Dear Patient,

Thank you for choosing OsteoMed II as part of your journey to optimal health. It is our intent to provide you with a personal and informative consultation in a friendly and comfortable environment.

We sometimes need to perform elective procedures that may not be covered entirely by insurance or healthcare reimbursement programs.

For all services, we require payment in full at time of service. We accept cash, check, Master Card, Visa and Discover Card.

How do you plan to pay for your treatments? (Check all that apply)

- ❑ Cash
- ❑ Check
- ❑ Credit Card

We look forward to serving you.

Best of Health,

Melissa Hammad
General Manager

7271 Engle Road, Suite 115
Middleburg Heights, Ohio 44130

Last Name ____________________ **First Name** ____________________ **MI** ______

Address ____________________ **City** __________ **State** ______ **Zip** ______

Phone ____________________ **Work** ____________________

Sex: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Other

Birthdate ____________________

Occupation ____________________ **Employer** ____________________

(Substitute parent information below if patient is a minor)

Responsible Party ____________________ **Birthdate** ____________________

Employer ____________________ **SSN** ____________________

Insurance Carrier ____________________ **Policy/Group No.** ____________________

How did you hear about us?

❑ Radio
❑ Newspaper
❑ TV Commercial
❑ ____________________

PATIENT INFORMED CONSENT

1.) Acknowledgement – Notice to all Medicare Subscribers
Please be advised that OsteoMed II and its physicians no longer accept Medicare. I desire the services to be performed by a physician of OsteoMed II and I agree to pay for the above medical/surgical services.

2.) General Disclaimer Regarding Non-Toxic Therapy
Homeopathy, acupuncture, electro-acupuncture, Chinese herbal therapy, nutritional counseling, bioenergetic medicine, food allergy testing, Osteopathic manipulation and some instrumentation may not be recognized by some insurance companies, the Food & Drug Administration or traditional medicine as reimbursable or acceptable. Nevertheless, in expressing my constitutional right of freedom of choice of medical care, I choose to be diagnosed and treated by physicians of OsteoMed II.

RELEASE OF INFORMATION
I hereby give authorized release of my medical information to the physician(s) at OsteoMed II has referred to me to, or any person designated by me, and to my insurance carriers.

Patient's signature ____ Date ____________________
Parent/Guardian if minor

Pediatric Questionnaire

No matter how discouraging the evaluation or how frustrated you are with the process, what is happening is only a measure of where s/he is TODAY. There is help, there is hope, and they will get better.

Date: ____________________

Reason for visit: ____________________

____

Child's name: ____________________

Parents' names: ____________________

Child's age: ________ Date of birth: ____________ Weight: ____________

1. Medical History
    a. Did your child reach his developmental milestones on time? ❑ yes ❑ no
    b. Medical problems besides developmental delay (circle):
        1. Asthma
        2. Allergies
        3. Eczema
        4. Diarrhea
        5. Constipation
        6. Seizure disorders
        7. Other ____________________
2. Family History
    a. Mother's health: ____________________
    b. Father's health: ____________________
    c. Sibling's health: ____________________
    d. Any other significant health problems in family? Genetic problem, etc? ____________________

    ____

3. Types of therapies that your child has been through or is currently undertaking (circle all that apply):
    a. Occupational therapy
    b. Applied Behavioral Analysis
    c. Listening therapy
    d. Music therapy
    e. Horse therapy
    f. Art therapy
    g. Craniosacral therapy
    h. Others: ____________________

    ____

    ____

4. Please describe your child's diet: ____________________

____

____

Have you ever tried a food rotation or allergy elimination diet? ❑ yes ❑ no

If so, what did you try?

How when and how long was the trial?

5. Is your child currently taking any medications? Please list and include dosages: ______________________
____
____
____

6. Is your child currently taking any supplements or vitamins? Please list all: ______________________
____
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____

7. Is your child currently receiving private occupational therapy (other than school-provided)?

❑ yes ❑ no

If yes, with whom?

8. Has any of the following tests been performed:

______	audiology (hearing test)	______	speech/language evaluation
______	vision exam	______	vision therapy
______	neurological exam	______	behavioral assessment
______	psychology exam	______	sensory integration testing
______	psychiatric evaluation	______	other

9. Have any of the following tests been done in the last 12-18 months:

PLEASE BRING THEM IF YOU HAVE COPIES

______	Blood test (thyroid, CBC, viral titers, etc.)		
______	Hair analysis	______	Heavy metal testing
______	Stool testing	______	Vaccine titers
______	Urine testing	______	Other ______________

FOR CHILDREN WITH DEVELOPMENTAL DELAYS AND/OR AUTISM:

10. When did you first notice that your child had developmental delays? Please tell your story, starting at his/her birth. Include ***anything*** that you feel MAY BE important, including injuries, illnesses, vaccinations, medications, etc. that others may have told you was unimportant.

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Please bring a copy of all vaccination records

Thank you for choosing OsteoMed II and allowing us to assist in the care of your child. Please know that many of our treatments are considered "unconventional" by standard medicine and that we are considered an Integrative Medicine office.

Sincerely,

The Doctotrs of OsteoMed II

Consent Form

I consent to allow the doctors of OsteoMed II to treat me medically using whatever treatment they determine medically necessary or advantageous for me.

I understand that some of the treatments and diagnostic tests offered in this office are not used by the majority of doctors in this community and are not deemed "standard of care."

I understand that they will explain the usefulness of the treatment and that I will have a choice of whether or not to participate in the treatment of choice.

I will also have the opportunity to discuss any risks involved in testing or treatment with the doctors at OsteoMed II.

Signature: ______________________________ Date: ____________________

I agree to be personally responsible for any charges incurred in the office of OsteoMed II for diagnostic testing and treatment.

This covers any charges which may or may not be covered in full by any insurance company for any reason.

Signature: ______________________________ Date: ____________________

7271 Engle Road, Suite 115
Middleburg Heights, OH 44130
(440) 239-3438

Emergency Services

OsteoMed II provides a variety of health services on an outpatient basis. Sherri Tenpenny D.O., R.C. Walsh Jr. D.O., and Dr. Cindy Fraed, M.D., are not primary care physicians and do not admit patients to the hospital. Patients are advised to have a regular physician for routine medical problems. If an urgent situation should arise outside of regular office hours, you may attempt to reach **Dr. Tenpenny** on her cell phone at **(440) 263-0405** or **Dr. Walsh** on his beeper at **(330) 560-5508**. If the doctor cannot be reached, patients should call their primary care physician or go to the nearest emergency room or urgent care facility.

I have read and understand the above statement regarding the restriction of medical services outside regular office hours.

Signature ______________________________ Date ____________

Today's date: ____________________
Your name: ____________________
Street address: ____________________
City: ____________________ State: ____________
Email address: ____________________

How did you hear about us? (mark all that apply)

- ❑ Patient referral (name) ____________________
- ❑ Doctor referral (name) ____________________

- ❑ Osteomed II website
- ❑ NMA website
- ❑ Other website
- ❑ E-newsletter
- ❑ Direct mail

- ❑ Seminar (topic) ____________________
- ❑ TV (show) ____________________
- ❑ Radio (show) ____________________

- ❑ Other (please list source) ____________________

What services will we be providing for you today?

- ❑ Allergy elimination
- ❑ Asthma
- ❑ Pain
- ❑ Thermography
- ❑ Women's health
- ❑ Specialized tests
- ❑ Fibromyalgia
- ❑ Autism
- ❑ Thyroid
- ❑ Sleep issues

Which practitioner are you scheduled to see:

- ❑ Dr. Tenpenny
- ❑ Dr. Walsh
- ❑ Dr. Fraed
- ❑ Gail/Carol (thermography)
- ❑ Linda Corlett
- ❑ Sandi Asazawa
- ❑ Paula Vetter

Thank you for taking the time to help us. Please return all forms to our receptionist.