Nicola McFadzean Ducharme, N.D.
Anayibe Ramos, N.D.

Dear New Patient:

Thank you for choosing RestorMedicine as your healthcare provider. We are dedicated to making your experience a most satisfying one.

The following information is necessary in order for us to complete your in office file and for our participation in your health care. You are encouraged to make copies of these documents for your records. **Please fill out and submit these forms at least 48 business hours prior to your appointment.**

- ✓ Patient Information Form
- ✓ Office Policies and Procedures
- ✓ Lyme Disease Consent Form
- ✓ Credit Card Authorization
- ✓ Health History Questionnaire

Please supply us with copies of any relevant lab work and medical records in electronic (PDF) format. A summary of your illness – symptoms, medications, supplements, timelines, treatments used etc, will also be very helpful. If you cannot provide them prior to your appointment, you may bring them with you.

Please don't hesitate to contact us should you have any questions. We look forward to assisting you.

928 Ft. Stockton Drive, #213
San Diego, CA 92103
(619) 546- 4065 ph
(619) 270- 2582 fax
Web: www.restormedicine.com
Email: info@restormedicine.com

Nicola McFadzean Ducharme, N.D.
Anayibe Ramos, N.D.
Patient Information

(PLEASE PRINT CLEARLY)

Patient Name _____
Last First Middle initial

Home address _____ Birth date ____/____/____

City _____ State _____ Zip _____

Primary phone: Daytime ( ) _____ Evening ( ) _____

Cell phone ( ) _____ Fax ( ) _____

Skype ID (or email) _____

Would you like to receive our newsletter? Yes or No (Circle One)

Email address _____

Employed by _____

Occupation _____

What name do you prefer to be called?

_____

Who referred you to our office?

_____

Who is your medical insurance carrier? HMO ____ PPO ____

_____

In case of emergency contact:

Name _____ Relationship _____

Address _____

City _____State _____ Zip _____

Home phone ( ) _____ Work phone ( ) _____

For children under 18 years of age:

Mother's full name _____

Father's full name _____

Office Hours, Fees, Policies and Procedures

Dr. Nicola's Hours:

- Monday and Thursday 2 PM-4 PM (PST)
- Wednesday 10AM- 4PM (PST)
- Office visits, skype and telephone consultations are by appointment only.

Dr. Ramos's Hours:

- Monday 12 PM-4 PM (PST)
- Tuesday 10 AM-3 PM (PST)
- Wednesday 10 AM- 5 PM (PST)
- Thursday 12 PM- 5PM (PST)
- Friday 9 AM- 2 PM (PST)
- Office visits, skype and telephone consultations are by appointment only.

Dr. Nicola's Fees:

- Initial consultation (45-60 mins) - $500.
- Follow up (20-30 mins) - $225.

Dr. Ramos's Fees:

- Initial consultation (45-60 mins) - $325.
- Follow up (20-30 mins) - $160.
- Extended follow up (60 mins) - $325.

Appointments

- Appointments can be scheduled by telephone or email. Please leave possible dates and times. The staff at RestorMedicine will confirm your appointment time with you.
- Appointments can also be scheduled online by going to www.restormedicine.com, and clicking on "schedule now". You can select your own appointment time. Please note that all times are Pacific Standard Time and adjust for your time zone accordingly.
- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, American Express, check, and cash.
- A credit card is required to hold your initial appointment.
- All initial paperwork must be completed, signed, and received by our office at least 2 business days prior to your scheduled appointment. Please fax or email these forms (in a single PDF file if emailing). Also send an electronic photograph (JPEG format) for our medical records.
- If paying by check for a phone consultation, the check must be received in advance of the consultation.
- Follow-up consults may be scheduled in 30 or 60-minute blocks of time.
- Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
- Medical letters to schools, insurance companies, disability, etc. are a billable service. If these items are requested there may be an additional charge based on the time involved at the hourly rate to complete your request.

Office Consultations:

- Our office is wheelchair accessible. There is complimentary parking on-site and 2-hour metered parking nearby.
- We generally recommend that all patients minimally have an office consultation every 6 months.
- If you have not had a consultation within 1 year, you will be required to schedule a 1 hour consultation and update your patient paperwork and information.

Phone Consultations:

- Dr. Nicola or Dr. Ramos will call you at the time of your scheduled consultation. Please allow a 10-minute window from your appointment time to hear from your doctor.
- If planning to use Skype for your appointment, please send Dr. Nicola or Dr. Ramos a contact request at least two days prior to your appointment.

  Dr. Nicola's Skype user name is **NicolaMcF**
  Dr. Ramos's Skype user name is **AnayibeRamos**

Cancellations/ No Shows:

- **Patients who forget their appointment or cancel less than 24 hours prior to the appointment will be charged for half the cost of the visit**. Please understand that a missed appointment could have gone to another patient.

Acceptance of Policies and Procedures

By completing the following you agree to the policies and procedures detailed above.

Patient (please print):_____ Date: _____

Signature (patient or responsible party): _____

If signed by party other than patient, print name: _____

Questions and Follow-up:

- Please direct e-mails regarding you or your child's care to info@restormedicine.com. Questions must be brief and concise. It will be determine if a phone or office consult is needed to answer your question. When leaving a voice mail message, please be brief and concise and always include your name and phone number, including the area code.

Email policy:

- All emails must be directed to info@restormedicine.com.
- While email is a convenient way to communicate with the office, please be aware that responding to emails does take time and expertise.
- We try to accommodate questions regarding treatment clarification at no charge. Simply put, if you have a quick/ simple question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, by all means contact us.
- **If your email inquiry requires the doctor to access your chart and study aspects of your case in order to answer the question, then a $45 fee will apply.**
- If your email inquiry requires any further research or if the doctor needs more information from you in order to answer your questions, or if your email inquiry involves discussion of new treatment options or symptoms, we will request that you schedule a consultation.

Therapy Packages:

- Packages of various therapies, including but not limited to IV Therapy, Ionic Foot Baths, biofeedback and neurofeedback are offered at a discounted rate. Packages, once commenced, are not refundable. Packages have no expiration date, and may, in some cases (at the discretion of RestorMedicine) be transferable.

Dispensary:

- We offer a range of high-quality products to our patients through both our office and online store. Not all products we sell are available on the online store due to manufacturer restrictions. If you need refills on products that are not in the store, please feel free to email a list to our office and we will arrange for your order to be shipped out.
- Unopened products may be returned within 30 days of purchase with a 15% restocking fee.
- **Opened products are non-refundable. Probiotics are non-returnable items.**

Insurance:

- We currently do not accept any insurance plan, nor bill insurance on your behalf. We can supply you with a "superbill" or medical receipt that you can submit to your carrier for reimbursement. We make no guarantee of payment or reimbursement by your insurance carrier. **Please request a superbill at the time of your appointment.**
- We do not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

Acceptance of Policies and Procedures

By completing the following you agree to the policies and procedures detailed above.

Patient (please print):_____ Date: _____

Signature (patient or responsible party): _____

If signed by party other than patient, print name: _____

Lyme Disease Consent for Treatment

I understand that I will be treated for Tick-Borne Diseases by Dr. Nicola McFadzean Ducharme or Dr. Anayibe Ramos and their representatives. Treatment often involves the use of antibiotics, antiarthritics, vitamin supplements, a rehabilitation program, lifestyle changes, diet, and possibly other therapies.

Currently there exists two "standards of care" for these illnesses. One standard believes that Lyme is a simple illness, easily diagnosed and easily cured with one or two short courses of antibiotics. The other recognizes that Lyme and associated diseases comprise a complex medical condition that often require prolonged or repeated courses of possibly multiple antibiotics, given in generous doses. The latter point of view is reflected in the treatment guidelines as published by the International Lyme and Associated Diseases Society (ILADS). This office does follow the latter standard and supports the ILADS guidelines. Dr. McFadzean and Dr. Ramos, as a Naturopathic Doctors, try to use natural treatments where possible, but they may also recommend antibiotic regimens depending on the case. In the state of Connecticut she is not permitted to actually prescribe those medications, nor can she for patients overseas.

I understand that it is conceivable that some or all of my current symptoms either may not be due to tick-borne diseases, or they may represent permanent changes to my system, in which case further antibiotic treatment may be of no further benefit. Also, as no single treatment regimen is universally successful, it is possible that the antibiotic therapy maybe of minimal or no benefit.

There are potential risks involved in using antibiotics. Some of the more common problems can include, but are not limited to: allergic reactions manifested as rashes, swelling, and possibly difficulties in breathing; such problems may require medications to reverse the allergy, and may even require emergency treatments. Other potential complications include stomach and bowel upset, including abdominal pain, diarrhea, and possibly even colon inflammation, which may require interruption of the Lyme medications and the prescribing of other medications to manage the digestive upset. It is also possible that secondary infections, such as yeast infections of the skin, mouth, intestinal, and genital tracts may occur, resulting in discomfort and the need for corrective therapies. Although unlikely, it is also possible that the medications used in the treatment of Lyme and its symptoms may result in other problems, such as negative effects on the liver, kidneys, and other internal organs.

On the other hand, I realize that if I am indeed infected, then the risk of not taking treatment must be considered. Not receiving treatment may be more hazardous to short and long term health than the potential risks of using medications and other remedies.

Because much of the diagnosis, management, and clinical conclusions made by Dr. McFadzean Ducharme, Dr. Anayibe Ramos and their staff in my case require my input, such as honest and accurate reporting of all of the symptoms, and willingness to agree to ongoing, reasonable testing as requested as well as follow-up office visits as often as deemed necessary by Dr. McFadzean Ducharme and Dr. Ramos, I realize that I therefore am an active participant in the diagnostic and therapeutic process and do accept and share responsibility for any and all potential outcomes.

I have discussed the above points with Dr. McFadzean Ducharme or Dr. Anayibe Ramos. I understand and accept the treatments offered and my role in my care. I also understand that complications may result. With all this in mind, I consent to being treated by Dr. McFadzean Ducharme or Dr. Ramos in order to combat the effects of Lyme and associated diseases.

PATIENT'S NAME_____
PATIENT'S SIGNATURE_____
DATE _____

Nicola McFadzean Ducharme, N.D.

Credit Card Authorization

I, (print name)_____ , authorize Nicola McFadzean Ducharme, ND, dba RestorMedicine to bill my credit card as listed below.

Name on Credit Card _____

Credit Card Details

Visa Card # _____Exp date _____

MasterCard Card # _____Exp date _____

3 digit code on the back of the card _____

Billing Address for Credit Card

Name: _____

Address: _____

City: _____ State:_____Zip: _____

Phone (include area code): _____

Authorization

_____ _____

Card Holder's Signature Today's Date

_____ _____

Patient's Signature Today's Date

This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

Nicola McFadzean Ducharme, N.D.
Anayibe Ramos, N.D.

Health History Questionnaire

(Please Print)
Patient Name: _____ Date: _____Birth Date: _____

Weight_____ Height_____ Blood Pressure (if known) _____

Primary Health Concerns:

_____

_____

_____

_____

When did your health concerns begin?

_____

_____

Known tick bite? Yes/ No When? _____ EM rash? Yes/ No

Medication Allergies?_____

Other Allergies (ie. Molds, Chemicals) _____

_____

Current Medications You Are Taking _____

_____

Current Supplements You Are Taking _____

_____

_____

Past and/or Current Medical History: (please circle)

Arthritis	Asthma	Cancer	Diabetes	Hepatitis
High Blood Pressure	Heart Disease	Leukemia	Migraines	Headaches
Paralysis	Rheumatic Fever	Chronic Fatigue	Fibromyalgia	Chemical
Sensitivities	Menstrual Irregularities	Thyroid (low/high)	Stroke	Seizure
Kidney Disease	Celiac Disease	Venereal Disease	Autoimmune Disease (ie. MS,	
Lupus, Rheumatoid)	Lung Disease (ie. pneumonia, tuberculosis, etc.)		Other: _____	

Surgical History:

_____

_____

_____

Family Medical History:

_____

_____

_____

Habits:

Alcohol intake per week____ Tobacco____packs/day – Yrs. Quit____

Cups of caffeinated coffee/day____ Cups of caffeinated Teas/day____

Colas or sodas____cans/day Antacids taken____/week

Laxatives____/week

Do you use caffeine as a "pick-me up" drink, or to "get going in the morning" Yes__ No__

Travel history: Traveled/lived outside the USA? Yes__ No__ If Yes, where have you traveled/lived_____

Developed an illness as a result of your travels? _____

Dental History:

Orthodontics? Yes__ No__ If yes, explain_____

Braces? Yes__ No__ Did you have any complications with your braces? Yes__ No__ If yes, explain

_____

_____

Mercury Fillings? Yes__ No__ How many___ Root Canals? Yes__ No__ How many

_____

Previous Gum Inflammation (Gingivitis)/Infections? Yes__ No__

Occupation:_____

_____

Please Describe Your Hobbies:_____

_____

Please check any of the following that you have experienced in the last 30 days:

___Do you feel nauseous?

___Do you have heartburn?

___Do you have gas?

___Do you have abdominal/intestinal pain?

___Do you have diarrhea?

___Do you feel bloated?

___Do you have constipation?

___Do you belch after meals?

___Do you get bloated after meals?

___Are your stools compact and hard to pass?

___Do your bowel movements alternate between constipation and diarrhea?

Please use this space below to share additional information with us regarding your health concerns.

_____

_____

_____

_____

_____

_____