

Fremont Holistic Center: Shibuya Integrative Health - Informed Consent & Office Policies

Our commitment here at the Fremont Holistic Center is to serve our patients with professionalism and genuine concern, being sure at all times to protect the privacy and security of all protected health information. During the course of serving you, it may be necessary to share pertinent information with other health care providers or associates for the purpose of ordering laboratory tests, determination of fees, collection of fees, scheduling of your appointments or to obtain a second opinion. If any other uses or disclosures other than the ones listed above (treatment, payment or health care operations) are needed, information will be released only with your written consent, as provided for by law.

As a patient of the Fremont Holistic Center, you acknowledge that you will be receiving treatments from traditional healing systems, also known as “complementary” or “alternative” therapies, which are generally NOT utilized in Western allopathic medicine. Furthermore, you also acknowledge that both traditional and allopathic therapies may be beneficial for you and you may use them simultaneously and that you will actively participate and keep all of your practitioner(s) involved in your care aware of your participation in the others’ care to facilitate optimal outcomes and to minimize side effects.

All health and laboratory information will be given at scheduled office or phone appointments. Please be aware when scheduling phone appointments, our normal fees- for- service apply. If you need to have lab tests and are unable to make an appointment, we will fax them to another doctor, but will not send them to you directly unless you have already discussed them with the doctor.

Please be aware that Health and Safety Code section 109250, et seq., specifically prohibits the use of any unconventional remedy in the diagnosis, treatment, alleviation, or cure of cancer. If you have been diagnosed with cancer, we will be unable to treat you for this diagnosis.

We do **NOT** accept insurance nor do we submit claims to insurance companies. We ask that you know your insurance coverage prior to visiting us. Labs, supplements, medical devices and prescriptions are not included as part of our office fees and may be billed by other parties. It is your responsibility to make payment arrangements with them. If you have insurance and wish to submit a claim, you authorize the Fremont Holistic Center to release any necessary information needed to determine your benefits, upon written request by your insurance. All payment is expected at the time of service. Debit Cards, MasterCard, VISA, cash, and checks are acceptable forms of payment.

Please be advised that if for any reason you cannot keep your scheduled procedure or appointment, we require that you cancel at least 48 business hours prior to your follow-up appointment and 72 business hours prior to your NEW patient appointment. Failure to cancel within that time frame or failure to show for the appointment will result in a \$150 / \$300 fee respectively. This fee may change without notice.

Thank you for your cooperation. We look forward to assisting you on your journey to wellness.

Sincerely,
Barry Shibuya, M.D. and Associates

I have read and understand this form.

Print Name: _____ Signed: _____

Date: _____

MEN'S HEALTH INTAKE FORM

PATIENT INFORMATION – Please PRINT and complete as thoroughly as possible in BLACK INK then fax back to (866) 291-4756.

First Name:	Middle:	Last:	Date:
Date of Birth:	Age:		Gender: Male
Street Address:		Occupation:	
City:		State:	Zip Code:
Phone 1: () <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Phone 2: () <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Email: _____			
May we email you information about our office? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Emergency Contact (Name):		Phone () <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Relationship to you:		May we leave messages at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who is your current Primary Care Doctor ?			
Phone: () _____		Fax: () _____	
Please list other health care professionals from whom you receive ONGOING care (Name, specialty, phone):			
Dr: _____	Specialty: _____	Phone: () _____	
Dr: _____	Specialty: _____	Phone: () _____	
Dr: _____	Specialty: _____	Phone: () _____	
Dr: _____	Specialty: _____	Phone: () _____	
How did you find our office? <input type="checkbox"/> Referred by Dr: _____ <input type="checkbox"/> Referred by current patient: _____			
<input type="checkbox"/> Online search <input type="checkbox"/> ABIHM Website <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> Community Talk <input type="checkbox"/> Word of mouth <input type="checkbox"/> Other: _____			
WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.			
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____
PLEASE CHECK ANY OF THE FOLLOWING YOU ARE INTERESTED IN & RANK IN ORDER OF IMPORTANCE (#1 = MOST, #15 = LEAST)			
<input type="checkbox"/> Food Allergy Testing ____	<input type="checkbox"/> Hormone Testing ____	<input type="checkbox"/> Heavy Metal Testing ____	
<input type="checkbox"/> Nutritional Testing ____	<input type="checkbox"/> Fertility Testing ____	<input type="checkbox"/> Wellness Screening ____	
<input type="checkbox"/> Testing for Depression ____	<input type="checkbox"/> Complete Cardiovascular Panel ____	<input type="checkbox"/> Erectile Dysfunction ____	
<input type="checkbox"/> Anxiety or Mental Health ____	<input type="checkbox"/> Anti-aging/Preventive Medicine Testing ____	<input type="checkbox"/> Digestive Analysis ____	
<input type="checkbox"/> Non-hormonal Birth Control ____	<input type="checkbox"/> Naturopathic Pain Management ____	<input type="checkbox"/> Detoxification Diet ____	
What do you hope to accomplish with this holistic consultation? Please be as SPECIFIC as you can.			
1. _____			
2. _____			
3. _____			

PAST MEDICAL HISTORY: Please check **ALL** that apply

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Attack/CHF | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Headaches | <input type="checkbox"/> Gout | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Colitis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Cataracts/Glaucoma | <input type="checkbox"/> Pulmonary Embolus |

Please list any **OTHER** past or present diagnoses, if any:

Please list past hospitalizations and surgical procedures (include date, hospital and reason for hospitalization):

Do you have all the recommended **vaccinations** for your age? Yes No Unsure

List any known **allergies** to medications, foods or other substances as well as your reaction(s):

Have you traveled outside the United States in the past two years? Yes No. If yes, where?

MEDICATIONS AND SUPPLEMENTS

List all current medications, vitamins, herbs and other supplements you take, including dosages and how often you take them.

Medications:	Vitamins, Herbs, Other Supplements:
--------------	-------------------------------------

FAMILY HISTORY

List any serious health conditions your family members have experienced. Include diabetes, heart disease, auto-immune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

Relationship	Age	Died @ age - of	Health Conditions
Father			
Mother			

SOCIAL HISTORY AND LIFESTYLE

Please list all persons and pets currently living with you:

HABITS	Yes	No	Details
Current tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day:
Past tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: When did you quit?
Alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	How often? Types: <input type="checkbox"/> Beer <input type="checkbox"/> Wine (Red/White) <input type="checkbox"/> Hard Liquor
Recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>	Types: <input type="checkbox"/> In the past <input type="checkbox"/> Current Use (Regularly/Occasionally)
Exposure to toxic chemicals, solvents, other harmful toxins	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain:
Caffeine use (circle all): Coffee, tea, soda, energy drinks	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day?
Regular exercise	<input type="checkbox"/>	<input type="checkbox"/>	How often? Activities:

STRESS - I have seen Dr	Phone#	Fax#
I have seen Dr	Phone#	Fax#

Current stress level: Low Medium High

Source of stress: Job Financial Family/Relationship Other:

Please indicate current (C) or past (P) symptoms	C	P		C	P
Tension	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>
Chronic procrastination	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP – I have seen Dr	Phone#	Fax#	
Problems falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	What keeps you awake?
Problems staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wake feeling refreshed?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you snore or have sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>	

NUTRITION – I have seen dietician at	Phone#	Fax#
Do you follow a particular diet?	Are there foods that you avoid eating? Why?	
How many meals do you typically eat in a day?	Where do you buy food? Who cooks the food you eat?	

Describe your typical
Breakfast:

Lunch:

Dinner:

Snacks & Sweets:

Drinks:

Are you frequently thirsty?	<input type="checkbox"/>	<input type="checkbox"/>	How many 8 ounce cups of water do you drink a day?
Check any of the following that you consume regularly: <input type="checkbox"/> Highly seasoned foods <input type="checkbox"/> Processed foods <input type="checkbox"/> Soda (Regular/Diet) <input type="checkbox"/> Candy <input type="checkbox"/> Juice			

List foods you crave for:	List foods to which you have a reaction:
Are you satisfied with your diet?	<input type="checkbox"/> <input type="checkbox"/> If no, why not?

MALE HEALTH INFORMATION – I have seen Dr

Phone#

Fax#

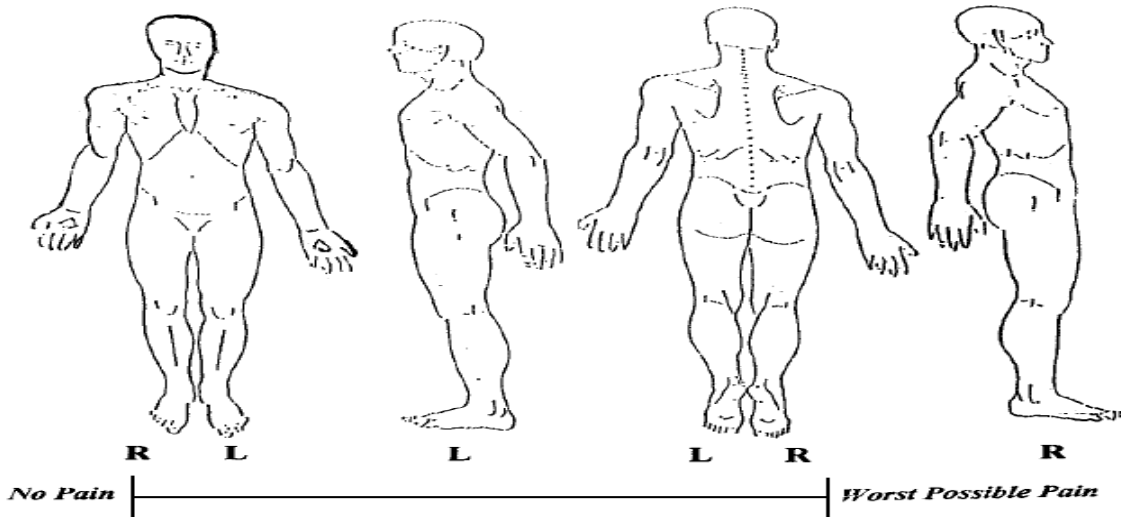
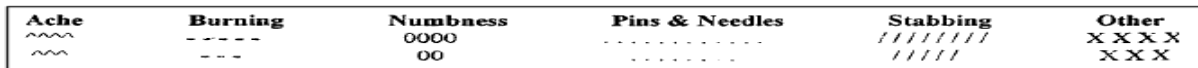
DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Decreased or absence of libido	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes or night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Decreased physical agility	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Memory changes	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes	<input type="checkbox"/>	<input type="checkbox"/>	History or current STD If yes, which ones?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your bone density checked?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? Results: <input type="checkbox"/> Normal <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis		
SEXUAL HEALTH					
Are you currently sexually active? <input type="checkbox"/> Women <input type="checkbox"/> Men <input type="checkbox"/> Both	<input type="checkbox"/>	<input type="checkbox"/>	If yes, current method of contraception?		
Are you content with your libido/sex life?	<input type="checkbox"/>	<input type="checkbox"/>			
CHILDREN					
Do you have children?	<input type="checkbox"/>	<input type="checkbox"/>	___ Boys & ___ Girls		
Are you trying to conceive?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had problems with infertility?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please explain:		

MUSCULOSKELETAL HEALTH – I have seen Dr

Phone#

Fax#

Please use the symbols in the diagram below to describe any symptoms you may have



Over the past week, on a scale from 0 = No pain, to 10 = Worst pain imaginable, please rate:

The Worst Pain you have experienced: _____

Your Daily, Average Pain Level: _____

The Least Pain you have experienced: _____

Your Pain Right Now: _____

Over the past week, on a scale from 0 = Does Not Interfere, to 10 = Completely Interferes, please rate the effect of your pain on:

Your overall, general activity level: _____

Your mood: _____

Your ability to work (Inside & Outside the house): _____

Your personal relationships: _____

Your walking ability: _____

Your sleep: _____

Your ability to exercise: _____

Your enjoyment of life: _____

RHEUMATOLOGICAL (ARTHRITIS) HEALTH - I have seen Dr				Phone#	Fax#
DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Osteoarthritis (OA)	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (RA)	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative Joint Disease (DJD)	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosing Spondylitis (AS)	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Psoriatic Arthritis (PsA)	<input type="checkbox"/>	<input type="checkbox"/>
Pseudo-Gout	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease (IBD) Related Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis / Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus Erythematosus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia / Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Avascular Necrosis (AVN)	<input type="checkbox"/>	<input type="checkbox"/>	Mixed Connective Tissue Disease (MCTD)	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Steroid Use (5 mgs/day for >3 months)	<input type="checkbox"/>	<input type="checkbox"/>	Vasculitis	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia Rheumatica (PMR)	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL HEALTH – I have seen Dr				Phone#	Fax#
Number of bowel movements per day:			Is your stool <input type="checkbox"/> loose or <input type="checkbox"/> formed?		
Do you tend to have: <input type="checkbox"/> constipation or <input type="checkbox"/> diarrhea?			Stools have an unusual color or odor?		<input type="checkbox"/>
			If yes, explain:		<input type="checkbox"/>
Recent changes in bowel habits?	<input type="checkbox"/>	<input type="checkbox"/>	Any blood or mucous in stool?	<input type="checkbox"/>	<input type="checkbox"/>
Recent changes in appetite?	<input type="checkbox"/>	<input type="checkbox"/>	Any abdominal pain or upset stomach?	<input type="checkbox"/>	<input type="checkbox"/>
Any excessive gas or bloating?	<input type="checkbox"/>	<input type="checkbox"/>	Any heartburn? Or Reflux?	<input type="checkbox"/>	<input type="checkbox"/>
Any loss of bowel control?	<input type="checkbox"/>	<input type="checkbox"/>	Any nausea or vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with Irritable Bowel Synd?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an upper endoscopy? When?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Inflammatory Bowel Disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a colonoscopy? When?	<input type="checkbox"/>	<input type="checkbox"/>
WEIGHT HISTORY – I have seen Dr				Phone#	Fax#
Are you content with your current weight?	<input type="checkbox"/>	<input type="checkbox"/>	If no, what is your ideal weight?		
Does your weight fluctuate?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, give highs and lows:		
Any family history of weight problems?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, who?		
What factors do you feel contribute to your changes in weight, if any (nutrition, exercise, hormones, stress, etc.)?					
EARS, EYES, NOSE AND THROAT – I have seen Dr				Phone#	Fax#
Please indicate current (C) or past (P) symptoms	C	P		C	P
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	ringing or buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>
Chronic congestion or nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Eye glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Excessive tearing or dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Sores in mouth, lips or gums	<input type="checkbox"/>	<input type="checkbox"/>
Tooth pain	<input type="checkbox"/>	<input type="checkbox"/>	Mercury dental fillings	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY HEALTH – I have seen Dr				Phone#	Fax#
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Scarring of lungs due to:	<input type="checkbox"/>	<input type="checkbox"/>
Date of last chest x-ray:			Date of last pulmonary function test:		
Date of BCG Vaccination for TB:					
Date of last chest CT scan:					
CARDIOVASCULAR HEALTH – I have seen Dr				Phone#	Fax#
Please indicate current (C) or past (P) symptoms	C	P		C	P

Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina / Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE HEALTH – I have seen Dr			Phone#	Fax#	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger or thirst	<input type="checkbox"/>	<input type="checkbox"/>	Fever or excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia (Low Blood Sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions	<input type="checkbox"/>	<input type="checkbox"/>

Readiness To Change: Please rate on a scale of 1 (Very Willing) to 5 (Not Willing) how willing you are to

Significantly modify your diet: 1 2 3 4 5

Take several nutritional supplements each day: 1 2 3 4 5

Keep a detailed record of everything you eat each day: 1 2 3 4 5

Modify your lifestyle (work demands, sleep habits): 1 2 3 4 5

Engage in regular exercise: 1 2 3 4 5

Practice a relaxation technique daily: 1 2 3 4 5

How confident are you of your ability to organize and follow through with the above: 1 2 3 4 5

How supportive do you think the people in your household will be to you making these changes: 1 2 3 4 5

The above information is true to the best of my knowledge.

_____ X _____ Date _____
 (PRINT name / person legally responsible) (Signature of Patient / Person Legally Responsible)

If you are interested in a focused initial consultation only and you would NOT like to discuss your health history, please complete the following:

I _____ understand the doctors of The Fremont Holistic Center will not assess or address any extensive health issues. I am here solely on an acute care or informational visit. The doctors will not be responsible for anything we have not discussed. I understand I will need to make additional appointments to address any other health concerns.

_____ X _____ Date _____
 (PRINT name of patient / person legally responsible) (Signature of Patient / Person Legally Responsible)

**Fremont Holistic Center: Shibuya Integrative Health –
Informed Consent to Naturopathic Treatment and Care**

I have had an opportunity to discuss the nature and purpose for naturopathic care and its procedures with the doctor named below and/or other office or clinic personnel. I hereby request and consent to Integrative Medicine as an alternative treatment for my health conditions (or for those of the patient named below, for whom I am legally responsible) as performed by the doctor named below and/or other licensed Doctors of Naturopathic Medicine who may now, or in the future, treat me while employed by, working or associated with, serving as back-up for the Doctor of Naturopathic Medicine named below, whether they work at the clinic or office listed below or any other office or clinic.

Treatments may include, but are not limited to- herbal medicine, homeopathic medicine, lifestyle and nutritional counseling, naturopathic manual therapy, physical therapy, injection therapy, and hormone replacement. I have been informed that in the practice of medicine there are some risks to treatment, including, but not limited to, side effects of medication, allergic reactions, anaphylaxis, fractures, disc injuries, strokes, dislocation, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. Therefore, I wish to rely on the doctor’s judgment based upon the facts then known, to provide me with any care and procedures considered to be in my best interest during the course of my treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and I agree to the procedures mentioned above. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient OR by patient’s representative, if necessary
(e.g. if the patient is a minor or physically or legally incapacitated).

Print Name: _____ Signed: _____ Date: _____

If applicable:

PRINT Patient’s Representative’s Name & Relationship (if applicable)

Signature of Patient’s Representative:

Date Signed: _____

Name of Doctor treating this patient: **Dr. Barry Shibuya, MD, ABIHM**