Dr. Katelyn Kalstein ND, MS
Lotus Integrative Medicine
2222 Santa Monica Blvd #105
Santa Monica, CA 90404
T | 310.828.8258
F | 310.828.5258

New Patient Welcome Letter

Dear New Patient,

Welcome! Thank you so much for your interest in our center. We do our best in every way possible to assure that you receive the best quality care. We want you to know that everyone on our staff is trained to:

- Make sure that our customer service always meets the highest standards.
- Make sure that any questions you have about your care are answered in a way that you can understand.
- Make sure that your phone calls are returned promptly.
- Make sure that your private health care information is kept secure and private.

Enclosed you will find several forms that we'd like you to fill out and bring with you to your first appointment. If you have any questions about these forms, please call us at 310.828.8258 and any one of us will be happy to help you.

Please understand your appointment time is reserved for you. We recognize there may be occasions when you need to cancel or reschedule an appointment.

If you need to cancel or reschedule your appointment for any reason, **we require a minimum of 24-hour advanced notice to avoid cancellation/rescheduling fees in the full amount of your scheduled visit.**

Thank you for respecting this policy.

Again, welcome to Lotus Integrative Medicine Santa Monica. You have taken an important step on the road to more vibrant health. We look forward to serving you.

Yours Sincerely,

Dr Katelyn Kalstein at Lotus Integrative Medicine Santa Monica

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Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 310.828.8258.

Kindly,

Dr. Katelyn Kalstein and Lotus Integrative Medicine Santa Monica

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Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Dr Katelyn Kalstein, ND, MS at Lotus Integrative Medicine Santa Monica for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr Kalstein may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Healthcare practitioners at Lotus Integrative Medicine Santa Monica are not required to agree to the restrictions that I may request. However, if healthcare practitioners at Lotus Integrative Medicine Santa Monica agree to a restriction that I request, the restriction is binding upon healthcare practitioners at Lotus Integrative Medicine Santa Monica.

I have the right to revoke this consent, in writing, at any time except to the extent that Dr Kalstein has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Dr Katelyn Kalstein's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lotus Integrative Medicine Santa Monica. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.lotusew.com. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Lotus Integrative Medicine Santa Monica with respect to my identifiable health information.

Dr Katelyn Kalstein reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name of Patient or Authorized Representative and Relationship

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Patient Payment Responsibility Agreement and Cancellation Policy

Please read thoroughly.

Dear Patient,

As a patient you are responsible for the total charges incurred from each visit at the time of your appointment. We recognize and appreciate that health care can involve major financial commitment. We aim to provide you with effective and affordable health care. Visa, MasterCard, American Express, Checks and Cash are all acceptable forms of payment.

Insurance:
We do not take any form of insurance. You are responsible for the total amount owed at the time of your visit. We will provide you with the appropriate super-bill with the appropriate codes needed *upon request* for you to seek reimbursement from your insurance company. You will need to mail the super-bill provided, to your insurance company and your insurance company will reimburse you for all the amounts covered within your policy.

Cancellation:
All patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule an appointment. If you cancel/reschedule your appointment with less than 24 hours' notice, or fail to show for your appointment without notification, your credit card will be charged for the cost of your office visit.

_____ **(initial) I am aware of the cancellation policy, and that for reasons other than emergencies, if I should cancel less than 24 hours before my appointment I will be charged in full.** Patient visits require us to block out large time slots, making last minute cancellations and rescheduling problematic. We spend an inordinate amount of time and energy with each and every one of our patients because we are committed to providing the highest quality care. Assuring that all established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need.

_____ **(initial) I am aware that Dr. Kalstein may correspond about my care via email and phone, and that I will be billed at an hourly rate of $100/hour**. Email and phone (call or text) require the same time and expertise as office visits. If you choose to email, text or call for medical advice between appointments you will be billed at a rate of $100/hour. You will be sent an invoice via email for these services. Since we realize email is not 100% privacy protected, you have the option to opt-in or out.

_____ **(initial)** OPT-IN for paperless billing. I give permission to send invoices through email.

OR
_____ **(initial)** OUT-OUT of paperless billing. Please send my invoices via regular mail.

By signing this payment agreement and cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card if any of the above stipulations apply to you.

Name of Patient or Legal Guardian:_____

Signature: _____ Date: _____

Type of card: Visa MC AMEX Card Number: _____

Expiration: _____ Security Code: _____ Billing Zip Code: _____

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PATIENT INFORMATION

Today's Date: _____/_____/_____

First Name: _____ Last Name: _____

Preferred Name: _____

Date of Birth: _____/_____/_____ Legal Gender ☐Male ☐Female Gender _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other _____

Address: _____

Apt. _____ City: _____ State: _____ Zip: _____

Billing Address: _____ Apt. _____ City: _____ State: _____ Zip: _____

Home Phone ( ) _____-_____ Cell/Alternate.: ( ) _____-_____ Fax: ( ) _____-_____

Which phone do you prefer we leave voice messages containing health information?
☐Home ☐ Cell ☐ Please **DO NOT** leave voice messages

E-mail: _____ (*your information is confidential)*

Do we have permission to contact you through email about health information? ☐Yes* ☐ No

*Your privacy is very important to us. We realize email is the best use of communication for many people. However, email is currently not HIPAA compliant, privacy is not ensured through this medium, and there may be risks to your health information if choosing to use email.

_____ I understand the privacy risk and I wish to use email to communicate about my health information.

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship to you _____

Daytime Phone: ( ) _____-_____ Cell/Alt: ( ) _____-_____

PRIMARY CARE PROVIDER

NAME _____ Phone ( ) _____ - _____

ADDRESS: _____

DATE OF LAST PHYSICAL: _____ DATE OF MOST RECENT BLOODWORK: _____

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Health History Questionnaire

Please complete this questionnaire as thoroughly as possible.

Allergies. List all allergies including to foods, medications, herbs, supplements, dusts/environment/molds, chemicals, household items, insect stings, and indicate how each affects you:

☐ No Known Allergies to Medications

Allergic to:	Effect:
_____	_____
_____	_____
_____	_____
_____	_____

Medications and Supplements. List all medications and supplements with dosage and frequency of use. For example, magnesium 300 mg nightly.

Health Coordination. Coordination between providers can be a critical part of healthcare. Please list other health team members that you have seen in the last 3 years**.**

Physican/Provider's Name: _____

Type of Provider: _____

Phone Number: _____ Reason for treatment: _____

☐ Permission for Dr. Kalstein to communicate with this provider

Physican/Provider's Name: _____

Type of Provider: _____

Phone Number: _____ Reason for treatment: _____

☐ Permission for Dr. Kalstein to communicate with this provider

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Physician/Provider's Name: _____

Type of Provider: _____

Phone Number: _____ Reason for treatment: _____

☐ Permission for Dr. Kalstein to communicate with this provider

If you have not seen a healthcare provider in the past 3 years, when and where did you last receive medical or health treatment?

_____

Health Goals

What are your top health goals in order of importance?

1. _____
2. _____
3. _____

General Health

Height: _____ Weight: _____ Weight 1 yr ago: _____ Max Weight: _____ When: _____

Please list all your current medical diagnoses, conditions and/or symptoms:

Which of these conditions or symptoms most noticeably affect your daily life?

_____

Which of these conditions or symptoms are you most motivated to change?

_____

Past Medical History

Dr. Katelyn Kalstein ND, MSA
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Please list any hospitalizations, operations, significant injuries, etc.:

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Do you have any known contagious diseases at this time? ☐ **Y** ☐ **N** If yes, what? _____

Symptoms Checklist. Please mark what symptoms you are currently expereince or have recently experienced.

Mental /Emotional

☐ Emotional fragility
☐ Depression
☐ Considered/Attempted Suicide
☐ Poor concentration
☐ Insomnia due to racing thoughts
☐ Mood Swings
☐ Anxiety
☐ Anger easily
☐ Memory concerns
☐ Mental sluggishness or "Brain fog"

Other _____

Endocrine

☐ Hypothyroid or Hyperthyroid
☐ Hypoglycemia
☐ Diabetes
☐ Excessive Hunger
☐ Fatigue
☐ Infertility (men or women)
☐ Unexplained weight loss/gain (circle)
☐ Autoimmune Disease
☐ Night sweats
☐ Heat or cold intolerance
☐ Dizziness when standing from a seated or lying position
☐ Excessive thirst
☐ Excessive urination
☐ Seasonal Depression
☐ Unexplained hair loss
☐ Low libido or High Libido (circle)
☐ History of cancer
☐ New facial hair growth

Other: _____

Immune

☐ Frequent cold or flu, or other infection
☐ Chronic Infections
☐ Slow wound healing
☐ Chronic Fatigue Syndrome
☐ Chronic swollen glands

Vaccination History:
Please list all vaccinations you recall having. If you believe you were fully vaccinated, write "fully vaccinated"

_____

Any reactions to vaccinations? ☐Y ☐N If yes, what reaction? _____

Neurological

☐ Seizures ☐ Paralysis ☐ Muscle weakness ☐
Numbness or tingling ☐ Loss of memory ☐ Easily stressed

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☐ Vertigo or dizziness ☐ Loss of balance

Other: _____

Musculoskeletal

☐ Joint pain or stiffness ☐ Arthritis ☐ Broken bones
☐ Weakness ☐ Sciatica ☐ Muscle spasms or cramps
☐ Prolapsed organs ☐ General feeling of heaviness in body
☐ Sore, cold or weak knees ☐ Low back pain

Other: _____

Cardiovascular

☐ Heart disease ☐ Chest Pain (Angina) ☐ High blood pressure
☐ Low blood pressure ☐ Murmurs ☐ Stroke
☐ Blood clots or DVT ☐ Fainting ☐ Phlebitis

☐ Rheumatic fever ☐ Palpations/Fluttering ☐ Swelling in ankles
☐ Easy bleeding or bruising ☐ Anemia ☐ Deep leg pain
☐ Cold hands/feet ☐ Varicose Veins ☐ Thrombophlebitis
☐ Swollen hands/feet ☐ Numbness of hands and feet

Other: _____

Skin

☐ Rashes ☐ Eczema/Hives ☐ Acne/Boils
☐ Color change ☐ Hair loss ☐ Excessive sweating
☐ Diminished sweating (can't break a sweat even if exercising)

Other: _____

Head

☐ Headaches ☐ Head injury ☐ Migraines ☐ Jaw/TMJ problems

Other: _____

Eyes/Ears

☐ Spots in eyes ☐ Cataracts ☐ Impaired vision ☐ Glasses or contacts
☐ Blurriness ☐ Eye pain ☐ Color blindness ☐ Tearing/dryness
☐ Double vision ☐ Glaucoma ☐ Blood shot/dry eyes
☐ Ringing in ears ☐ Deafness ☐ Earaches

Other: _____

Nose and Sinus

☐ Frequent colds ☐ Nose bleeds ☐ Stuffiness/Congestion
☐ Hay fever ☐ Sinus Problems ☐ Loss of smell

Other: _____

Mouth and Throat

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☐ Frequent sore throat ☐ Copious saliva ☐ Teeth grinding
☐ Sore tongue/Lips ☐ Gum problems ☐ Hoarseness
☐ Dental cavities ☐ Jaw clicks ☐ Mouth sores/canker sores

Other: _____

Neck
☐ Lumps ☐ Swollen glands ☐ Goiter ☐ Pain/Stiffness

Other: _____

Respiratory
☐ Cough ☐ Sputum ☐ Spitting up blood
☐ Wheezing ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Pleurisy ☐ Emphysema
☐ Difficulty breathing ☐ Pain on breathing ☐ Shortness of breath
☐ Shortness of breathing at night ☐ Shortness of breathing lying down

Other: _____

Gastrointestinal
☐ Heartburn ☐ Pain/Cramps ☐ Belching/Gas
☐ Constipation ☐ Diarrhea ☐ Bloating
☐ Black stools ☐ Gallstones ☐ Jaundice
☐ Ulcer ☐ Liver disease ☐ Hemorrhoids
☐ Trouble swallowing ☐ Bad breath ☐ Irritable Bowel Disease
☐ Change in thirst ☐ Change in appetite ☐ Nausea
☐ Vomiting ☐ Blood in stool ☐ Bitter taste in the mouth

Number of Bowel Movements? _____ per day or week (circle) The color is normal, dark, black, light, green, red, etc.? _____

Stool (Check all that apply):
☐ Well-formed ☐ Loose ☐ Hard ☐ Incomplete ☐ Foul Odor ☐ Undigested Food ☐ Blood ☐ Mucus

Other: _____

Urinary
Color is: _____ Amount is: _____

☐ Odor ☐ Pain ☐ Difficulty ☐ Urgency ☐ Burning ☐ Increased frequency
☐ Frequency at night ☐ Inability to hold urine ☐ Frequent infections ☐ Kidney stones

Other: _____

Male Reproduction
☐ Low libido ☐ Hernias ☐ Testicular masses ☐ Testicular pain
☐ Prostate disease ☐ Breast lumps ☐ Venereal disease ☐ Discharge/sores
☐ Impotence/ Erectile dysfunction ☐ Condyloma/Warts ☐ Premature ejaculation
☐ Herpes ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea

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Sexual Habits:
☐ Currently sexually active ☐with one partner ☐with multiple partners
☐ Not currently sexually active

Date of most recent sexually transmitted infection (STI) testing: _____

Female Reproduction
☐ Difficult, irregular or painful menstrual cycles ☐ Low libido ☐ Bleeding between cycles
☐ Painful menses ☐Clotting ☐ Heavy/Excessive flow ☐ Discharge
☐ Breast tenderness/lumps ☐ Nipple discharge ☐ Endometriosis ☐ Hot flashes
☐ Ovarian cysts ☐ Difficulty conceiving ☐ Cervical Dysplasia ☐ Menopausal Symptoms
☐ Abnormal Pap ☐ Pain during intercourse ☐ Sexual difficulties
☐ Herpes ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea
☐ PMS symptoms/ Symptoms get worse around menses

Sexual Habits:
☐ Currently sexually active ☐with one partner ☐with multiple partners
☐ Not currently sexually active

Birth control?_____ What type? _____

Age at the time of first menses? _____ Are cycles regular? _____ Length of cycle? _____

Date of last menses? _____ Date of last Pap?_____Date of last Mammogram? _____

The flow is (circle): Normal heavy light The color is (circle): Bright Red Red Purple Brown Light Red

Number of pregnancies? _____ # of live births? _____ # of miscarriages? _____ # of abortions?_____

Are you pregnant now? _____ A ge of menopause (if applicable) _____ Do you do self-breast exams?_____

Psycho-Social History.

Exercise and Activity

How many hours of exercise/activity do you get per week? _____
What types of exercise do you do? _____

Y N Do you smoke? If yes, how much? _____ How long? _____

Y N Are you a previous smoker? If yes, when did you quit? _____

Y N Do you drink alcoholic beverages? If yes, how much? _____ How long? _____

Y N Do you use recreational drugs? If yes, what type? _____ How often? _____

Y N Do you live alone? If no, who else lives with you? _____

Y N Have you traveled abroad in the past year? If yes, where? _____

DIET

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Please fill in your diet over the past 24 hours including meals, snacks and beverages.

Morning _____

Afternoon _____

Evening _____

Foods you crave: _____ Foods you dislike: _____

Do you eat refined sugar/artificial sweeteners?_____ Do you add salt? _____

How much coffee do you drink each week? _____ Tea per week? _____ Soft drinks per week? _____

Y N Are you aware of any food sensitivities? (These differ from true allergies in that they tend to have a delayed response – up to 3 days after the food is consumed - and/or result in gastrointestinal discomfort, change in bowels, foggy thinking, disturbing emotions).

If yes, to which foods and what is the effect? _____

SLEEP

Hours of sleep per night?_____ Do you sleep well? _____ Awaken rested? _____

What hours do you go to sleep? _____ What hours to wake? _____ Light Sleeper? ____

Do you have difficulty falling asleep? _____ Difficulty staying asleep?_____ Do you remember your dreams? _____

ENERGY

On a scale of 1-10 (0 = cannot get out of bed, 10 = have more than enough energy to get through my day), please rank you energy on an average day.

0 1 2 3 4 5 6 7 8 9 10

When during the day is your energy the best? _____ The worst? _____

INTERESTS

Main interests and hobbies?_____

Do you have a religious or spiritual practice?_____

Level of joy with your job?_____ Level of stress with your job? _____

Do you take vacations?_____ Spend time outside? _____ Have a supportive relationship? _____

Watch television? _____ hours/day?_____ Read? hours/day?_____

How does your condition affect you?_____

_____

_____

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What do you think is happening? Why?_____

_____

What do you feel needs to happen for you to get better?_____

_____

_____

What do you enjoy most about your life?_____

_____

How much effort are you willing to make at this time to improve your health? [ ] Minimal [ ] Some [ ] Maximum

Family History.

Mother	
Maternal Grandmother	
Maternal Grandfather	
Father	
Paternal Grandmother Paternal Grandfather	
Siblings	
Other	

Consent. Please initial below for acknowledgment of privacy rights and patient responsibilities.

Accuracy of Information

_____ ☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

_____ I authorize Dr. Kalstein, Lotus Integrative clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health

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professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the doctor's day that could have been filled by another patient. We understand that circumstances may arise in which you need to cancel your appointment. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, for reasons other than emergencies or illness, will be responsible for 50% of the appointment. Patients who miss appointment (no-shows) will be charged in full.

☐ _____ I am aware of the Cancellation Policy.

Thank you for taking the time to fill out this form. Please bring it with you to your first appointment, along with any and all medications, vitamins or supplements you are currently taking. If you have any questions, please ask! We look forward to working with you.

Warmly,

Dr. Katelyn Kalstein,

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Dr. Katelyn Kalstein's Financial Policies

Service	Time in Office	Fee for Service
First Office Call (FOC)	1.5-1.75 hours	$250
First Office Call -Phone	1.5-1.75 hours	$250
Missed Visit Without 24 hours cancellation, or 20 minutes late to scheduled visit	N/A	Billed in full
Return Office Call (ROC) All follow up and prevention visits. Time determined, as needed, by doctor.	Regular: 30-55 minutes Extended: 56-90 minutes Comprehensive: 91-120 minutes	$155 $205 $250
Independent Lab Evaluation, Analysis, or Interpretation	N/A	$25 per standard test item e.g. standard tests: CBC, CMP, Thyroid $100 per Specialty Lab Tests e.g. SpectraCell, Genova, ZRT, GPL, etc.
Acute Office Call	15-20 minutes	$75
Chart Copied	N/A	$35
Prescription Refills (if not seen within last 3 months)	10 minutes	$30
Emails	20 minutes maximum If there is a new problem, or the problem requires more than 20 minutes to answer email, patient must schedule appointment.	$50 per non-complex email consult Emails relating to clarifying treatment plan are complimentary.
Specialty Lab Tests Please note these are the lab's fees, not the doctors. It is illegal for doctors to charge extra for lab tests, but common to charge for the interpretation.	N/A	SpectraCell Micronutrient Insurance: $190 SpectraCell Micronutrient Cash: $290 Genova AdrenoCortisol Insurance: $75 Genova AdrenoCortisol Cash: $159 Labrix Saliva Hormones: $45 per hormone Labrix Complete Hormone Panel: $190

CANCELLATION POLICY:
Your appointment time is scheduled specifically for your needs. If you need to reschedule or cancel your appointment, kindly give 24 hours notice so we may accommodate another patient. Our new booking system now requires that you provide a credit card number in order to secure your appointment. **Your credit card will be charged a cancellation fee the first late cancelation or no show of $50, then 2nd no show or cancellation for the full price of office visit or injection if we do not receive 24 hours notice.**

I have read and agree to the terms above, and on the additional information sheet. I understand the cancellation policy and that payment is due at time of service for all fees.

_____ _____
Patient Signature Date

_____ _____
Credit Card #, Expiration Date Exp Date and Office Staff Witness Signature

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Informed Consent to Treatment

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of Naturopathic medicine.

The primary treatments used by doctors of naturopathy are natural, non-invasive techniques which stimulate the body's natural healing capacity. Naturopathic medicine is considered a complement to traditional allopathic medicine. We will use clinical nutrition, botanical medicine, homeopathic medicine, lifestyle counseling and physical medicine to treat you.

Analysis / Examination / Treatment

As a part of your case history you are consenting to the analysis, examination, and treatment recommended by our clinic. This may include a basic/complaint-oriented physical examination including specific urine and/or blood laboratory tests.

The material risks inherent in Naturopathic medicine.

As with any healthcare procedures, there are certain complications which may arise during even the most basic of Naturopathic treatments. These complications may include, but are not limited to, aggravation of pre-existing conditions, allergic reactions to supplements or herbs, complications in certain physiological conditions such as pregnancy, lactation, those on multiple medications, young children, elderly patients, or those with specific diseases such as heart, liver, kidney, cancer, or diabetes.

The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor of such conditions. Please advise the Doctor if you are pregnant, suspect you are pregnant, are trying to become pregnant, or if you are breast- feeding. I understand that my Doctor will answer any questions that I have to the best of their ability. I understand that, as with any type of treatment, results cannot be guaranteed. I do not expect my Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the assessment and therapeutic procedures/treatments recommended by the Doctor.

_____ (Initials) **All female patients** must alert the Doctor if they know or suspect they are pregnant as some of the therapies used could present a risk to pregnancy. All individuals with bleeding disorders, pace makers, and/or cancer must also alert the Doctor.

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The relationship with other healthcare providers.

Naturopathic Medicine may be a complement to traditional allopathic medicine. I acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive, from any other licensed health care provider.

- I am at liberty to seek or continue medical care from a physician or surgeon or other qualified health care provider.

- No employee or other practitioner under our clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider.

- The treatment and therapies rendered or recommended by our clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

The availability and nature of other treatment options.

Other treatment options for your condition may include:
- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may worsen your condition. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Katelyn Kalstein to perform diagnostic tests and render naturopathic therapies and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include laboratory and radiographic examination at the doctor's discretion.

Dr. Katelyn Kalstein ND, MSA
Lotus Integrative Medicine
T | 310.828.8258
info@lotusew.com

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the naturopathic medicine and related treatment.

I have discussed it with *Dr. Katelyn Kalstein ND* and have had my questions answered to my satisfaction. I understand that it is my responsibility to request the Doctor to explain therapies and procedures to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name: _____

Signature: _____

Dated:

Doctor's Name: _____

Signature: _____

Signature of Parent or Guardian (if a minor):

_____