Brenda Marshall MD

11622 El Camino Real, Suite 100

San Diego, CA 92130

Phone: 858.663.7699 Fax: 858.764.2405

WELCOME TO OUR OFFICE!

We are pleased you have chosen us to assist you in your healthcare.

INITIAL INFORMATION: Included in this letter you will find important information on how our office functions so we may transform you towards optimal health. Also, enclosed are forms to be filled out and returned to us at the time of your initial consultation.

DR. MARSHALL: Dr. Brenda Marshall holds a Medical Degree (M.D.) from Eastern Virginia Medical School, and is licensed to practice in the State of California. She has been in general medical practice for over 25 years, and she currently specializes in Integrative/Functional and Regenerative Medicine focusing on optimizing health for her patients.

INITIAL CONSULTATION: You will be in our office approximately 1½ hours for your initial and return consultations; please arrive approximately 15 minutes early for appointments to fill out forms. New patients please download and complete initial consult forms **prior** to your arrival. Should you need to cancel or reschedule your appointment with us, we request by telephone at least 72 hours in advance, as it is difficult to fill in the doctor’s schedule on short notice. If we do not receive your cancellation during our office hours at least 72 hours in advance, a $125 cancellation fee will apply. We ask that you make every effort to keep your current appointment as it may take several weeks to reschedule.

INFORMATION TO BRING WITH YOU: In addition to bringing this letter and our completed forms, please bring copies of any current **lab work** and have in mind your goals for the visit. The doctor may give you a lab slip to obtain further lab work, if necessary. Also, bring any **medications/vitamins** you are taking for review.

FOLLOW UP VISITS: The doctor will normally ask for a follow up visit two weeks after your initial consult to review lab results and plan of therapy. Follow up appointments are scheduled as 50 minute appointments. Phone consultations may be appropriate in some cases; the fees are the same as office visits. No insurance is taken for phone consults. You must be seen at least once every six months in order to refill your medications.

CHARGES: All consultation fees are payable at the time of the visit. We accept MasterCard, Visa, AMEX, most HAS cards and cash or checks. We will provide you with a copy of your superbill in order to facilitate your filing of your own insurance. We currently do not take PPO’s, HMO, Medi-cal, or Medicare.

LABORATORY: All patients are sent to a Lab Corp/Quest drawing station most convenient for them. Many insurance companies require that you use a specific lab, and it is your responsibility to determine which is contracted with your insurance. Some lab test, including hair metals, mold/mycotoxins, GI-MAP parasites, ZRT saliva hormones & cortisol and others are not covered by insurance. Other test like ALCAT food allergy, Neurolab may be covered depending on your carrier.

REFILLS: You must be seen at a minimum once every six months, or depending on your conditions, more frequently, to refill your medications. Although most of these may be natural medicines, they still must be professionally monitored. Please call San Diego Compounding Pharmacy directly for refills @ 858.277.8884 or have your pharmacy fax a refill request to 858.764.2405.

MEDICAL RECORDS: Lab results and plan of treatment are provided at office visits. A full copy of your records is available upon request and requires a signed release authorization. A $25.00 fee may be charged for a full copy.

ARBITRATION FORM: As of May 1st 2008, all patients will be required to read and sign an arbitration agreement. This form is required by our insurance carrier in order to be evaluated and treated by Dr. Brenda Marshall.

OFFICE HOURS: Appointments are available Mondays, Tuesdays and Thursdays by appointment only between 11:00am and 5:00pm. Phone calls are returned the following business day within depending on urgency, usually in the evenings. Texting is often the quickest way to have your questions resolved.

Again, we welcome you to our office and we look forward to assisting you in your efforts to improve your health and healthcare.

Signature:

Date:

Dr. Marshall’s Consultation Service Waiver

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**Waiver**

I the undersigned do agree and consent to all medical treatment and services provided by Dr. Marshall and her staff. Medical Services are defined as any and all diagnostics

and treatments and diagnosis provided by Dr. Marshall or her staff. This includes but is

not limited to exercise programs, medicinal and alternative therapies, drug therapy, and any and all efforts to diagnose and treat any condition of myself. I further understand that the Dr. Marshall’s Consultation Service is not a walk in, or emergency services clinic and deals with specialized diagnostics and protocols. In the event that an emergency care need arises, I realize I must go to a medical facility qualified to treat such conditions I understand that any medical services provided to me by Dr. Marshall do not constitute those for life threatening situations.

I agree to hold harmless and indemnify Dr. Marshall and its professionals from any and all claims involving the medical services provided by this service. Further, I understand that Dr. Marshall does not guarantee results and will not assure me progress of any condition or conditions I may have. I understand that successful treatment with Dr. Marshall’s recommendations is primarily based on my own decisions and life choices.

I agree that payment is considered due in full at the time of services or before. Payment may be made with cash, check or credit card or approved PPO insurances. I understand that copays and deductibles not paid at my visit or covered by my insurance will be billed to my credit card held on file.

I acknowledge that this agreement has been fully read and I understand its content.

**Patient’s signature**: **Date:**

*If this pertains to you*: Medicare / Medicaid Agreement

I the undersigned do agree and understand that all treatment and services provided to me by Dr. Marshall and staff are voluntary services provided for my personal benefit. I understand that these services are not covered by Medicare Parts A or B. I agree therefore to pay as fee-for-service and not file under Medicare or Medicaid.

I understand that Dr. Marshall does not submit claims to for reimbursement for Medicare / Medicaid.

Patient’s signature: Date:

**Dr. Marshall’s Health History Form**

**PART I.** Personal Information and Medical History

Last Name First Middle Initial

Social Security # Birth Date E-Mail Address

Mailing Address City/State Zip Cellular No.

Employer Office Phone Home Phone

Emergency Contact Person Relationship Telephone No.

**You may leave personal medical information on my (check):** **Home Phone** **Cell Phone**

**PART II.** Medications /Immunizations

Which of the following do you take more than once a week? **Allergies (food/meds)\_\_\_\_**

Acetaminophen

Antacids

Antihistamines/allergy pills

Arthritis medication

Aspirin

Birth Control Pills

Blood Pressure Pills

Decongestants/Cold Pills

Heart Medication

Hormones

Ibuprofen (Advil/Motrin)

Insulin, Diabetic Pills

Laxatives

Stomach/Intestinal Pills

Thyroid Medication

Tranquilizers/Sedatives

Vitamins

Weight Reduction Pills

List medications (prescriptions, non -prescriptions, herbals & vitamins) you currently take:

**Part III. Exercise Routine**

Type/Frequency Other hobbies/ Relaxation

**PART IV.** Hospitalizations and Surgeries

**Year Reason**

**PART V.** Family History

Is your mother living ? Yes No  Age

Is your father living ? Yes No  Age

Cause of Death

Cause of Death

Which of the following have your parents, brothers, sisters, or children ever had?

|  |  |  |
| --- | --- | --- |
| Thyroid disease | Depression/Suicide | Heart trouble or disease |
| Diabetes | Other Psychiatric Diseases | Cancer or Leukemia |
| High Blood Pressure | Alcoholism | Tuberculosis |
| High Cholesterol | Kidney Trouble | Asthma |
| Genetic Disease | Stroke |  |

**PART VI.** Occupation/ Social History

Describe the activities of your current job (#years/occupational exposures/illness)

Tobacco use

Alcohol #drinks/week

Caffeine drinks/day

Artificial Sweetners/ Other substance use

Married/Divorced/ #children & ages

**PART VII.** Sleep Quality

Describe your quality of sleep (doze easily, sleep through night, # hours, refreshed upon awakening):

Have you been told you snore, gag, or have sleep apnea? :

**Brenda Marshall MD**

**New Consultation Review of Function** Today’s Date: \_\_\_\_\_\_\_\_

Patient Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

**Please list your top four concerns/symptoms you would like addressed today:**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please rate the following body systems by circling/filling in:**

1. My sleep is usually: deep, uninterrupted, restful, disrupted \_\_\_\_\_ times a night, unrestful.

2. I wake up feeling: refreshed, energized, happy, still tired, grumpy, groggy, achy.

3. I go to bed at \_\_\_\_\_pm and it takes \_\_\_\_\_ minutes to fall asleep. I usually/rarely dream.

4. For sleep I use: Nothing/ Melatonin/ 5-HTP/ Gaba/ Inositol/ Progesterone, \_\_\_\_\_\_\_\_\_\_\_\_.

5. My Bowels move: at least daily/ not daily and are typically: normal, loose, lumpy, hard.

6. My stomach feels: general fine/ bloated/ acid/ upset and irritable with meals/ when empty.

7. My level of anxiety is 1=none, 10=panic daily \_\_\_\_\_\_\_. My life feels balanced/ crazy train.

8. My libido is 1=poor, 10=great \_\_\_\_\_\_\_. My sexual function is normal/ not working right.

9. Cravings: Sugar/ salt/ carbohydrates/ alcohol/ nicotine/ exercise/ gambling/ none of these.

10. My memory & brain function feels normal/ focused/ foggy/ forgetful/ slow/ word search.

11. I exercise \_\_\_\_\_\_\_\_ times per week by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

12. My family would describe me as: content, motivated, balanced, healthy, stressed, irritable,

isolated, overwhelmed, moody, hyper-active, depressed, forgetful, lazy, tired.

13. Over-all I rate my health as 1=poor, 10=great \_\_\_\_\_\_\_. I would like to weigh more/ less.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as “Physician”) to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§

1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator’s fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I may receive a copy if requested.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: By:

Physician’s or Duly (Date) Patient’s Signature (Date) Authorized Representative Signature

**Brenda Marshall, M.D.**

Print Patient’s Name

Physician

HIPAA

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

 Protected health information may be disclosed or used for treatment, payment, or health care operations.

 The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

 The Practice reserves the right to change the Notice of Privacy Practices.

 The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.

 The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

 The Practice may condition receipt of treatment upon the execution of this Consent.

 The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient/Signature Date

Relationship to Patient

(If other than Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Representative: Dr. Brenda Marshall

**Cancellation and Missed**

**Appointment Policy**

We would like to remind you of our office policy regarding missed appointments. Our goal is to provide quality individualized medical care in a timely manner. “No-Shows”, and late cancellations inconvenience those individuals who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of medical care.

If it is necessary to cancel your scheduled appointment, we require that you call at least 72 hours in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

**As of January 1st, 2017, there will be a charge of $125.00 for no shows and cancellations less than 72 hours in advance. I approve that the credit card on file will be charged.**

Printed Name Signature Date

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