Fill in the first three (3) sections only.

Print all entries clearly.

1. Employment- Enter the name of your employer/company.
2. Education- The highest level of schooling/degree you have received.
3. Drugs- List all street drugs you have ever used.
4. Sex Hx- List number of partners you have had during your sexually active lifetime.
5. M=Mother. Enter her age or age she died. List of her medical/mental ailments.
6. F=Father. Enter his age or he died. List of his medical/mental ailments.
7. Siblings. Enter number of brothers and sisters you have total (living and deceased). List of their medical/mental ailments.

Outpatient Health Summary

wak SOAP version 5: 091102b

1

Patient's Name		**Date**	**Update:**		
Date of Birth	**Sex**	**Phone Numbers:**	**Home**		
Marital Status: M S D W			**Work**		
Significant Others:		**DNR Status: Resuscitate?**	**Yes**	**No**	**Qualifications:**
Religion:		**Next of Kin:**			

2

Social History:	**Employment**	**Occupation**	**Education**	
	Tobacco	**ETOH**	**Drugs**	**Sex Hx**
Family History:	**M**	**Siblings**	**Others:**	
	F			

Past Medical History

3

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop

Allergies, Adverse Drug Reactions: _____

Health Maintenance

Parameter	Dates							
DPT/DT/TD								
OPV								
MMR								
HIB								
Influenza								
Hepatitis								
PPD/Tine								
Pneumovax								
H & P								
Eye exam								
Dental exam								
PAP smear								
Mammogram								
Urinalysis								
Hemoccult								
Cholesterol								
Sigmoidoscopy								
Others								

Past Surgical History

Date	Type

Consultants

Funded by a grant from the Bureau of Research.
Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Patient Registration Form Camille Dillard, D.O., MPH

Patient Information

Last Name_____ First Name _____ Middle_____

Date of Birth _____ Age _____ Referring Physician _____

Your Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone_____ e-mail_____

Social Security #_____ Marital Status_____ Sex_____

Emergency Contact_____ Relationship_____ Phone_____

Pharmacy Name_____ Location_____ Phone_____

Employer_____ Location_____ Phone_____

Responsible Party for Patient (Guarantor)

Name_____ Relationship_____ Phone_____

Address_____

Insurance (For workers' comp, No-Fault and other Liability, also complete an Accident Information Form)

(1) Primary Insurance _____

Subscriber_____ Subscriber DOB_____ Relationship to Pt_____

Policy #_____ Group #_____

(2) Secondary Insurance_____

Subscriber_____ Subscriber DOB_____ Relationship to Pt_____

Policy #_____ Group #_____

Signatures – Please review each paragraph below and sign where indicated

Assignment of Benefits

I hereby authorize payment directly to the provider of the surgical or medical benefits, if any, for his services. I realize I am responsible for non-covered services, co-payments and deductibles. I also understand that this assignment does not relieve my liability on these services.

Signature _____ Date _____

Responsibilities and Cost Items

My insurance may require pre-authorization or referral for services, I understand that I may discontinue services should my insurance company deny authorization, but realize that I am responsible for non-authorized services. At times, I may elect to purchase cost item, including supplies and durable medical equipment, and I understand that items of this nature must be paid in full at time of receipt; however, I may request insurance be billed for any cost items received upon payment in full.

Signature _____ Date _____

Release of Information

I hereby authorize the provider to release any information acquired in the course of my treatment, including the coordination of care with other providers and the processing of insurance claims.

Signature _____ Date _____

Statement to Authorize Medicare

I certify that the information given by me in applying for payment XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its carriers, any information required to process my Medicare claims. I request that the payment under the Medical Insurance Program be made to the Provider for services provided to me during my lifetime.

Signature _____ Date _____

Collection Fees

A collection agency or lawyer will be used on all delinquent accounts. Extra charges including, but not limited to finance charges, collection agency fees, attorney fees, court costs will be added to the balance. My signature attests to my understanding of these terms.

Signature _____ Date _____

Release of Medical Records

No Information is released or requested prior to your consent.

1. Only complete the areas marked by an asterisk (*).

Camille Dillard, D.O.
900 Erie Blvd, West
Rome, NY 13440-2904
PH: 1-888-338-WELL (9355) FAX: 315-337-3297

PATIENT'S AUTHORIZATION FOR RELEASE OF HEALTH RECORDS
REQUEST TO **RELEASE OR OBTAIN** RECORDS

This form for Authorization for Release of Medical Information is designed to comply with Title 42 of Federal Regulations, Part 2 (regarding alcohol and substance abuse records) and/or state laws respecting confidentiality of records and patient communications with mental health professionals, other healthcare providers and medical center support staff.

Patient's Name: _____ _____ _____
Last First MI Birthday

Address: _____ _____
Street City State Phone

The undersigned hereby authorizes and requests:

_____ Name and address of person(s) or organization(s) from whom information is being requested
Name

_____
Address

To release any and all information contained in the records of the patient listed above, INCLUDING INFORMATION REGARDING DRUG AND/OR ALCOHOL TREATMENT, PSYCHOLOGICAL AND SOCIAL SERVICES RECORDS, COMMUNICATIONS MADE TO A SOCIAL WORKER, PSYCHOLOGIST OR PSYCHIATRIST, AND HIV/AIDS/AIDS-RELATED COMPLEX DOCUMENTATION, and information that may have been received from other physicians or facilities, to the individual(s) or organizations listed below, by providing copies of medical/hospital records to:

Camille Dillard, D.O.
900 Erie Blvd, West
Rome, NY 13440-2904

Name and address of person(s) or organization(s) from whom information is being requested

Include dates of treatment for requested information: _____

Indicate any limitations to disclosure: _____

PURPOSE AND NEED FOR SUCH DISCLOSURE:

____Continued Care ____Patient Request ____Insurance

____Attorney Request ____Court Request ____Other_____

Unless earlier revoked, consent will expire six months from date signed.

This consent is subject to revocation at any time, except to the extent that Camille Dillard, D.O. or staff have already taken action in reliance upon it.

_____ _____
Signature of PATIENT OR PATIENT'S LEGAL REPRESENTATIVE Date

If signed by a legal representative, indicate his/her relationship to patient (parent, guardian, conservator, etc.) and attach legal documentation.

_____ _____
Witness to Signature Date

NOTICE OF PRIVACY PRACTICES SUMMARY

Camille Dillard, DO

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, or health care operations and for other purposes that are permitted or required by law.

1. Uses and Disclosures of Protected Health Information

   Treatment Payment Health Care Operations

2. Permitted and Required Uses and Disclosures That May Be Made With Your Authorization and Opportunity to Object

   We may use and disclose your protected health information in the following instances:

   - Facility Directives
   - Psychotherapy notes (for Treatment and Payment Operations)
   - Others involved in Your Health Care
   - Marketing
   - Emergencies

3. Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

   We may use or disclose your protected health information in the following situations without your consent:

   - Required by Law
   - Communicable Diseases
   - Legal Proceedings
   - Law Enforcement
   - Research
   - Workers' Compensation
   - Military Activity and National Security
   - Coroners, Funeral Directors, and Organ Donation
   - Public Health
   - Health Oversight
   - Abuse or Neglect
   - Criminal Activity
   - Inmates
   - Food and Drug Administration
   - Required Uses and Disclosures

4. Your Rights

   Following is a statement of your rights with respect to your protected health information and how you may exercise these rights. You have the right to:

   - Inspect and copy your protected health information
   - Request a restriction of your protected health information
   - Request to receive confidential communications from us by alternative means or at an alternative location
   - Have your physician amend your protected health information
   - Receive an accounting of certain disclosures we have made, if any, of your protected health information
   - Obtain a paper copy of this notice from us

5. Complaints

   You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

HIPAA Notice of Privacy Practices
Camille Dillard. DO

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 888-338-WELL.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

Camille Dillard, D.O., Health and Wellness, P.C.
900 Erie Blvd, West, Rome, NY 13440-2904
1-888-338-WELL

Neuro-Nutrition Response Testing (NNRT)

1. What is it?

It is a test of the integrity of the visero-somatic reflex.

'Visero' means *organ* and 'somatic' means *body part* (e.g. arm). The test is done right here in the office during your visit to give the doctor an initial assessment of how healthy your organs are.

The visero-somatic reflex is similar to the patellar reflex in that both reflexes uses the neuronal input/output or circuit from the spinal cord level to the body part of interest, e.g. patella or heart.

The visero-somatic reflex is apart of the *autonomic division* of the nervous system as opposed to the voluntary division. 'Autonomic' means 'self-regulating'. You do not have to consciously think about making your heart to beat or your lungs to breathe. The autonomic nervous system automatically does this.

2. How does the Neuro-Nutrition Testing work?

The visero-somatic reflex is to remain strong while the doctor applies pressure to your out-stretched arm. If the reflex is weak there is a problem with the target organ and requires further evaluation. This more in-depth evaluation may require additional examination of other visero-somatic reflexes (target organs), blood, urine, hair sample tests, x-ray, ultrasound, Computed Tomography (CT scan), etc.

3. What Neuro-Nutrition Testing is NOT.

a) Psychic energy
b) Reiki
c) Spiritualism, etc.

4. Other terms commonly used for Neuro-Nutrition Testing

a) Nutrition Response Testing
b) Contact Reflexology
c) Applied Kinesiology

Camille Dillard, D.O., M.P.H.
900 Erie Blvd., West, Rome, NY 13440-2904
Telephone: (888) 338-WELL FAX: (315) 337-3297

PERMISSION & AUTHORIZATION REGARDING THE USE OF NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Natural Health Improvement Center to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City _____ State ____ Zip _____

Phone: (____) _____ - _____

Signed: _____
(If minor, signature of parent or guardian required)

Witness: _____

Health Care Survey

Please complete all questions to the best of your ability.

Camille Dillard, D.O., MPH

Health Care Survey

So that we at Camille Dillard, D.O., MPH may know how to best serve you, please complete all of the questions. Answer honestly and to the best of your knowledge.

I. Exercise

1. Do you exercise?

2. If so, what type of exercise (s) do you do?

3. What days of the week do you normally exercise?

4. On average, how many minutes do you spend each session performing the exercise(s)?

II. Nutrition

1. On average, how many times a day do you eat vegetables?

2. On average, how many times a day do you eat fruit?

3. What kinds of snacks do you have?

4. On average, how many times a day do you have rice, potatoes, bread?

5. What kinds of meat do you eat?

II. Nutrition

6. How do you prepare your meats (e.g. baked, fried, microwave, broil)?

7. On average, how much coffee do you drink a day?

8. On average, how many times a week to you buy your meals from a restaurant?

III. Sleep

1. On average, how many hours of sleep do you get a night (day)?

2. Once you lay down to sleep, how long does it take for you to actually fall asleep?

3. If you wake up use the bathroom, etc., do you fall right back to sleep?

4. Do you feel refreshed after sleeping?

5. Do you get up before you would like to?

IV. Environment

1. Do you use an air purifier, humidifier, air filter in your home?

2. Do you use a water filter or shower filter in your house?

3. Have you had your home tested for radon?

4. Does anyone who lives with you or visits you regularly smoke?

Review of Symptoms (List of Symptoms)

1. Only circle or mark off symptom that you have experienced.
2. Check off the frequency at which you have had each symptom by
    a. Locate the "three melons" to the left of (the word) each symptom.
    b. **C=** Constant or all the time. This is the melon in the far left-hand column.
    c. **F=** Frequently or most of the time. This is the melon in the middle column.
    d. **O=** Occasionally or "every now and then". This is the melon in the right-hand column.

Last Name: First Name: DOB: MR:
DATE:

PLEASE CHECK THE APPROPRIATE BOX FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR HAVE HAD PREVIOUSLY.

C=Constant F = Frequent O=Occasionally

C F O	C F O	C F O
GENERAL	GASTRO-INTESTINAL	CARDIO-VASCULAR
☐☐☐ Allergy	☐☐☐ Belching or gas	☐☐☐ Hardening of arteries
☐☐☐ Chills	☐☐☐ Colitis	☐☐☐ High blood pressure
☐☐☐ Convulsions	☐☐☐ Colon trouble	☐☐☐ Low blood pressure
☐☐☐ Dizziness	☐☐☐ Constipation	☐☐☐ Pain over heart
☐☐☐ Fainting	☐☐☐ Diarrhea	☐☐☐ Poor circulation
☐☐☐ Fatigue	☐☐☐ Difficult digestions	☐☐☐ Rapid heart beat
☐☐☐ Fever	☐☐☐ Distention of abdomen	☐☐☐ Slow heart beat
☐☐☐ Headache	☐☐☐ Excessive hunger	☐☐☐ Swelling of ankles
☐☐☐ Loss of sleep	☐☐☐ Gall bladder trouble	RESPIRATORY
☐☐☐ Loss of weight	☐☐☐ Hemorrhoids	☐☐☐ Chest pain
☐☐☐ Nervousness/depression	☐☐☐ Intestinal worms	☐☐☐ Chronic cough
☐☐☐ Neuralgia	☐☐☐ Jaundice	☐☐☐ Difficult breathing
☐☐☐ Numbness	☐☐☐ Liver trouble	☐☐☐ Spitting up blood
☐☐☐ Sweats	☐☐☐ Nausea	☐☐☐ Spitting up phlegm
☐☐☐ Tremors	☐☐☐ Pain over stomach	☐☐☐ Wheezing
MUSCLE AND JOINT	☐☐☐ Poor appetite	SKIN
☐☐☐ Arthritis	☐☐☐ Vomiting	☐☐☐ Boils
☐☐☐ Bursitis	☐☐☐ Vomiting of blood	☐☐☐ Bruise easily
☐☐☐ Foot trouble	EYES, EARS, NOSE, THROAT	☐☐☐ Dryness
☐☐☐ Hernia	☐☐☐ Asthma	☐☐☐ Hives or allergy
☐☐☐ Low back pain	☐☐☐ Colds	☐☐☐ Itching
☐☐☐ Lumbago	☐☐☐ Crossed eyes	☐☐☐ Skin eruptions (rash)
☐☐☐ Neck pain or stiffness	☐☐☐ Deafness	☐☐☐ Varicose veins
☐☐☐ Pain between shoulders	☐☐☐ Dental decay	GENITO-URINARY
Pain or numbness in:	☐☐☐ Earache	☐☐☐ Bed-wetting
☐☐☐ Shoulders	☐☐☐ Ear discharge	☐☐☐ Blood in urine
☐☐☐ Arms	☐☐☐ Ear noises	☐☐☐ Frequent urination
☐☐☐ Elbows	☐☐☐ Enlarged glands	☐☐☐ Inability to control kidneys
☐☐☐ Hands	☐☐☐ Enlarged thyroid	☐☐☐ Kidney infection or stones
☐☐☐ Hips	☐☐☐ Eye pain	☐☐☐ Painful urination
☐☐☐ Legs	☐☐☐ Failing vision	☐☐☐ Prostate trouble
☐☐☐ Knees	☐☐☐ Farsightedness	☐☐☐ Pus in urine
☐☐☐ Feet	☐☐☐ Gum trouble	FOR WOMEN ONLY
☐☐☐ Painful tail bone	☐☐☐ Hay fever	☐☐☐ Congested breasts
☐☐☐ Poor posture	☐☐☐ Hoarseness	☐☐☐ Cramps or backache
☐☐☐ Sciatica	☐☐☐ Nasal obstruction	☐☐☐ Excessive menstrual flow
☐☐☐ Spinal curvature	☐☐☐ Nearsightedness	☐☐☐ Hot flashes
☐☐☐ Swollen Joints	☐☐☐ Nosebleeds	☐☐☐ Irregular cycle
	☐☐☐ Sinus infections	☐☐☐ Menopause symptoms
	☐☐☐ Sore throat	☐☐☐ Painful menstruation
	☐☐☐ Tonsillitis	☐☐☐ Vaginal discharge
		☐ Yes ☐ No Are you pregnant?

Camille Dillard, D.O., (8/2004)

Your Level of Readiness Survey (Five-Questions Survey)

Answer this questionnaire based on your current feelings.
There is no right or wrong answers.

Camille Dillard, DO, MPH

Camille Dillard, DO, MPH is interested in how we can best help you to be in optimal health. In order to do this, please complete the following questions. Answer them according to how you feel now. There is no right or wrong answer.

1. I am willing to be seen by Camille Dillard, DO, MPH (Circle One.)
    a. Three times a week for 36 consecutive weeks
    b. Once a week for 36 consecutive weeks
    c. Every other week over the next year
    d. Once a month over the next year
    e. Every three months over the next three years
    f. Every six months over the next three years

2. I am willing to spend the following a month to become and remain healthy (Circle One.)
    a. $20-$120
    b. $121-$250
    c. $251-$500
    d. $501-$1000

3. I want to know how to (Circle as many as you want.)
    a. How to read food labels
    b. Prepare wholesome meals
    c. Eat healthy when I am away from home
    d. Choose the best exercise program for me
    e. Other (Please fill in.) _____

4. I am ready to change my eating habits (Circle One.)

1	2	3	4	5
Not at All				Very Much

5. I am ready to exercise more effectively. (Circle one.)

1	2	3	4	5
Not at All				Very Much

6. I heard about Camille Dillard, DO, MPH from (Circle all that apply.)
    a. A person who sees the doctor now
    b. A person who used to see the doctor
    c. Television Ad
    d. Used a search engine, e.g. Google, Yahoo, MSN, etc. on the internet
    e. Through http://www.drcares.com
    f. Through http://romenynaturalhealthcenter.com
    g. Another health care provider (Fill in the name.) _____
    h. Other (Please fill in.) _____