Lysander Jim, MD
Pasadena Chronic Fatigue Center
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General Details and Policies

Thank you for your interest in our clinic. We specialize in treating Chronic Inflammatory Response Syndrome (CIRS) and our policies are listed below. Please complete the following sections.

We do not provide primary care services. You understand that for all general medical conditions you will contact your primary care provider. You understand that we do not provide any urgent or emergent care.
Patient Initials: _____

Primary Care Provider Name: ________________________

Phone Number: ___________________________________

Test results will be reviewed at your next scheduled appointment. It is your responsibility to schedule a follow-up appointment to review results.
Patient Initials: _______

There is a **non-refundable** $100 deposit upon booking. This is applied toward your visit and can be carried forward in the event of rescheduling, provided there is 48-hour notice for rescheduling.
Patient Initials: _______

Calls and emails that take over 10 minutes will be billed at the same rate as a standard 45-minute in-person appointment.

Appointments for telephone consultations are available for existing patients. In general, there is no charge for brief, uncomplicated questions.

Please do not email regarding issues that require same day attention.

Initials: __________

You must cancel your appointment within 48 business hours. If you cancel your appointment on the same day or do not show for your appointment, you will be billed a **$100 cancellation fee**.

Initials: __________

Fee Schedule:

- **Initial Consultation:** **Flat Rate of $665**
  - 1.5 -Hour Appointment
  - Visual Contrast Sensitivity Test
  - In-Office Nasal Swab

    This does not include the $85 laboratory process fee billed by the laboratory

- **Follow-up Appointments:**
  - 45 minutes **$320**
  - every 15 minutes thereafter **$100**

- **Nasal Swab Laboratory Fee** **$85 and up**
- **Administrative Fees**
  - Record Retrieval **$50 and up**
  - Lab Order Adjustments **$35 and up**
  - Letters/Paperwork/ Prior Authorizations (based on time taken to complete, billed by 15 minute increments) **$400/hr**

Initials: __________

Confidentiality:
We can maintain the privacy of our communications, as is required by law. In most cases, we can only release information about your treatment to others if you sign a written authorization form. There are other situations that require only that you provide written, advance consent. Signing this form provides for these activities, as follows:

- We may occasionally find it helpful to consult other health professionals about a case. During such consultations, we make every effort to avoid revealing the patient's identity. The other professionals are also legally bound to maintain confidentiality.
- We do not file insurance claims, but are occasionally contacted by patients' insurance companies regarding payment for claims. If you have given the insurance company permission your records will be released to them.
- If a patient threatens to harm himself/herself or others, we are obligated to report it to medical and/or other relevant parties and would have to break confidentiality.
- De-identified clinical information may be used for academic and scientific purposes including but not limited to research, scientific presentations and publications

Please read this agreement thoroughly and sign below to acknowledge acceptance of terms of service.

Patient Name: ____

Patient Signature: ____

Date: ____________

PASADENA CHRONIC FATIGUE CENTER
Medical Services Agreement

______________________(PATIENT) and Pasadena Chronic Fatigue Center (Dr. Lysander Jim) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT agrees not to submit a health insurance claim (or request the PHYSICIAN to submit a claim on PATIENT'S behalf) under the Social Security Act (MEDICARE) for the services, even if you may think that such services are or maybe otherwise covered under health insurance or MEDICARE.

2. **The PATIENT agrees to be responsible for the SERVICES.** Although treatment for "mold disease" or Chronic Inflammatory Response Syndrome is medically beneficial and scientifically validated, insurance companies have a varying degree of acceptance regarding this position. The United States Department of Health and Human Services, Office of Inspector General takes the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this potential disagreement, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government.

3. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provided reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a",'- 1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.

4. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.

5. Our **INVOICE** contains pertinent information regarding your office services and purchases. This form was generated for your personal records primarily although patients have submitted it to their insurance company with a claim form for reimbursement. **This frequently causes subsequent inquiries by the insurance company to which we reserve the right to not respond**.

Patient's Signature and Date:

____

Pasadena Chronic Fatigue Center
HIPAA Privacy Form

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your medical reports, appointment confirmations and/or receivables of lab results:

I wish to be contacted in the following manner(s). Please check all that apply:

[ ] Home Phone
Leave message with detailed information
Leave message with call back number
Home Number: ____

[ ] Cell Phone
Leave message with detailed information
Leave message with call back number
Cell Number: ____

[ ] Email Report
Email address: ____

[ ] Mail (written communications)
Please continue to send to my home
Address: ____
City: ____

Environmental Exposure Assessment

How long have you been suffering from Chronic Illness?

What year did your symptoms begin?

What was the progression of symptoms?

What diagnoses have you been given and when?

What labs or imaging studies have been done to validate the diagnoses? When?

What are your 6 most prominent symptoms currently?

Do you have family members with similar symptoms?

Have you ever lived in a water-damaged building?

Have you experienced a tick bite? If yes, when?

Have you been in a high-risk situation for tick bites? If yes, when?

Have you ever traveled to a tropical locale? If yes, when?

Have you eaten or handled tropical reef fish such as barracuda, grouper, red snapper, eel, amberjack, sea bass or Spanish mackerel?

Have you lived in or traveled to an area affected by algae “blooms”? If yes, when and where?

Do you react adversely to scents, chemical smells, or smoke?

LIVING ENVIRONMENTS (Most Recent First)

Moved-In	Left	Brief Description	Symptoms
______	______	____________________	____________________
______	______	____________________	____________________
______	______	____________________	____________________
______	______	____________________	____________________
______	______	____________________	____________________

WORK / SCHOOL ENVIRONMENTS (Most Recent First))

Started	Left	Brief Description	Symptoms
______	______	____________________	____________________
______	______	____________________	____________________
______	______	____________________	____________________
______	______	____________________	____________________

Other factors affecting health including surgeries, trauma, severe stress, NOT already listed (Most Recent First)

Date	Event
______	____
______	____

Pasadena Chronic Fatigue Center

Patient Profile Intake Form

Please complete this confidential profile of your health history so we can offer you the most comprehensive naturopathic care.

Name ____ Birth Date ___________

Age ___________

Address ____________________________ City & State _________________________

Zip _________

Home Phone ___________________ Work Phone ___________________

Cell Phone ___________________

Email _________________

INSURANCE INFORMATION

Insurance Name: ____

ID#_______________________________Group#______________________________________

Insured's Name [Name Insurance is Under]:

____

Emergency Contact & Phone __________________________

Occupation _______________________

Previous Occupations

____

Where did you grow up?

____

Married Partnered: Separated Divorced Widowed Single

Children? Yes / No

How did you hear about the clinic?

____

What are your current health concerns or goals, in order of priority?

1. ____

2. ____

3. ____

Where, when, from whom, and for what reason did you last receive any health care?

____

Previous hospitalizations or surgeries:

____

Serious illnesses or injuries

____

____

Family Health History: Y = Yes N = No D = Caused Death (age of death) P = In the past
Please indicate if a family member has had any of the following. If yes, specify who.
Anemia Y N D P____
Arthritis Y N D P____
Asthma / Hay fever Y N D P____
Cancer (type?) Y N D P____
Cystic Fibrosis Y N D P____
Diabetes Y N D P____
Epilepsy Y N D P____
Glaucoma Y N D P____
Heart Disease Y N D P____
High blood pressure Y N D P____
Kidney Disease Y N D P____
Mental Illness Y N D P____
Lyme Disease Y N D P____
Lung Disease Y N D P____
Obesity Y N D P____
Stroke Y N D P____
Substance Abuse Y N D P____
Thyroid disorder Y N D P____
Other ____
Childhood Illnesses Please circle if you have had any of the following:
Scarlet fever Measles Diphtheria German measles Chicken pox Rheumatic fever
Mumps Other ___________________Last Tetanus shot ____________________

Drug Allergies?

Food Allergies?

Diagnosed illnesses for which you currently take medications:

Current Medications and Supplements (please include amount and frequency)

Medical Diseases/Problems (For example: Diabetes, heart attack, stroke)

ON LIST BELOW, PLEASE RATE ON A SCALE OF 0 TO 3 FOR CURRENT SYMPTOMS

0 = NONE, 1 = LOW, 2 = MODERATE, 3 = SEVERE

Initial Visit Symptom List

Name ______________________Pharmacy/Phone___________________________
Date _________________ DOB______________________

Yes ___ No ___ Fatigue ____
Yes ___ No ___ Weakness ______________________________________
Yes ___ No ___ Aches ____
Yes ___ No ___ Cramps ____
Yes ___ No ___ Unusual Pains ____
Yes ___ No ___ Ice Pick Pains _______________________________
Yes ___ No ___ Lightning Bolt Pains _______________________________
Yes ___ No ___ Headache ____
Yes ___ No ___ Light Sensitivity _______________________________
Yes ___ No ___ Red Eyes _______________________________
Yes ___ No ___ Blurred Vision _______________________________
Yes ___ No ___ Tearing _______________________________
Yes ___ No ___ Sinus Problems _______________________________
Yes ___ No ___ Cough ____
Yes ___ No ___ Shortness of Breath ____
Yes ___ No ___ Abdominal Pain ____
Yes ___ No ___ Diarrhea _______________________________
Yes ___ No ___ Joint Pain ____
Yes ___ No ___ Morning Stiffness _______________________________
Yes ___ No ___ Numbness ____
Yes ___ No ___ Tingling ____
Yes ___ No ___ Metallic Taste _______________________________
Yes ___ No ___ Vertigo _______________________________
Yes ___ No ___ Memory Problems ______________________________________
Yes ___ No ___ Focus/Concentration ______________________________________
Yes ___ No ___ Confusion _______________________________
Yes ___ No ___ Decreased "Learning" _______________________________
Yes ___ No ___ Decreased Word Finding Ability _______________________________
Yes ___ No ___ Disorientation _______________________________
Yes ___ No ___ Skin Sensitivity _______________________________
Yes ___ No ___ Excessive Thirst ____
Yes ___ No ___ Frequent Urination _______________________________
Yes ___ No ___ Static/Shocks ____
Yes ___ No ___ Sweats _______________________________
Yes ___ No ___ Mood Swings _______________________________
Yes ___ No ___ Heat/Cold Problems _______________________________
Yes ___ No ___ Appetite Swings _______________________________

Yes ___ No ___ Dizziness
Yes ___ No ___ Orthostatic Hypotension
Yes ___ No ___ Black Sputum/Mucous
Yes ___ No ___ Cold Hands/Feet
Yes ___ No ___ Dreams
Yes ___ No ___ Tremors