BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER
PROFESSIONAL CORPORATION
9333 Double R Blvd., Suite 100, Reno NV 89521
Tel.: (775) 828-5388 Fax: (775) 828-6588

NOTICE OF PRIVACY PRACTICES

Effective: ________________________________ 200____

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.

BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION.

How BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION May Use or Disclose Your Health Information

For Treatment. BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider such as a physician, nurse or other person providing health services to you, is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment. BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you for a third-party payor, such as an insurance company health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and other to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Required by Law. BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION may use and disclose information about you as required by law. For example, BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Specialized government functions such as protection of public officials or reporting to carious branches of the armed services that may require use of disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent BRUCE K. FONG, D. O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. §164.5222; however, BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION is not required to agree to a requested restriction;

- obtain a paper copy of the notice of information practices upon request; inspect and obtain a copy of your health record as provided for in 45 C.F.R. § 164.524;
- request that your health record be amended as provided in 45 C.F.R. §164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Complaints

You may complain to BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing complaint.

Obligations of BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION

BRUCE K. FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION is required to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we re unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or a alternative locations; and
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

BRUCE K FONG, D.O., SIERRA INTEGRATIVE MEDICAL CENTER, PROFESSIONAL CORPORATION reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by mail.

Contact information

If you have any questions or complaints, please contact:

Sierra Integrative Medical Center
9333 Double R Blvd., Suite 100, Reno NV 89521
Tel.: (775) 828-5388 Fax: (775) 828-6588

Sierra Integrative Medical Center

9333 Double R Blvd., Suite 100, Reno NV 89521
Tel.: (775) 828-5388 Fax: (775) 828-6588
E-mail: info@sierraintegrative.com

NEW PATIENT INFORMATION

Today's Date: ____________________

Patient Name: ____________________

Address: ____________________

City: __________ State: ____ Zip: ________

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

Fax: ____________________

Email: ____________________

DOB: __________ Age: __ Gender: F__ M__

Place of Birth: ____________________

SSN: ____________________

Drivers License Number: ____________________

State Issued: ____________________

Occupation: ____________________

Title: ____________________

Employer: ____________________

Address: ____________________

City: __________ State: _____ Zip: ________

Marital Status:

S __M __Widow __Domestic Part.__

Spouse Name: ____________________

Spouse Home: ____________________

Spouse Cell: ____________________

EMERGENCY INFORMATION

Emergency Contact: ____________________

Phone: ____________________

Relationship to Patient: ____________________

Alternate Contact: ____________________

Phone: ____________________

Relationship to Patient: ____________________

Where are you staying while at SIMC?

____

Local Contact Number: ____________________

PAYMENT FOR SERVICES INFORMATION

Cash: ___ Check: ___ Visa: ___ MC: _____

AMX: ___ Discover: ___ Debit Card: _____

Other: ____________________

Credit Card Number: ____________________

Expiration Date: ____________________

Insurance Company: ____________________

Address: ____________________

City: __________ State: ____Zip: ________

Phone: ____________________

Fax: ____________________

PPO: ___ POS: ___ HMO: ___ Other: ______

Group Number: ____________________

Other Information: ____________________

Sierra Integrative Medical Center

9333 Double R Blvd., Suite 100, Reno NV 89521
Tel.: (775) 828-5388 Fax: (775) 828-6588

PATIENT QUESTIONNAIRE

Name: ______________________________ Date: ____________

Present Ailment (What is your primary reason for coming to Sierra Integrative Medicine?)

____

____

Other Major Medical Problems (Start with most troublesome first and include month/year of onset): Ex: pain, cough, hepatitis, weakness, insomnia, depression, anxiety, chest pain, numbness, asthma, allergies, short of breath...

1. ________________ 2. ________________ 3. ______________
4. ________________ 5. ________________ 6. ______________
7. ________________ 8. ________________ 9. ______________

Have you ever been tested for HIV? (Check one) YES___ NO ___
If YES, please indicate the result? Positive___ Negative ___

Surgeries (List the procedure and year of operation. Start with most recent and work back in time) Ex: tonsils, appendix, gallbladder, uterus removal, c-sections, vasectomy/tubal ligation, hernia, joint repair, heart bypass, treatment of congenital or trauma-related illness.

1. ________________ 2. ________________ 3. ______________
4. ________________ 5. ________________ 6. ______________

Non-surgical hospitalizations (List reason and date, start with most recent and work back in time) Ex: asthma, pneumonia, congestive heart failure, heart attack, stroke, cancer, mental or emotional problems, obstructed bowel

1. ________________ 2. ________________ 3. ______________
4. ________________ 5. ________________ 6. ______________
7. ________________ 8. ________________ 9. ______________

(Women) Gynecological: Number of children ___Miscarriages ____ Abortions _______
Do you have a normal monthly period? YES__ NO__ If not, please explain: ________

____

Date of last PAP _____ Normal? YES __ NO __
Date of last mammogram _____ Normal? YES __ NO __

Habits: Do you now or have you ever used tobacco in the past? YES___ NO ___
Quantity per day: _____ packs/cans/pouches (circle). Total years: ________________
Have you quit smoking/chewing/dipping (circle)? YES__ NO__ When? ____________
Do you drink alcohol? YES __ NO __ If so, how much per week? ________________
Prior history of illicit drug (ex: cocaine) or pain medication (ex: narcotics) addiction? YES__ NO__
How about addictions to "food" categories such as sugar or caffeine? YES__ NO__
Do you exercise? YES__ NO__ How often? ____________________________

Do you have problems with any of the following? (Please check)

GENERAL
- o Weakness
- o Night Sweats
- o Mental fogginess
- o Rapid gain/loss of weight
- o Fatigue

SKIN
- o Rashes
- o Eruptions
- o Itching
- o Acne
- o Cancer

LYMPH NODES
- o Enlargement
- o Pain

EYES
- o Sensitive to light
- o Loss of vision
- o Dry eyes

EARS
- o Ringing sounds
- o Recurrent infections
- o Pain
- o Fullness
- o Hearing loss

NOSE
- o Broken
- o Runny nose
- o Frequent nosebleeds
- o Loss of smell
- o Poor air flow

MOUTH
- o Ulcerations, canker sores
- o Abnormal sensations

TEETH
- o Root canals
- o Recurring dental illness

THROAT
- o Recurrent soreness
- o Recurrent tonsilitis

NECK
- o Swelling
- o Enlarged lymph nodes
- o Goiter (enlarged thyroid)

BREASTS
- o Masses
- o Lumps
- o Pain
- o Nipple changes

RESPIRATORY
- o Short of breath
- o Cough
- o Pleurisy
- o Asthma
- o Pneumonia
- o Bronchitis
- o Obstructive sleep apnea

CARDIOVASCULAR
- o Chest pain
- o Chest tightness
- o High blood pressure
- o Irregular heartbeat
- o Palpitations
- o Coronary artery
- o disease
- o Rheumatic fever
- o Murmurs
- o Increased pulse rate
- o Decreased pulse rate
- o Mitral valve prolapse
- o Calf pain with walking
- o Pericarditis
- o Foot and ankle
- o swelling
- o Inflammation of veins
- o Varicose veins

GASTROINTESTINAL
- o Loss of appetite
- o Nausea
- o Vomiting
- o Difficulty swallowing
- o Abdominal pains
- o Constipation (< 2 BM/day)
- o Diarrhea
- o Hemorrhoids
- o Blood in the stool
- o Black, tarry colored
- o stool
- o Irritable bowel
- o Bloating
- o Heartburn
- o Peptic ulcers
- o Diverticulitis

GENITOURINARY
- o Pain with urination
- o Frequent or urgent
- o urination
- o Cannot control bladder
- o Difficulty starting or stopping
- o Urinary tract infections
- o Kidney infections
- o Flank pain
- o Kidney stones
- o Urethral discharge
- o Hernias
- o History of STD's
- o Genital sores

(MALE)
- o Testicular problems
- o Prostate problems

(FEMALE)
- o Premenstrual syndrome
- o Menopausal
- o Perimenopausal
- o Used oral or injectable contraceptives in past
- o Pain with period
- o Bleeding between periods
- o Pain with intercourse
- o Vaginal/urethral discharge
- o Vaginal yeast infections

ENDOCRINE
- o Thyroid disease
- o Hot/Cold intolerance
- o Excessive hunger, eating
- o Excessive thirst, drinking
- o Excessive urination
- o Sterility
- o Brittle hair/nails
- o (male) enlarged breasts
- o (female) excessive facial hair

BLOOD
- o Excessive Bruising
- o Bleeding disorder
- o Anemia

MUSCULOSKELETAL
- o Arthritis
- o Joint pain
- o Muscle/soft-tissue
- o pain
- o Scoliosis
- o Fractures
- o Dislocations
- o Retained surgical hardware
- o Loss of strength
- o Herniated disc
- o Muscle atrophy
- o Abdominal hernias

NEUROLOGICAL
- o Migraine
- o Headache
- o Speech problems
- o Dizziness/vertigo
- o Insomnia
- o Blacking out/fainting
- o Seizure disorder
- o Loss of sensation
- o Loss of muscle
- o control
- o Arms or legs changing red/white and hot/cold
- o Muscle twitching
- o Convulsions
- o Past loss of consciousness
- o Memory loss

PSYCHIATRIC
- o Depressed
- o Moodiness
- o Panic Attacks and Anxiety
- o Phobias
- o Post-traumatic stress disorder
- o Obsessions
- o Compulsions
- o Addictive behaviors
- o Suicidal Thoughts

NOTE:
If you would like to add to or further elaborate upon any of your problems, please do so on the final page under "Additional pertinent information"

Initial: ________

Medications: (name, amount, how often ... ex: Lopressor 10mg 1x/day; Zyrtec 10mg 1x/day as needed)

1. ____________	4. ____________	7. ____________
2. ____________	5. ____________	8. ____________
3. ____________	6. ____________	9. ____________

Supplements: (vitamins, herbs, etc.)

1. ____________	4. ____________	7. ____________
2. ____________	5. ____________	8. ____________
3. ____________	6. ____________	9. ____________

Allergies to medications: (Give the drug name and reaction ... ex: Penicillin-rash; Sulfa-rash; Codeine-nausea)

1. ____________	3. ____________	5. ____________
2. ____________	4. ____________	6. ____________

Other Allergies or Sensitivities: (ex: pollen-runny nose; bee sting-can't breathe; chemicals-headache; dust-sneezing)

1. ____________	3. ____________	5. ____________
2. ____________	4. ____________	6. ____________

Vaccinations: (Please check to indicate if you had the vaccinations)

Diptheria/Pertussis/Tetanus (DPT): Yes__ No__
Polio: Yes__ No__
Measles/Mumps/Rubella (MMR): Yes__ No__
Smallpox: Yes__ No__
Tuberculosis Test (PPD): Yes__ No__
Hepatitis: Yes__ No__
Other vaccinations:

____

Family History: (Please check to indicate whether you have had family members with these problems)

- o Cancer
- o Diabetes
- o Epilepsy
- o Gout
- o Heart Disease
- o Kidney Disease
- o Mental Illness
- o Obesity
- o Rheumatism
- o Thyroid
- o Tuberculosis
- o Others____________

Additional Pertinent Information:

____

____

____

Patient's Signature: ______________________ **Date:** ____________

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Beck Depression Inventory

Read all statements in each number 1-21. Pick a statement or statements in each group that best describes the way you feel today, at this moment and circle your choice(s).

Name: ______________________ **Date:** ______________ **Total:** __________

1. 0. I do not feel sad.
   1. I feel blue or sad.
   2a. I am blue or sad all the time and can't snap out of it
   2b. I am so sad or unhappy that it is quite painful.
   3. I am so sad or unhappy that I can't stand it.

2. 0. I am not particularly pessimistic or discouraged about the future
   1. I feel discouraged about the future.
   2a. I feel I have nothing to look forward to.
   2b. I feel that I don't ever get over my problems.
   3. I am so sad or unhappy that I can't stand it.

3. 0. I do not feel like a failure
   1. I feel I have failed more than the average person.
   2a. I feel I have accomplished very little that is worthwhile or that means anything.
   2b. As I look back on my life, all I can see is a lot of failures.
   3. I feel I am a complete failure as a person.

4. 0. I get as much satisfaction out of things as I used to.
   1. I don't enjoy things the way I used to.
   2. I don't get real satisfaction out of anything anymore.
   3. I am dissatisfied or bored with everything.

5. 0. I don't feel particularly guilty.
   1. I feel bad or unworthy a good part of the time.
   2a. I feel quite guilty
   2b. I feel bad or unworthy practically all the time now.
   3. I feel as though I am very bad or worthless.

6. 0. I don't feel I am being punished.
   1. I have a feeling that something bad may happen to me.
   2. I feel I am being punished or will be punished.
   3. I feel I deserve to be punished.

7. 0. I don't feel disappointed in myself
   1. I am disappointed in myself.
   2a. I don't like myself.
   2b. I am disgusted with myself.
   3. I hate myself.

8. 0. I don't feel I am worse that anybody else.
   1. I am critical of myself for my weaknesses or mistakes.
   2. I blame myself for my faults.
   3. I blame myself for everything bad that happens.

9. 0. I don't have any thoughts of killing myself.
   1. I have thoughts of killing myself, but I would not carry them out.
   2a. I feel I would be better of dead.
   2b. I feel my family would be better off if I were dead.
   3a. I have definite plans about killing myself.
   3b. I would kill myself if I could.

10. 0. I don't cry any more than usual.
 1. I cry more now than I used to.
 2. I cry all the time now.
 3. I used to be able to cry, but now I can't cry even thought I want to.

11. 0. I am no more irritated by things than I ever have been.
 1. I am slightly more irritated now than usual.
 2. I am quite annoyed or irritated a good deal of the time.
 3. I feel irritated all the time now.

12. 0. I have not lost interest in other people.
 1. I am less interested in other people than I used to be.
 2. I have lost most of my interest in other people.
 3. I have lost all of my interest in other people.

13. 0. I make decisions about as well as I ever could.
 1. I put off making decisions more than I used to.
 2. I have greater difficulty in making decisions than before.
 3. I can't make decisions at all anymore.

14. 0. I don't feel that I look any worse than I used to.
 1. I am worried that I am looking old or unattractive.
 2. I feel that there are permanent changes in my appearance that make me look unattractive.
 3. I believe that I look ugly.

15. 0. I can work about as well as before.
 1. It takes an extra effort to get started at doing something.
 2. I have to push myself very hard to do anything.
 3. I can't do any work at all.

16. 0. I can sleep as well as usual.
 1. I don't sleep as well as I used to.
 2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
 3. I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0. I don't get tired more than usual.
 1. I get tired more easily than I used to.
 2. I get tired from doing almost anything.
 3. I am too tired to do anything.

18. 0. My appetite is no worse than usual.
 1. My appetite is not as good as it used to be.
 2. My appetite is much worse now.
 3. I have no appetite at all anymore.

19. 0. I haven't lost much weight, if any, lately.
 1. I have lost more than five pounds.
 2. I have lost more than ten pounds.
 3. I have lost more than fifteen pounds.

20. 0. I am no more worried about my health than usual.
 1. I am worried about physical problems such as aches, pains, upset stomach or constipation.
 2. I am very worried about physical problems and it's hard to think of much else.
 3. I am so worried about my physical problems that I cannot think about anything else.

21. 0. I have not noticed any recent change in my interest in sex.
 1. I am less interested in sex than I used to be.
 2. I am much less interested in sex now.
 3. I have lost interest in sex completely.

Patient Name: ______________________________ **Date:** ____________________

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Burns Anxiety Inventory

Name: ______________________ **Date:** __________________ **Score:** __________

Instructions: The following is a list of anxiety symptoms that people sometimes have. Circle the number in the right column that best describes how much that symptom or problem has bothered you during the past week.

Rating Scale for your answers: **0 = Not at all 2 = Moderate**
1 = Some what 3 = A lot

Symptom List:

Category I: Anxious Feelings

1. Anxiety, nervousness, worry and/or fear	0	1	2	3
2. Feeling that things around you are strange, unreal or foggy.	0	1	2	3
3. Feeling detached from all or part of your body.	0	1	2	3
4. Sudden unexpected panic spells.	0	1	2	3
5. Apprehension or a sense of impending doom.	0	1	2	3
6. Feeling tense, stressed, uptight, or on edge.	0	1	2	3

Category II: Anxious Thoughts

7. Difficulty concentrating.	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to the next.	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control.	0	1	2	3
11. Fears of cracking up or going crazy.	0	1	2	3
12. Fears of fainting or passing out.	0	1	2	3
13. Fears of physical illness or heart attacks or dying.	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated, or abandoned.	0	1	2	3
16. Fears of criticism or disapproval.	0	1	2	3
17. Fears that something terrible is about to happen.	0	1	2	3

Category III: Physical Symptoms

18. Skipping or racing or pounding of the heart (palpitations).	0	1	2	3
19. Pain, pressure or tightness in the chest.	0	1	2	3
20. Tingling or numbness in the toes or fingers.	0	1	2	3
21. Butterflies or discomfort in the stomach.	0	1	2	3
22. Constipation or diarrhea.	0	1	2	3
23. Restlessness or jumpiness.	0	1	2	3
24. Tight, tense muscles.	0	1	2	3
25. Sweating not brought on by heat.	0	1	2	3
26. A lump in the throat.	0	1	2	3
27. Trembling or shaking.	0	1	2	3
28. Rubbery or "jelly" legs.	0	1	2	3
29. Feeling dizzy, light-headed or off balance.	0	1	2	3
30. Chocking or smothering sensations or difficulty breathing.	0	1	2	3
31. Headaches or pains in the neck or back.	0	1	2	3
32. Hot flashes or cold chills.	0	1	2	3
33. Feeling tired, weak, or easily exhausted.	0	1	2	3