

# *The Institute of Multidimensional Medicine, PLLC*

## REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Physician:				
PATIENT INFORMATION							
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age: 	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )		
City:		State:	ZIP Code:		Cell phone no.: (    )		
E-mail Address:		Occupation:			Work phone no.: (    )		
Referred by:							

INSURANCE INFORMATION						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: (    )	
Please indicate primary insurance						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize TIMM, PLLC or insurance company to release any information required to process my claims.</p>				
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>			<hr style="width: 100%;"/> <i>Date</i>	

*The Institute of Multidimensional Medicine*  
*Notice to Patients*

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.

- A. The general authorization for Release of Medical Record that you sign authorizes your medical care provider, TIMM, to disclose the information in your medical records to the extent needed for the following purposes:
1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of your provider, or with other health care providers who are treating you or consulting in your care.
  2. For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
  3. For the purpose of provider's health care operations. This would include, such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.
  4. For the purpose of other health care provider's health care operations, to the extent that they have a treatment relationship with you.
- B. A specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.
- C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.
- D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.
- E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- F. You have the following rights with respect you your medical records/information:
  1. You have the right to request restrictions on the use and disclosure of your medical records/information, however, Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
  2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
  3. You have the right to inspect and copy your medical records. {Provider is entitled to charge you a reasonable fee related to the cost of copying your records}.
  4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to not your objection in the medical record.
  5. You have a right to receive an accounting (list) of disclosures that are made to you or with your specific authorization, that fall within the scope of Provider's health care operations, or disclosures made for payment or treatment purposes.
  6. You have the right to receive a paper copy of this notice.
  
- G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as Well as changes to those practices. Patients will be provided with revised notices, as appropriate.
  
- H. If a patient believes that his or her privacy rights have been violated, the patients may complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.
  
- I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated Privacy Complaints Contact Person.
  
- J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an update "Notice to Patients" to all of Provider's patients.

Please acknowledge receipt and review of this notice by signing below.

\_\_\_\_\_

\_\_\_\_\_

Name of Patient (Printed)

Date

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient or Lawfully Authorized Representative

AUTHORIZATION & ACKNOWLEDGEMENTS

THE INSTITUTE OF MULTIDIMENSIONAL MEDICINE PLLC

1425 K Street N.W., Suite 350, Washington DC, 20005  
Tel: 202-587-2792

**TREATMENT AUTHORIZATIONS:** I [Print Name] \_\_\_\_\_ authorize medical treatment of myself or my minor child by physicians, dentists or medical assistants and staff at The Institute of Multidimensional Medicine (TIMM).

**NOTICE TO NATURE OF SERVICES:** I understand that care I receive at TIMM may be non-traditional or unconventional. Such services are commonly referred to as complementary/ or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my doctor may request laboratory evaluation that may include venipuncture, and analysis of stool.

**NOTIFICATION THAT SERVICES ARE NOT PRIMARY CARE:** I understand that Dr. Mines is not acting as my primary care physician unless agreed to by Dr. Mines in writing, I understand that even though Dr. Mines may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is my best interest to also have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform TIMM who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physician and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at TIMM in order to properly and safely coordinate my care.

My primary care physician is:

Name \_\_\_\_\_ Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_ Phone \_\_\_\_\_

I am also being treated for \_\_\_\_\_ by:

Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_

# THE INSTITUTE OF MULTIDIMENSIONAL MEDICINE

## PATIENT REPORT OF HEALTH HISTORY

Thank you for your careful answer to these questions. This will help our Integrative Medicine approach  
to your health care. If more space is needed for any item, please continue on the last page.

Who referred you to *TIMM*? \_\_\_\_\_

Please list the main health issues you would like addressed today, and list symptoms related to these issues. Please rate your symptoms by degree of severity, on a scale of 1-5 [1 = mild, 5 = very severe]

Health Issues	Symptoms	Rate 1-5	Physician Comments
1.			
2.			
3.			
4.			
5.			