY CURRENT WEIGHT IS: ☐Satisfactory ☐Unsatisfactory

HAS YOUR WEIGHT VARIED SIGNIFICANTLY THROUGHOUT YOUR LIFE? _____

EXERCISE REGIMEN: ☐None
Type of Exercise _____ How Often _____

HOW WOULD YOU DESCRIBE YOUR AVERAGE STRESS LEVEL? _____
ON A SCALE OF 1-10 _____

HOW WOULD YOU DESCRIBE YOUR ENERGY LEVEL? _____
ON A SCALE OF 1-10 _____

HOW MANY HOURS DO YOU SLEEP EACH NIGHT? _____
RATE THE QUALITY OF YOUR SLEEP 1-10 _____

HOW MUCH WATER DO YOU DRINK EACH DAY? _____ WHAT TYPE? _____

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT? _____

DO YOU USE COFFE, TEA, OR SODA? ☐YES ☐NO
Type _____ Frequency _____

DO YOU USE CHOCOLATE? ☐YES ☐NO
Type _____ Frequency _____

DO YOU USE SUGAR? ☐YES ☐NO
Type _____ Frequency _____

DO YOU USE RECREATIONAL DRUGS? ☐YES ☐NO
Type _____ Frequency _____

SOCIAL HISTORY (cont.):

ALCOHOL USE: ☐None ☐Occasional / Rarely ☐Weekly ☐Daily
☐Beer ☐Wine ☐Spirits
Estimated number of drinks per day/week _____

TOBACCO USE: ☐None ☐Current Use ☐Prior Use
Year Started _____ Year Quit _____
Amount (per day/week) _____
Type _____

ARE YOU CURRENTLY EMPLOYED? ☐NO ☐YES Occupation: _____

HOW MANY HOURS DO YOU WORK EACH WEEK? _____

DATE OF YOUR LAST BLOOD WORK: _____

LIST OTHER HEALTH PROFESSIONALS THAT YOU CONSULT:

NAME	SPECIALTY	OFFICE LOCATION	TELEPHONE

LIST YOUR HEALTH GOALS:

1. _____
2. _____
3. _____
4. _____

HOW COMMITTED ARE YOU TOWARDS MAKING VALUABLE CHANGES IN YOUR HEALTH?

☐ I'll do whatever it takes to obtain optimal health
☐ I'm willing to change my lifestyle somewhat
☐ I may consider change, if needed, to feel better
☐ Just give me a pill, Doc

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Informed Consent for Medical Diagnosis and Treatment

I understand that Dr. Nicole D. Barreda, N.M.D. is licensed as a Naturopathic Medical Doctor by the State of Arizona Naturopathic Physicians Board of Medical Examiners (NPBOMEX). She practices such modalities as acupuncture, botanical medicine, hydrotherapy, homeopathy, nutritional counseling, IV vitamin and chelation therapy, Reiki, craniosacral therapy, and hypnosis.

Dr. Barreda subscribes to the accepted standard of care for the practice of Naturopathic medicine. The practice of Naturopathic medicine means a medical system of diagnosing and treating the human mind and body including natural means, drugless methods, non-surgical methods and devices, physical, electrical, hygienic and sanitary measures of all forms of physiotherapy.

Dr. Barreda may elect to utilize therapies that are experiential. If so, she will describe in detail the nature, risks, alternatives, possible benefits and possible complications of the treatment being offered. Such additional consents not withstanding, I also give general consent for Dr. Barreda and her staff to administer to my needs according to the standards of naturopathic medical practice in Arizona.

I understand that I will not be involved in any research or experimental project without my full knowledge and consent.

I understand Naturopathic Medical Doctors have not been designated as physicians in the Medicare Act and as such, all services or procedures performed will not be paid by that program. I understand that the contract I may have with any insurance company, whether personal or through work, may not provide for payment of the diagnostic and/or treatment procedures used by Dr. Barreda. Therefore, I agree to pay for all diagnostic and treatment procedures as they are provided.

Date _____

Patient or Authorized Representative _____

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Financial Policy/Obligation

PLEASE BE AWARE: An insurance policy is a contract between you and your insurance company. The patient is ALWAYS responsible for payment of all charges incurred regardless of any insurance or other third party payment arrangements.

Payment wil be collected at time of service.

Most insurance companies do not cover some Naturopathic medical procedures. These include, but are not limited to:

Acupuncture
Vitamin Injections
Intravenous Nutrition and Metabolic Therapy

The natural medicines that are prescribed by Dr. Barreda may be purchased here or at a pharmacy of your choice.

Billing Policy Regarding Rescheduled/Cancelled Appointments:

PLEASE BE AWARE: The patient is ALWAYS responsible to call a minimum of 24 hours prior to a scheduled appointment time to reschedule or cancel. All missed appointments or appointments canceled less than 24 hours before the scheduled appointment will result in a $75.00 charge to the patient for the missed appointment. All missed IV appointments will result in a $175.00 charge to the patient.

I, _____, certify that I have read
Print Name

and understand the above policy. I guarantee payment of all charges incurred as a patient of Dr. Barreda.

Signed _____ Date_____

Parent or Guardian (if minor)_____ Date_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

Dr. Nicole D. Barreda
480-281-1797

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

_____ _____

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

_____

Date

THIS SECTION IS TO BE COMPLETED BY MEDICINE FOR YOUR SOUL IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

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

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

_____ _____

Name and title of employee Date

it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation:
We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities:
We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement:
Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders:
We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services:
We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

Questions and Complaints

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

(Vers. M1SSS04)

NOTICE OF PRIVACY PRACTICES*

We Care About Your Privacy

Dr. Nicole D. Barreda
Medicine For Your Soul

480-281-1797
www.MedicineForYourSoul.com

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

*These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

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 people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory:

Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification:

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief:

We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising:

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances:

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner:

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions:

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings:

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities:

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence:

We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if