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

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.

At Balance of Life Clinic, we look at medicine from a different point of view. 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 it's full potential of well being. This may include nutrients, bio-identical hormones or other supplements. 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.

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.
Holly Zamiska, C.N.P.

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 EMAIL YOU? _____

WHO REFERED YOU TO US? _____

History of **Present** Illness

Patient Name:_____ Date:_____

In the LEFT column please describe the problem you have, when it started and what kinds of treatment has been done for it so far. Please include any medications, prescribed or over the counter that you have or are currently taking. Use the back of the sheet of necessary.

PATIENT TO COMPLETE: **FOR STAFF USE ONLY:**

#1._____

#2._____

#3._____

PAST MEDICAL HISTORY

PATIENT NAME: _____ DATE_____

____MARRIED _____SINGLE _____DIVORCED _____# OF CHILDREN _____ # LIVE WITH YOU

Please list any known medical problems with your families and indicate deceased or living:
Mother ___ Age___ Living___ Deceased _____
Father ___ Age___ Living___ Deceased _____
Grandmother ___ Age___ Living___ Deceased _____
Grandfather ___ Age___ Living___ Deceased _____
Siblings: _____

Please check all that apply:

____ Abdominal pain
___ Double vision
___ Pneumonia
___ Anemia
___ Epilepsy
___ Shortness
___ Arthritis
___ Gall Bladder issues
___ Sinus issues
___ Asthma
___ Headaches
___ Skin issues
___ Back pain
___ Heart Disease
___ Stroke
___ Black Stools
___ Hepatitis
___ Swallowing issues
___ Bleeding conditions
___ High Blood Pressure
___ Sweating feet
___ Cancer
___ Irregular heartbeat
___ Swelling of joints
___ Chest pain
___ Leg pain
___ Tuberculosis
___ Colitis
___ Lung Disease
___ Thyroid Disease
___ Constipation
___ Mouth sores
___ Ulcers (GI)
___ Coughing blood
___ Nosebleeds
___ Ulcers (skin)
___ Depression
___ Osteoporosis
___ Varicose veins
___ Diabetes
___ Phlebitis
___ Dental (Mercury)

___ Other: please explain _____

Please list past surgical procedures: _____

Allergies (Environmental, food & medicinal): _____

Current prescription medications including dosages: _____

Current supplements you are taking: _____
_____

Please list the occupations you have had and whether or not you may have been exposed to hazardous materials:_____
_____

Please list any habits including the duration and quantity of the habit: _____
_____

Please indicate what you usually eat and when:
1st meal: _____
2nd meal: _____
3rd meal: _____
Snacks: _____
Beverages: _____
Cravings: _____

Number of ounces of water you drink per day_____

FOR WOMEN:
_____ # of pregnancies ____# of births

Gynecological History: _____

Obstetrical History: _____

Use of any hormone replacement therapy? ____Y ___N

Have you had a Bone Density Test? ___Y ___N

BALANCE OF LIFE CLINIC
TREATMENT CONSENT FORM

I hereby request and consent to treatment of preventive medicine including, but not limited to chelation therapy, intra-venous nutrition therapy, allergy elimination, by Dr. Clifford M. Sonnie, Holly Zamiska C.N.P., or employees of the Balance of Life Clinic, whether signatories to this form or not.

I will be 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 on 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 will also have 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 can discuss and understand there are other treatment options that may be available to me through standard medicine approaches and/or other healthcare providers.

Clifford M. Sonnie, M.D. and Holly Zamiska C.N.P., do not offer to diagnose or treat any disease of condition found in the body. We're not here to replace your 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

Print Name_____

Sign Name_____

Date_____

Completed by patient's representative

Print Name_____
(Representative of Patient)

Sign Name_____
(Representative of Patient)

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.

I. This is a formal notification, as required by the government concerning the privacy of the 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 any other confidential issues. Patient information about healthcare 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 written notification. Changes can only impact the care of information from that point forward.

II. Your protected health information (PHI) 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 registration form.
- For operations of this practice such as accounting and compliance with state and federal 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. As emergency is identified as a medical condition that, in the judgement of the physician, requires information for care on your behalf.

<u>Certain disclosures can be made without your consent. They are as follows:</u>

- Disclosures required by the government or law enforcement agencies. An example would be victims of abuse.
- Information used for public health purposes and medical examiners.

III. Your rights for your health information include: The right to require limits on the uses and disclosures at registration or anytime during your care. The right to choose how we send 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 whom 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 no payment is received for a month, a late fee will be applied to the account. 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

Balance of Life Clinic

Medicare Opted Out

I, _____ understand that the providers at Balance of Life Clinic have OPTED OUT of Medicare. This means that:

1. Medicare CANNOT BE BILLED for any services done here at the clinic.
2. Private Insurance is NOT accepted. I can submit the claim to my insurance company on my own, and I must deal with them on my own to resolve any issues should they arise. If the services are reimbursed, the check should be sent directly to me, not the clinic.
3. I am responsible for payment to the clinic at the time the services are rendered.
4. I understand that I have a right to services provided by other providers who have not opted out of Medicare, and I am not being forced to utilize the services provided by the clinic.
5. I understand that the providers are not excluded from participating in Medicare, but that they have chosen to opt out of Medicare.
6. Again, I understand that Medicare will not pay for services rendered here at this clinic, even though they would have at another office in the Medicare network.

Signature _____ Date _____