

***Balance of Life Clinic***  
***3985 Medina Rd. Suite 250***  
***Medina, Ohio 44256***  
***330-764-4242***

First we would like to sincerely thank you for your interest in the Balance of Life Clinic and welcome you as one of our valued patients.

Second, we would like to introduce ourselves. I am Dr. Clifford M. Sonnie, M.D. I am a Board Certified Medical Physician who has chosen to look at medicine from a different point of view. And I am Dr. Alphonzo Monzo, N.D. I am a Biblical Naturopathic doctor that looks at medicine through natural, non-invasive & spiritual modalities. Traditional medicine usually takes a reactive stance with respect to healthcare. Typically, once a disease shows itself, treatment begins. Here at the Balance of Life Clinic we take a proactive and preventative stance.

A preventative stance looks at the body as a whole and does not limit each patient by diagnosing specific diseases. Each section of the body is an integral piece of the entire being. Once the body is balanced on all levels, it operates the way God intended for it to operate. Then the symptoms and ailments plaguing patients today can ameliorate themselves.

How do we balance the body? We look at the body in two main venues. The first venue is to detoxify the body. Many of us have been on this earth for quite sometime. We have been exposed to many things such as heavy metals, pesticides and other chemicals. Infectious agents such as yeast, fungus, parasites and viruses also contaminate our world. Each of these aspects, as well as others places a burden on our bodies. They present our bodies with hurdles, so to speak, that we must jump each day in order for our bodies to function effectively. Once we remove those toxins our bodies naturally operate more efficiently.

The second venue we address is replenishing the body with what it needs to function at its full potential of well being. This may include nutrients, bio-identical hormones or other supplements, TKM treatments or a homeopathic remedy. Each item plays an important role in bringing your body back to the balance that God created it in. Lifestyle and dietary changes can eventually lead to the supplements being minimized or eventually eliminated.

We would like to emphasize we do not want to or are we willing to replace your primary or family physician. Our goal is to offer you a complementary program in addition to any treatment program your doctor may have started. Do not stop or alter any treatment without the advice and/or permission of your primary care physician.

Your initial appointment will be approximately 60 minutes long. We will take a brief history and physical evaluation, and let you know what testing will be necessary. Any records you bring with you will be reviewed and become part of your medical history with us. When your testing has been completed, we will schedule a follow up visit to go over all the results and discuss our recommendations for your personal wellness program. I will discuss with you what therapies and treatments will be needed.

***We encourage you to be prompt and prepared for your appointments. If you are more than 10 minutes late you WILL BE rescheduled for a different day. You are the only one scheduled for your time slot. PLEASE have ALL of your paperwork completed and arrive a few minutes early to allow us to prepare your file. If the paperwork IS NOT completed, you WILL BE rescheduled. We strive to be timely in the care of each and every patient. WE ARE NOT LIKE OTHER OFFICES. Your time slot is yours alone and we do not like to keep you waiting.***

We hope this brief introduction answers many of your questions about our clinic. Please feel free to call us with any additional questions you may have. We look forward to your visit.

Sincerely,

Clifford M. Sonnie, M.D., M.P.H.  
Alphonzo Monzo, N.D.

**BALANCE OF LIFE CLINIC**  
**DEMOGRAPHIC INFORMATION**

**LAST NAME:** \_\_\_\_\_

**FIRST NAME:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**CELL PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**BIRTH DATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**SEX:** \_\_\_\_\_ **MARITAL STATUS:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_

**RETIRED?** Y\_\_\_\_\_ N\_\_\_\_\_ **HOW LONG:** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL:** \_\_\_\_\_

**WITH WHOM MAY WE SPEAK ABOUT YOUR MEDICAL  
CONDITIONS?** \_\_\_\_\_

**MAY WE LEAVE MESSAGES AT YOUR HOME?** \_\_\_\_\_

**ON ANSWERING MACHINE?** \_\_\_\_\_

**CAN WE EMIAL YOU?** \_\_\_\_\_

**WHO REFERED YOU TO US?** \_\_\_\_\_

**Health History**

Name \_\_\_\_\_ Date \_\_\_\_\_

Male/female \_\_\_\_\_ Age: \_\_\_\_\_

How long have you had health problems? \_\_\_\_\_

**Marital status:**     Single     Married     Divorced     Widowed

Do you have Children: \_\_\_\_\_ If yes, # of children \_\_\_\_\_ Do any still live with you \_\_\_\_\_

**Please list any known health issues with your families and indicate deceased or living:**

Mother: Age \_\_\_\_  Living  Deceased Health Issue \_\_\_\_\_

Father: Age \_\_\_\_  Living  Deceased Health Issue \_\_\_\_\_

Grandmother: Age \_\_\_\_  Living  Deceased Health Issue \_\_\_\_\_

Grandfather: Age \_\_\_\_  Living  Deceased Health Issue \_\_\_\_\_

Siblings: \_\_\_\_\_

**What is the main concern that brought you here? (If more than one, please place in order of importance to you)** \_\_\_\_\_

What other health professionals have you seen for this condition? \_\_\_\_\_

**Have you ever had or been diagnosed as having problems with any of the following?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abdominal pain              | <input type="checkbox"/> Double vision        | <input type="checkbox"/> Nosebleeds          |
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Edema                | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Eye problems         | <input type="checkbox"/> PMS / Menopause     |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Gallbladder issues   | <input type="checkbox"/> Pneumonia           |
| <input type="checkbox"/> Back Pain                   | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Prostate            |
| <input type="checkbox"/> Black stools                | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bleeding condition          | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Sinus issues        |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Skin issues         |
| <input type="checkbox"/> Chest pain                  | <input type="checkbox"/> High cholesterol     | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Colitis                     | <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Swallowing issues   |
| <input type="checkbox"/> Constipation                | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Sweating feet       |
| <input type="checkbox"/> Coughing blood              | <input type="checkbox"/> Kidney problems      | <input type="checkbox"/> Tinnitus            |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Leg pain / cramps    | <input type="checkbox"/> Thyroid disease     |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Low blood pressure   | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Ulcers (GI)         |
| <input type="checkbox"/> Digestion problems          | <input type="checkbox"/> Menstrual cramps     | <input type="checkbox"/> Ulcers (Skin)       |
| <input type="checkbox"/> Dizzy spells                | <input type="checkbox"/> Mouth sores          | <input type="checkbox"/> Varicose veins      |
| <input type="checkbox"/> Other: please explain _____ |   |  |

**Describe your normal day's eating habits:**

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Cravings \_\_\_\_\_

**Health History (cont.)**

**Please describe your normal day's fluid intake & amounts:**

Water \_\_\_\_\_ Alcohol \_\_\_\_\_  
Juice \_\_\_\_\_ Coffee/ Tea \_\_\_\_\_  
Soda \_\_\_\_\_ Other \_\_\_\_\_

What type of water do you drink (Tap/filtered/spring) \_\_\_\_\_

**Sleep, Rest, Stress, and Work Habits:**

How many hours do you sleep (average) \_\_\_\_\_ Is it sound? \_\_\_\_\_

Do you wake-up feeling refreshed or tired? \_\_\_\_\_

Do you wake to void? \_\_\_\_\_ Do you have urinary urgency? \_\_\_\_\_

Do you always wake up at a certain time during the night? \_\_\_\_ what time \_\_\_\_\_

Describe your energy level \_\_\_\_\_

Do you feel stressed?  Yes  No If yes, what is your major stressor \_\_\_\_\_  
\_\_\_\_\_

What do you do when you are stressed? \_\_\_\_\_

Do you have a day of rest \_\_\_\_\_ How many days / hours do you work (per week) \_\_\_\_\_/\_\_\_\_\_

What types of exercise do you do? \_\_\_\_\_

Do you participate regularly in religious worship, education, or meditation activities?  Yes  No

*If you feel comfortable, please share what types of activities?* \_\_\_\_\_  
\_\_\_\_\_

**Bowel Movements:**

How many bowel movements do you have # \_\_\_\_\_ per (month, week, day) \_\_\_\_\_

What is the color \_\_\_\_\_ Do they sink or float \_\_\_\_\_ Is there an odor \_\_\_\_\_

Do you go easily or do you labor? \_\_\_\_\_ Is there any blood \_\_\_\_\_

**Please list all surgeries / operations, Major or Minor (include approximate date, use back if you need more room):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list all injuries, Major or Minor (include approximate date, use back if you need more room):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health History ( cont.)**

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**Allergies (Environmental, food, & medicinal):** \_\_\_\_\_

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**Do you take any medications (list all):** \_\_\_\_\_

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**Do you take any supplements (list all):** \_\_\_\_\_

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**Have you been or are you currently exposed to hazardous materials:** \_\_\_\_\_

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**Dental / Metal History:**

Do you have any silver/amalgam fillings? \_\_\_\_\_ How many \_\_\_\_\_

Do you have any root canals or implants? \_\_\_\_\_ How many \_\_\_\_\_

Do you have any metal in your body \_\_\_\_\_ If yes, explain \_\_\_\_\_

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**Is there anything else you think I should know?** \_\_\_\_\_

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**For women:**

Are you pregnant? \_\_\_\_\_ If so, number of month's \_\_\_\_\_

# of Pregnancies \_\_\_\_\_ # of Births \_\_\_\_\_

Gynecological history: \_\_\_\_\_

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Obstetrical history: \_\_\_\_\_

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Do you use hormone replacement therapy? \_\_\_\_\_

Have you had a bone density test? \_\_\_\_\_

### Client Statement

I understand that I am here to learn about nutrition and better health practices and that I will be offered information and recommendations about food supplements, herbs, diets, and lifestyle as a guide to health and wellness.

I fully understand that Alphonzo Monzo, N.D. is not a medical doctor and will not be providing any medical diagnostic procedures, or any other "Medical Doctor" practice. I am not, on this visit or any subsequent visit, an agent for federal, state or local agencies or on mission of entrapment or investigation.

An "**MD**" (Medical Doctor) uses techniques and practices such as chemicals, drugs, surgery and other therapies designed to address the codified symptomology of disease.

An "**ND**" (Doctor of Naturopathy) is a professional that has earned a degree in alternative and complimentary methods that **do not** involve drugs, surgery, or any invasive methods. They are simply teachers of natural health and wellness practices!

The services performed by Alphonzo Monzo, N.D. include: 1) health evaluations and assessments. 2) Massage therapy and body work. 3) TKM® 4) Recommendations and teaching on Nutrition which may include; supplements, herbs, homeopathies, diets, and lifestyle changes. 5) Spiritual counseling, and Does Not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature of client: \_\_\_\_\_ Date \_\_\_\_\_

**ALL NEW CLIENTS:**  
**PLEASE REFRAIN FROM TAKING YOUR**  
**DIETARY SUPPLEMENTS FOR 24 HOURS**  
**BEFORE YOUR NEXT APPOINTMENT**

**BALANCE OF LIFE CLINIC  
TREATMENT CONSENT FORM**

I hereby request and consent to treatment of preventive medicine including, but not limited to meridian and reflex testing and balancing, chelation therapy, intra-venous nutrition therapy, allergy elimination, bio electric stress testing, muscle testing, acupuncture and other procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by Dr. Clifford M. Sonnie, or anyone employed by him whether signatories to this form or not.

I have been given the opportunity to discuss with the doctor and /or other office personnel the nature and purpose of all natural, alternative and integrative treatments and procedures being performed to me or asked of me. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of standard medicine in the practice of complementary and preventive medicine there are some risks to treatment, including but not limited to allergic reactions, side affects, or the use of needles (bleeding, venous infiltration, infection, bruising), pain, an increase in symptoms or no improvement at all. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known then, and is in my best interests.

I for my self and my personal representatives, heirs, next of kin hereby release, waive, discharge and covenant not to sue Balance of Life Clinic, its officers, and members, partners, owners and employees from all liability to myself, my personal representatives, assigns, heirs and next of kin for all loss or damage, or any claim or damage therefore, on account of injury to myself or death due to the negligence of the Balance of Life Clinic, it officers, members partners, owners and employees.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

I have discussed and understand other treatment options that may be available to me through standard medicine approaches and/or other healthcare providers.

**Clifford M. Sonnie, M.D. does not offer to diagnose or treat any disease of condition found in the body. We're not here to replace you primary care physician. However, if during the course of an examination we encounter unusual findings, we will inform you of these findings. If you desire advice, diagnosis, or treatment for those findings we will recommend that you seek the services of your primary care physician, or a healthcare provider that specializes in that area. We may give you information and/or advise about your present prescriptions. We are in no way recommending that you change or stop any of your medications. Please advise your primary care physician before making any changes.**

Completed by Patient

Completed by patient's representative

Print Name \_\_\_\_\_

Print Name \_\_\_\_\_  
(Representative of Patient)

Sign Name \_\_\_\_\_

Sign Name \_\_\_\_\_  
(Representative of Patient)

Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Office Use

Witness \_\_\_\_\_

Date Completed \_\_\_\_\_

Balance of Life Clinic  
Practice Privacy Statement

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

- I. This is a formal notification, as required by the government concerning the privacy of this practice. This practice has an obligation to maintain all medical information in the strictest confidence. Our practice cannot release information without your written consent, including medical records, conversation, reminder calls, test results, and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about the release of information. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward.

Your protected health information (HPI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under the immediate care for care needs. This may include any exam and evaluation, procedures done related to your needs, medication management, physical therapy, referral for services, diagnostic tests or treatment related to this care. Release of information to family and significant other (husband or wife) can be done only with your permission on the registered form.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes, pictures and procedure notes. This would also include eligibility verification, prior authorization, and claim submission.
- For operations of this practice such as accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form.
- Disclosure to your family and friends concerning any related health care information identified on the registration form which can be modified at any time orally and followed by written consent.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.

Certain disclosures can be made without your consent. They are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse.
- Information used for public health purposes, medical examiners, or related to a person's death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- For worker's compensation cases or employment related assessments.

- III. Your rights for your health information include: The right to requires limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address. The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of who we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

- IV. This practice reserves the right to modify or change the Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient unable to sign due to: \_\_\_\_\_ Date: \_\_\_\_\_

Patient refused to sign: \_\_\_\_\_ Date: \_\_\_\_\_



## Balance of Life Payment Policy

We are a fee for service facility. Payment is expected at the time of service. We accept cash, checks and credit cards.

In the event of a returned check, a returned check fee will be charged as well as the bank fees charged to us.

We do find it necessary upon occasion to extend credit to patients. This is done at our discretion, and needs to be discussed up front before charges start to accrue.

If credit is extended, we expect monthly payments until your bill is taken care of. If you are continuing to accrue charges we ask that you try to make as large of a payment as is possible to keep it from becoming too high. Each case is different and we will discuss terms with you individually.

If for some reason you fail to continue to make payments for a period of 3 months, without any contact with us, your account will be turned over to our collection agency, and a 40% collection fee will be added to your account total.

I \_\_\_\_\_ have read and understand the Balance of Life payment policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date