Thank you for your interest and confidence in choosing to enter a
Private Non-Negotiable Contract
with True Heath Partners.

INFORMATION FOR NEW PATIENTS

Because your first visit is especially important, we'd like to make it as smooth and fulfilling as possible. Our mission is to provide you comprehensive, corrective, and contextual care. To accomplish that and everything you would like the doctor to address, please:

- ☐ Complete all of the intake information and questionnaire before your appointment. Ideally, we would like to have received the completed form at least one week before your first appointment. You may fax the forms to 714-565-1035 or e-mail them as a PDF to frontdesk@drkaslow.com. If your paperwork is not completed when you arrive at our office for your scheduled visit, your visit may be shorter than scheduled. Fill in all sections please!
- ☐ Bring or have all of your doctors send us all **labs and medical records** within the past 5 years. The actual x-ray, CT, or other films are not necessary, just the reports. A request for your medical records is attached. Send it or fax it to your doctor (s) and then call your doctor a week or two before your appointment to confirm the records have been sent to us. It is best to have the records available at the initial visit.
- ☐ **Bring all nutritional products and medications** you have used recently to your first appointment. Bring the actual product(s) in their bottles and a list.
- ☐ Bring in any other literature or information you would like the doctor or staff to review.
- ☐ Plan to have a urine specimen and other diagnostic procedures done when you arrive. Avoid exercising, use of any unnecessary medications, nutritional supplements, and coffee on the day of the visit. If your appointment is before 10:00 am, try to skip breakfast in case labs are needed in a fasting state.
- ☐ Patients enrolled in **Medicare or Tricare** will need to complete an additional form before being seen.
- ☐ For patients who are minors, **BOTH** parents or guardians must sign the information form to prevent any conflict between parents with our management plan. Both parents are encouraged to attend the office consultations but this is not mandatory.
- ☐ At the request of our insurance carrier, please review and sign the binding arbitration agreement.

We have set aside 40-60 minutes of time and staff for your initial consultation. Your acceptance of the appointment is an acknowledgement that you are entering into a private non-negotiable contract with True Health Partners for consultative health care. This is why we ask that you provide us a credit card deposit at the time you schedule the appointment. If you cannot keep your appointment, we require 2 working days' notice. You will be charged for failure to show without advance notice. Patients who repeatedly cancel and do not show for appointments will not be rescheduled.

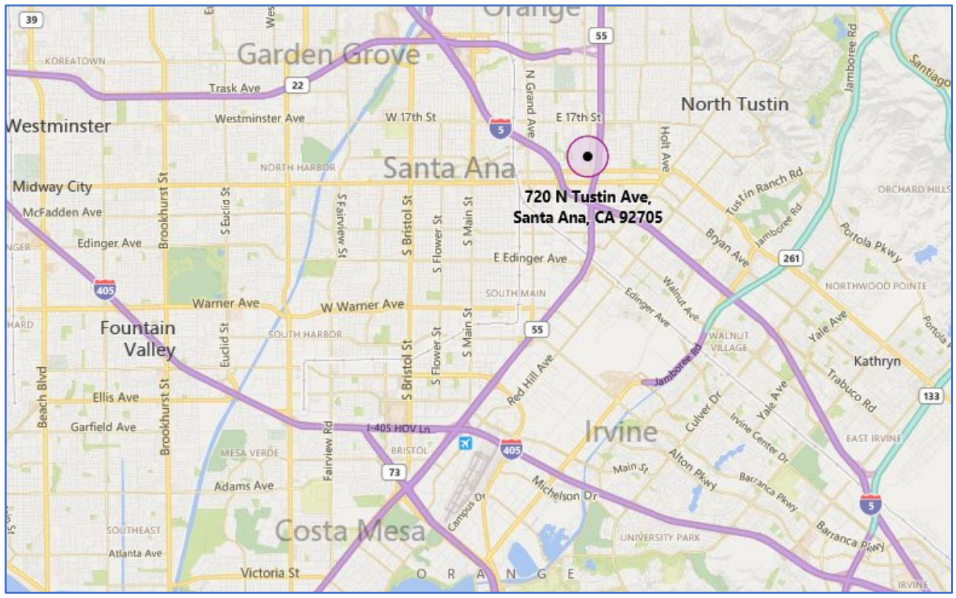
As you will see, it is our intent to provide you with exceptional and personal care. We consider it an honor that you have chosen us, and we look forward to seeing you. You can find out more about True Health Partners at www.drkaslow.com.

Welcome to our medical office and thank you for entrusting us with your health concerns.

Our office is on the second floor in Suite 202. Our office phone number is 714-565-1032. We look forward to seeing you.

"TIME MEDICAL PLAZA" is a **two story brown wood** office building at 720 North Tustin Avenue.

Our office is located just west of the 55 Freeway and south of the 22 Freeway between 17th Street and 4th Street in Santa Ana.



From the North, take the 5 Freeway southbound to the 4th Street off-ramp. Turn left onto 4th Street and go east to the stoplight at Tustin Avenue. Turn left onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.

From the South, take the 5 Freeway northbound to the Riverside Freeway (North 55) off-ramp. Stay in the far right lane and exit onto the 4th Street off-ramp. Turn left onto 4th Street and travel west to the second stoplight at Tustin Avenue. Turn right onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.

From the Southbound 55 Freeway driving towards Newport Beach, exit the 4th Street off-ramp. Turn right onto 4th Street and travel west to the stoplight at Tustin Avenue. Turn right onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.

From the Northbound 55 Freeway driving from the Newport Beach area, exit the 4th Street off-ramp. Turn left onto 4th Street and travel west to the second stoplight at Tustin Avenue. Turn right onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.

Health Bulletin – Introduction to True Health Partners

Appointments are scheduled in 20-minute time slots. An initial visit is 40-60 minutes with follow-ups scheduled for 20-40 minutes of "face-to-face" time with Drs. Kaslow. The staff will almost always perform some pre-visit evaluations that give insight into your metabolism, hydration, stress tolerance, nervous system function, etc. Plan on 20 minutes or so before your visit for collection of this information.

Physician consultations are available Monday, Tuesday, and Thursday 8:00am – 5:00pm and Wednesdays from 9:00am - 12:00pm. On Fridays' the office is open, but physician care is not available. There is typically a nurse in the office on Friday mornings available for IV therapies, NLS+, and other procedures. For more information about our services and selected health topics, go to our website at www.drkaslow.com.

Appointment intervals are generally every 4-12 weeks because the body requires time to detoxify and heal. This practice does not focus on acute care as much as long-term healing, rejuvenation, and solutions to chronic long-standing problems. That does not mean nothing happens in between your visits, rather it is your responsibility to make the lifestyle changes and observations that are critical to your success. Urgent appointments are often available if you call and explain your needs. If you are ever injured call us immediately to get therapy before the condition becomes chronic.

Concise **E-mail** communication is available to frontdesk@drkaslow.com. It saves our staff time on the phone re-writing your questions, updates, etc. Your e-mail also gives us a hard copy for your chart and a way for us to respond to you directly. I hope that you will honor our time in directing the e-mail to the proper person. Please do not send your email as an attachment (Word, etc.), this takes longer to read and can be a security risk to our network. Lengthy E-mails are typically responded to last since they require more time. For billing related matters, E-mail accounting@drkaslow.com. For anything related to supplements and other remedies such as re-orders or questions, arrival times, back-orders, E-mail supplements@drkaslow.com.

Lab specimen can be collected in our office. Typically, we are faster, friendlier, and get the right specimens compared to a lab patient service center. We spend a lot of time trying to track down lab results, giving you the right kits, and making sure the proper specimen gets done. We generally send specimens to LabCorp or Quest and they bill your insurance directly. For other specimens sent to specialty labs we will help with billing to hopefully minimize hassles. Although we can collect lab specimens whenever the office is open, please call to schedule a lab collection appointment to minimize your wait in the office. Remember to not eat anything after dinner the night before if you have been advised to fast. For some patients that are using hormones such as thyroid, it is better to have blood collection before lunch and afternoon thyroid dose taken (moderate water intake is encouraged) about 5 hours after morning dose of thyroid, meds, etc. taken. A light typical breakfast is fine. Please note this to the staff that collects the blood sample.

Some medical services have been reimbursed and in some cases supplements prescribed and purchased through our office. It may require a great deal of work on your part. You must talk directly with your insurance carrier (usually repeatedly) to explain that you are intolerant to other forms of therapy, and that you have derived significant and objective benefit for the first and only time from these specific agents. Insurers usually require that supplements are specifically prescribed for you and not available except through a health professional. We will not provide any further letters or records, etc. other than a simple generic letter. You will still need to pay at the time you receive your supplements, and we will not bill insurance even if they begin paying for them. Supplements purchased in the office are often eligible for Health Savings Account and Flexible Spending Account reimbursement.

Some of the specialized techniques that we use to assess and optimize your health may not be a covered service under your insurance plan.

There are three main biochemical foundations of a successful approach to health:

1) Giving your body the specific nourishment it needs to function optimally (ex: vitamins, minerals, etc.)

2) Avoiding those things or activities that make you worse (ex: allergic foods, sugar, caffeine, etc.)

3) Detoxifying or de-infecting something in your body that you cannot get rid of without help (ex: Candida, mercury, parasites, Lyme, etc.).

While these three fundamentals must always be addressed, two more aspects may need to be included. The fourth component is for individuals who have had a life event alter their health. It is for the person who says, "ever since I had that... (accident, surgery, infection, etc.) I haven't been the same..." These individuals have developed an **interference field** for which diet, nutritional support, hormone balancing, etc. will only provide partial resolution. Recovery has been impeded by an "interference field."

There are three basic types of events that seem to interfere with healing: 1) Physical trauma such as surgery, childbirth, car accident, bone fracture, biopsy, etc.; 2) Infection such as from immunizations, viruses, Lyme and related organisms, dental abscesses, etc.; and 3) An emotional event such as a death, abandonment, abuse, divorce, loss of home or business, etc.

Neural Therapy removes "interference fields" and allows healing of these refractory conditions. The underlying reason is that the Autonomic Nervous System controls everything, even your biochemistry and hormones. Neural Therapy "resets" the autonomic nervous system, which is in turn the master control of your health. Neural Therapy is usually covered by insurance. For more information, see my webpage on "Neural Therapy" at www.drkaslow.com. There are other modalities that we use as appropriate such as Micro-Dose Biopuncture, trigger point injections, low level lasers, prolozone, etc.

The fifth fundamental is identifying and reprogramming emotional behaviors that are maladaptive. We all have behaviors and **emotions** that work against us. We do things that we know we should not. It is as though we sabotage ourselves, and then we pay the price. Why is this? Why do we choose to do things that we know are not in our best interest? Why do we feel anxious or irritable or aloof or angry or frustrated or guilty for no apparent reason? Especially when it "gets the best of us." Many patients get better for a while, only to relapse again later. We fail to adapt to the higher level of function. Often it is a matter of practicality or lifestyle choices. However, too often it is our own maladaptive emotions that revert us back. It is often the consequences of these feelings that affect our health and our ability to feel wonderful.

In focusing on the nervous system, we try to balance and harness the control it has over all aspects of living - biochemical, hormonal, immune, and emotions. Emotions should be under the control of your nervous system - the unconscious nervous system. So if you are told that it's all in your head, there is some truth to it. We are reminded that ordinary people have walked across hot coals without burning their feet when they set their mind to it.

Our aim is to use techniques that address the core of the problem. For example, unlinking or re-programming your emotions to your physical response so that your nervous system works on the same team as the rest of you. There are specific connections between our emotions and our physical body, they probably involve acupuncture meridians. It seems that specific locations on your body are receptors to the outside world. Just as your eyes are for vision, your ears are hearing, your nose for smelling, etc. these special sensory sites are receptors for what is called subtle energy. "Subtle energy" includes things you know are there but are not felt physically - like radio waves, magnetism, etc. It may also involve spirituality - like prayer. There is no question they exist, but often we just take them for granted or do not appreciate them because we don't understand them. Homeopathy and acupuncture are examples.

Using **subtle energy** at specific locations in a specific sequence has been used successfully and there is convincing evidence that it impacts the nervous system. There is great healing potential in this modality. Our office includes on-site staff trained in specific healing techniques that rapidly get to the crux of the problem and help you re-program yourself to be free of these maladaptive subconscious responses.

Working together we can accomplish many things. Our goal is to guide you, enable you, and assist you in attaining and maintaining the best possible health. It is an honor and a blessing to care for you. On behalf of all of us, we look forward to a valuable health promoting relationship.

Jeremy E. Kaslow, M.D.
Fellow, American College of Physicians
Fellow, American College of Allergy, Asthma, and Clinical Immunology

- True Health Partners -
FAX to 714-565-1035 or e-mail to frontdesk@drkaslow.com with any diagnostic reports available

Oct 2020

POTENTIAL PATIENT BACKGROUND

Date Sent to Patient:_____

Patient's Name:	Patient's occupation:
Date of Birth:	If minor, both parents names:
Street Address:	
City, State, Zip:	
❑ Home Phone #:	❑ Mobile Phone #:
❑ Work Phone #:	Fax #:
Email Address:	

Please check off best daytime phone number and time of day to contact you.

Best Day(s) for Appointment:	❑ Monday ❑Tuesday ❑Wednesday ❑Thursday ☐Friday
Best Time of day for Appointment:	❑ Anytime ❑ Early am(8-10) ❑ Late am(10-12) ❑ Early afternoon (2-3:30pm) ❑ Late afternoon (4-5pm)
Insurance Carrier:	❑PPO ❑POS ❑HMO ❑Medicare/Tricare ❑None
Insurance for "Out of Network" Coverage/Restrictions:	
What are your financial limitations:	❑None ❑Can't afford anything beyond small co-pays ❑Can not afford any out of pocket expenses
How did you hear about us (be specific please)?	
What major medical issues concern you?	
Summarize your specific health goals:	
How much time do you expect for results?	
List type of treatments you have tried:	
How committed are you to following a nutritional program?	
List any special considerations (vegan, sensitivities, etc):	
Have you reviewed our website, www.drkaslow.com?	

_____ ← Initial here to acknowledge that Drs. Kaslow and Coughlin at this location are not affiliated with any PPO, HMO or medical group, payment in full at time of service is expected for all patients, and that you will be billed for missed appointments and late cancellations. Lab fees and nutritional supplements, herbs, etc. are not included in the office consult charges. Your initials indicate 1) you understand the basic philosophy of this medical practice; 2) you are seeking consultative care only for health reasons; and 3) any interaction with this office is considered part of a Private Non-Negotiable Contract with JEK, MD Inc. (dba True Health Partners). Both/all legal guardians of a minor must initial here and sign an informational contract in order to initiate care.

PLEASE ALSO FAX, MAIL, or E-MAIL (frontdesk@drkaslow.com) A COPY OF ANY RECENT/RELEVANT LABORATORY REPORTS. If you have a brief summary of your medical needs or history, a time-line of major or relevant life events include this as well.

---------- *For Office Response Only* ----------

MRR: get all❑ get lab only❑ get others if any❑
INFO: send NP packet❑ Prolo❑ ASD initial❑
?AIRES: Homeo❑ NTI❑ Neurochem❑ DOSHA❑ ANS❑
SCHED: 1st avail JEK❑ Routine JEK❑ with TC ❑ DNS❑
TESTS BEFORE VISIT: Lab❑ Genetics❑ OAT❑ RGCC❑
BE PREPARED at 1st VISIT for hTMA❑ Fasting AM lab❑
SCHED at 1st visit: NLS+❑ BRT❑ A❑ Prolo❑
SCHED at 1st visit: HMAHOT❑ UBI/MAHT❑

_____ _____
_____
_____
_____

THIS PRIVATE NON-NEGOTIABLE CONTRACT MUST BE FULLY COMPLETED and RECEIVED BY OUR OFFICE BEFORE YOUR 1st CONSULTATION

Jul 2022

Patient's Last Name:_____ First Name:_____ Middle Initial:_____ Marital status_____

Home Address:_____ Home phone: (_____)-_____ Soc Sec # xxx -xx-_____

City, State:_____ Zip:_____ Birth date:_____

Fax # for correspondence:_____ Email:_____ Cell Phone:_____

Employer:_____ City :_____ Work ph: (_____)-_____Ext:_____

Person responsible for payment:_____ Relationship to patient:_____

Address if not same as above _____ Soc Sec #_____-_____-_____

Employer:_____ City :_____ Work phone: (____)-_____ Ext:_____

Other parent or
Emergency contact:_____ Day Phone: (_____)-_____ Relationship to patient:_____

How did you hear about us (please be specific)? _____ ☐ Friend ☐ PPO ☐ My doctor ☐ Internet

INSURANCE & BILLING INFORMATION: Insurance Co _____ ☐No Insurance ☐Medicare ☐Tricare ☐HSA ☐FSA

We need a photocopy of your Policy Card and a full-length photograph

ANNUAL DEDUCTIBLE $_____ Will you meet it this year? _____

JEK MD Inc is **not a contracted provider for any insurance carrier** and as such you are responsible for full payment of all charges at the time of service.

☐ For patients with **MEDICARE** or **TRICARE:** at this location Dr. Kaslow is not an authorized provider and cannot bill either Medicare or Tricare under any circumstance for any services provided. In addition, you must sign an additional form before any care is provided. Ask if you did not receive it.

For those with insurance other than Medicare and Tricare, we *may* submit an insurance claim on your behalf for possible reimbursement directly to you. Your insurance policy may cover all, some, or none of the services/products provided or may discount your reimbursement. This does not affect the amount you will owe, and checks sent to us from the insurer will be returned. Some services/products are considered research or investigational; others historically have never been reimbursed. Claims for these services/products will not be submitted. If you do not have a list of those services/products, ask for an updated fee schedule.

Please ask beforehand if you are not sure about what will be submitted to your insurance company. Experience has shown that submitting some services/products delays or causes insurance companies to deny the entire claim. If an insurance carrier requests reports or your records, we will ask you for authorization to reply beforehand and may charge you additional fees to prepare such requests. If you do not have a list of our approximate fees, please ask for an updated fee schedule.

Many but not all lab services performed outside the office are billed directly by the lab, who may be contracted with your insurance carrier. Most labs will bill you or the insurer directly. Some lab services require prepayment or do not bill insurance. Our office will inform you beforehand.

☐ I understand that I will be charged for failing to show up to my appointment(s) or canceling an appointment less than 2 full working days beforehand.

☐ By agreeing to receive care and services in this office I am authorizing JEK MD Inc to store the credit card/debit card/HSA or FSA card I provided.

☐ For **PARENTS of MINORS:** Occasionally your child may need medical treatment when you are unavailable. Your signature (s) below indicates agreement and authorization for Jeremy E Kaslow MD and /or Thanh Coughlin, DO to perform any primary or consultative care for the purposes of examination, diagnosis, referral, research, or treatment of your child.

Because of the occasional parental disagreement about the approach or care of a minor, **BOTH** parents or legal guardians must sign this form before Dr. Kaslow and/or Coughlin will evaluate or treat your child. Both parents must understand and agree in concept to the nature and approach of this practice. This authorization shall remain effective until your child is age 18 unless revoked in writing and received by this medical office.

I hereby authorize Jeremy E. Kaslow, MD and /or Thanh Coughlin, DO to render any procedure deemed necessary in evaluating, diagnosing and treating me or my dependent in an irrevocable hold-harmless agreement. I also authorize him to furnish information to my insurance carrier concerning the services provided. I understand and accept full responsibility for all charges incurred. I will pay any legal costs I incur to or on this office, as well as any and all collection costs if my balance becomes delinquent (45 days after service). I authorize JEK MD Inc (dba True Health Partners) to charge the credit/debit/HSA or FSA card I provided.

The sole purpose of my consultation is for personal health care, and I am not part of an investigation or inquiry about Drs. Kaslow and/or Coughlin or any aspect of this practice. Signature below indicates irrevocable agreement to the above terms as a private non-negotiable contract.

☐ I/We received and reviewed the office policy. ☐ I/We reviewed the privacy policy of this office (HIPAA).

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov

Signature(s) of Responsible Person(s):_____ Date:_____

If patient under 18, both Mother AND Father must sign

ARBITRATION AGREEMENT RELATED TO MEDICAL CARE, TREATMENT & ALL DISPUTES

The patient and undersigned Medical Care Provider ("MCP") – which includes any affiliated physicians, employees, any related medical group, professional association, or any other entity or individual which has provided medical services in conjunction with the MCP – agree to submit any dispute whatsoever to binding arbitration including without limitation any claim for malpractice, personal injury, battery, breach of express or implied contract, loss of consortium, wrongful death or any payment or any other disputes relating in any way to past, present or future medical care. Any dispute will go to binding arbitration. This includes any non-U.S.A. dispute or any dispute brought by a patient against the MCP where the patient is not a U.S. citizen. It is the intent of the parties that all disputes under any circumstances of patient and/or physician nationality will go to binding arbitration as agreed herein under the aegis of the Federal Arbitration Act. The parties irrevocably agree that any clinician who has treated or will treat the patient may choose to execute and join in this Agreement at any time. Further, the parties agree that this agreement, in English, is sufficient for any patient or any provider whose native language is not English. By executing this agreement, the parties agree that they have been given sufficient opportunity to understand this agreement provided in English.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

The patient, and/or his or her spouse, born or unborn children, parents, heirs, or anyone launching any legal or equitable action (hereinafter "the Patient") and the MCP agree that any complaint of any type which in any way relates to medical services shall without exception be submitted to binding arbitration. The governing law shall be the Federal Arbitration Act, state law or any nation's law notwithstanding. It is the express intention of the parties that any and all claims or complaints of any kind shall be submitted to and resolved by binding arbitration, which will be the exclusive and sole remedy. It is the specific and irrevocable intention of the parties to submit any question concerning this Agreement's arbitrability to the arbitrators only and to no other person or entity. All issues regarding the validity, enforceability and scope of this Agreement or any part of it shall also be subject to arbitration. If either party challenges the validity of this Agreement in court, the prevailing party shall be entitled to attorneys' fees and to costs as determined by the court.

The MCP and any affiliated medical service provider that chooses to join in this Agreement agree to be equally bound as the Patient is to binding arbitration in the event of any dispute. Such disputes can be brought by the MCP against the Patient, including terms of payment, services rendered, physical or emotional abuse, and other disputes. The Patient understands that any and all medical care provided is sufficient consideration, and the Patient will be fully and legally bound by this Agreement. Both parties to this Agreement are giving up their constitutional right or their rights under the laws of any nation to have any dispute decided in a court of law before a jury. All parties understand that they are giving up the right to have any dispute decided by a judge or jury through the court system. Resort to the legal system by action at law or in equity will only be permissible if necessary to enforce any decisions reached through arbitration. The parties agree that any dispute about any provisions of this Agreement will be decided through arbitration. The parties understand that care may be provided electronically by the MCP and its agents via tele-medicine, anywhere in the world.

The parties hereby bind anyone whose claims may arise out of or relate to treatment or services provided by the MCP at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" means both the mother and the mother's expected child or children. The parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action if they have been involved in any way in the care of the Patient. This may include claims of the Patient against another physician, nurse or medical professional, or a hospital or other facility. Additionally, this Agreement is intended to resolve all claims for vicarious liability of the MCP. The parties agree that any treating medical provider may sign this agreement ex post facto and thereby participate in an arbitral process to resolve any and all claims against such an ex post facto signer. The parties agree that no claims against the MCP may be brought for medical services involving COVID-19 in any way whatsoever.

The signers agree that the maximum total amount of all non-economic and economic damages combined shall never exceed $250,000, applied on ***a per case*** basis, regardless of the number of claimants seeking compensation, and regardless of the number of physicians, professional associations, employees or entities named as defendants. The Patient agrees to waive any and all rights to any higher award. This limitation applies regardless of whether another healthcare provider, such as a physician, a hospital or other facility or employees of such a physician, hospital or facility are named as defendants in the binding arbitration or in any other proceeding. Non-economic means damages for pain and suffering, disfigurement, embarrassment and anything else not representing loss of past or future earnings, medical or other costs. However, the arbitrators may choose to award damages in excess of $250,000 only when extreme hardship is demonstrated. As consideration for the limitation on any awards, the MCP will pay up to and only the first $2,500 of attorney fees for the Patient. The parties agree that if any punitive damages are awarded, they may not exceed three times any compensatory award. Save as required by Medicare/Medicaid, the parties agree that any awards in excess of $10,000 shall be paid in equal annual payments over 10 years without being reduced to present value. The arbitrators may reduce this time period in cases of extreme hardship. They will also consider any other collateral sources of compensation (e.g., workers compensation, life insurance, disability, charitable, and governmental benefits, and other monies paid to an injured patient or any other party) which shall diminish any awards for non-economic and/or economic damages. The MCP shall be entitled to an off-set for any monies received by the Patient for claims against any other health care provider, if such claims arise out of or relate in any way to the claims of the Patient against the MCP. The parties agree to the complete disclosure of all collateral sources of compensation. Failure to promptly disclose any additional sources on request is agreed to be grounds for immediate and total dismissal of any claim.

Statute of Limitations: In no case shall the statute of limitations exceed 12 months from the date any alleged injury or problem could or should have been discovered regardless of the age of the Patient. The arbitrators and their empowerment under the FAA shall determine any question concerning the application of this provision. **Severability:** If any specific term or provision of this Agreement is determined by a court of competent jurisdiction to be illegal, invalid, or otherwise unenforceable, the entire remainder of this Agreement shall be construed to be in full force and effect, and all other provisions will still apply. The parties agree in general that any provisions so challenged will be brought to the arbitrators to decide upon, and

not to a judge or jury. **Timing*:*** The parties agree to try to resolve all issues within 9 months of any complaint. **Entire Agreement/Merger Clause:** This Agreement represents the entire agreement made between the MCP and the Patient. It supersedes any other agreements between the Patient and the MCP. Except as expressly set forth herein, there are no other representations, promises, understandings, or agreements of any kind between the parties. The Patient signing this Agreement acknowledges that he or she has not relied in any way upon any oral or written statements made to them besides what is contained within this Agreement. All parties acknowledge and understand that this Agreement cannot be changed, altered, or modified in any way except by an instrument in writing, signed by all parties. **Pronouns and Headings:** The singular shall be held to include the plural, the plural held to include the singular, and the use of any gender shall be held to include every gender. All headings, titles, subtitles, or captions are inserted for convenience only, and are to be ignored in any construction of the provisions hereof. **Governing Law and Payment and Selection of Arbitrators:** This Agreement, its substantive provisions, the scope of the Agreement, the authority granted to the arbitrators and the limitations contained in this Agreement, are to be governed by, and interpreted pursuant to the Federal Arbitration Act, any conflicting state or entity's law notwithstanding. To the extent not inconsistent with the FAA, it shall also be governed by the provisions of the Revised Uniform Arbitration Act as adopted in the principal state where the MCP practices. The parties agree that any dispute between them shall be determined by a panel of three arbitrators. Each party shall select one arbitrator from lists of qualified legal/medical experts provided by the MCP. All arbitrators will hold either medical or both medical and juris doctor degrees. The two arbitrators selected shall then select a third arbitrator from the same list. Each party may remove the other's chosen arbitrator only once. The three arbitrators shall resolve any and all disputes between the parties generally pursuant to such procedures or any code of procedure as they may jointly decide. All arbitration hearings shall be conducted by Internet-based videoconference as arranged by the arbitrators. The MCP will provide pay any costs of videoconference bridging of the arbitration process. The parties shall adopt rules of evidence such as the arbitrators may see fit. The MCP shall pay half the costs of the arbitration, but shall not be responsible for paying any fees or costs charged to the Patient by their attorney save the first $2,500 as indicated above. The Patient shall pay half the costs of the arbitration as well. Reasonable but brief discovery will be permitted by both sides. The parties agree that the arbitrators are to render a written decision with reasons stated for the decision. **Right of Counsel & Rescission:** The Patient understands that this Agreement is a legal document, and the Patient has the right to consult with an attorney before signing it if desired. Your MCP encourages you to consult an attorney prior to signing or during a 15-day rescission period. You may rescind this Agreement for 15 days after signing it; you agree that it will be in full force and effect until the date received at the MCP's office. To rescind it, return a copy to the MCP by certified mail-return receipt only with "CANCELED" written on the first page, and signed by you underneath that word. The Agreement will then be rescinded for all future care, but you agree it will be valid for any and all care provided by the MCP to the Patient for the entire period of all medical services up to rescission. You do not have to sign this agreement to receive care. **Authority to Sign:** The Patient represents that he or she does in fact have the authority to sign and execute this document on his/her own behalf (if signed by the Patient), or on behalf of the Patient (if signed by a person or persons other than the Patient.) The Patient or representative agrees and states that he/she has consulted with any and all others who might be a party to any action (spouse, family member, etc.) and all such parties have agreed to be party to this Agreement without the need to sign this Agreement. **No Undue Influence:** The individual signing this Agreement hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed it of his or her own free will and accord and not under duress of any kind. The parties agree that they have been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement. **Frivolous Legal Actions:** The Patient agrees that under no circumstances will a frivolous action or claim be brought against the MCP, and the MCP agrees to not bring any frivolous action or claim against the Patient. If two or more Arbitrators rule that any action or claim brought against either party is frivolous in nature, the prevailing party shall be entitled to economic and non-economic damages, including loss of wages or other compensation, damage to reputation, full attorneys' fees and punitive damages. **Mediation:** At the MCP's sole expense, upon any complaint or alleged injury to the Patient, the parties agree to promptly mediate in good faith with a qualified mediator prior to Arbitration. A qualified professional mediator with medico-legal background shall be mutually agreed upon. Mediation may occur by videoconference. **Provisions**: Any item of this Agreement may be discussed, negotiated, or changed by mutual agreement prior to signing it as presented here or during the 15-day rescission period. Please avail yourself of this opportunity.

BY SIGNING THIS CONTRACT, YOU AGREE TO HAVE ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR MCP OR OTHER PARTIES WHO LATER JOIN IN THE ARBITRATION DECIDED BY BINDING ARBITRATION IN WHICH BOTH PARTIES GIVE UP THEIR RIGHT TO A TRIAL BY JURY, OR TRIAL BY A JUDGE.

I hereby agree that all provisions of this Agreement as in full effect, and no item or provision may be crossed out, excised or removed save by mutual consent. I further agree and certify by signing this document that I have received my own separate copy of this Agreement in hard copy or electronically. I understand that this Agreement is valid, enforceable and legal anywhere, in any country, principality or geographical point on earth. I provide my consent to add any other parties at some later date who may participate in any arbitration process under this Agreement. For these parties added later as well, arbitration shall be the sole remedy for dispute resolution without any judge, jury or trial.

To Be Completed by the Patient, Parent, or other Authorized Representative

Name of Patient: _____

Signature (Patient, Parent, Authorized Rep.): _____ Date: _____

Signer's Relationship to Patient (pls. check one): ☐Self ☐Mother ☐Father ☐Other (Specify): _____

MEDICAL CARE PROVIDER'S (MCP'S) CONSENT TO ARBITRATION: In consideration of the execution of this Agreement, the undersigned as legal representative of the MCP hereby agrees to be bound by all the terms set forth above.

SIGNATURE of MCP Provider: _____individually & on behalf of Jeremy E Kaslow MD, JEK MD Inc, and/or True Health Partners

PARTIES ADDED After Date Above (Name, Company & Signature): _____

PATIENT NAME **AGE** **VISIT DATE**

List ALL DOCTORS you currently see:

OCCUPATION or GRADE IN SCHOOL

PLEASE LIST THE MAIN REASONS FOR YOUR VISIT	When did problems begin?

Please list **ALL** recent & current medications, vitamins, herbs, etc.	

History of ANTIBIOTIC use:

EAR – NOSE – THROAT – CHEST ALLERGIC SYMPTOMS

EYES	EARS	NOSE	SINUS	THROAT	CHEST
__ Itch __ Redness __ Tearing __ Burning __ Discharge __ Blurring __ Contact lens use	__ Itch __ Feel full __ Popping __ Ringing __ Reduced hearing __ Prior surgery/tubes __ Frequent infections	__ Itch __ Sneezing __ Clear runny __ Thick nasal discharge __ Stuffy / congestion __ Discolored mucus __ Polyps __ Bloody noses __ Mouth breather	__ Drainage __ Pain or pressure above, below or behind eyes __ Dark circles under eyes __ Bags under eyes __ Frequent sinusitis __ Prior sinus surgery __ Positive findings on sinus CT or X-rays	__ Frequent sore throats __ Itch __ Post-nasal drainage __ Clear throat often __ Voice cracks / gravely __ Bad taste __ Bad breath __ Hoarse __ Snoring	__ Asthma __ Wheezing __ Chest tightness __ Shortness of breath __ Easily winded __ Chest cough is __ Dry __ Wet __ Thick __ Upon arising __ In the middle of night

Above conditions worse when exposed to:

__ DUST __ CATS __ DOGS __ HORSES
__ GRASS __ TREES __ AIR-CONDITIONING __ HEAT
__ COLD __ WINDS __ CHANGE OF WEATHER __ ODORS
__ TOBACCO SMOKE __ FUMES __ DAMP/FOG

Other:

Condition is worse:

__ INDOORS __ OUTDOORS __ EARLY AM __ LATE AT NIGHT
__ DURING DAY __ AT SCHOOL __ AT HOME __ IN BEDROOM
__ AT WORK __ AFTER EXERCISE __ AROUND MENSES __ AFTER EATING
__ SPRING __ SUMMER __ FALL __ WINTER

Other:

How often do you have the above symptoms? __ Daily __ 2-3 times a week __ 2-3 times a month __ 1/month __ less than monthly __ 2-3x a year

How long do symptoms last? ____ Minutes ____ Hours ____ Days ____ Weeks ____ all the time _____# of school/work days missed due to the above?

Number of ER/hospitalization visits for asthma/allergies:

DRUG REACTIONS: __ Aspirin? __ Penicillin? __ Sulfa? Other (list)_____

Describe your reaction to the above _____

FOOD REACTIONS: _____

INSECT or TICK reactions: _____

Have you ever been skin tested for allergies? Blood tested for allergies? When results:

HOME and WORK ENVIRONMENT

List everywhere you have lived:

How long have you lived in your home? _____ Is your home near industry?____ Powerlines/transformers?____ Freeways/heavy traffic?____ Wilderness?____

How old is present home? _____ Do you have forced heating/cooling?____ Special filter system?____ Water purification system?____ Wi-Fi?____

Does your home have a mold/mildew/dampness problem? ____ Carpet age _____ years condition:_____ ever flooded?_____

Does anyone smoke indoors?___ How much exposure do you have (or have had) to chemicals, pesticides, paint, etc._____

IN YOUR BEDROOM: carpet?____ curtains?____ mini-blinds?____ waterbed?____ mattress age ____ years stuffed animals?____ a lot of pillows?____

Do you use a down comforter?____ feather pillows?____ allergy cover on mattress?___ allergy cover on pillows?____ curtains?____

LIST PETS indoors at home (_____) and outdoors (_____)

AT WORK/SCHOOL IS THERE CONTACT: __ Animals? __ Poor ventilation? __ Odors/Mildew? __ Chemical use? __ Fumes? __ Wi-Fi/EMF?

How is your school/work performance or health affected by the environment?

List where you have traveled:

Place one [X] if condition is chronic and two [XX] if condition is acute/significant. Leave all others blank.

IMMUNITY, INFECTIONS and RESISTANCE

__ Takes a long time to heal
__ Catch colds easily
__ Have had shingles
__ Toenail fungal infections
__ Yeast infections
__ Problem with boils
__ Warts
__ Frequent cold sores
__ Frequent canker sores
__ Have been HPV positive
__ Infections settle in lungs
__ Pneumonia(s) in 19_____
__ Frequent "bronchitis"
__ Many bladder infections
__ Recurrent streptococcal infections
__ EBV positive
__ HHV6 positive
__ Herpes 1 and/or 2
__ CMV positive
__ H pylori positive
__ Have had MRSA cultured
__ Mycoplasma positive
__ Positive TB skin test
__ Lyme positive
__ Have had shingles vaccine

CHRONIC FATIGUE

What was triggering event? | When did it start

__ Fatigue all day
__ Fatigue mostly in afternoon
__ Fatigue just after meals
__ Fluctuating energy levels
__ Exhausted after slight effort
__ Onset was sudden
__ Onset was gradual
__ Must nap ____ hours a day
__ Flu-like feelings (malaise
__ Muscles ache like after exercise

What makes it worse? | What makes it better?

AUTONOMIC & ACID-BASE

__ Feverish (temp_____)
__ Night sweats
__ Flu-like symptoms
__ Swollen lymph nodes
__ Sweaty/clammy palms, soles, forehead, or underarms
__ Dry mouth
__ Strong gag reflex
__ Easily startled
__ Make goosebumps easily
__ Cold hands or feet
__ Yawn frequently
__ Fingers or lips tingle
__ Unable to relax
__ Slow starter in the am
__ Chilled when stressed
__ Watery eyes or nose
__ Eyes blink often
__ Always hungry
__ Perspire easily
__ Rapid digestion
__ Hard to fall asleep at night
__ Staring, blinks little
__ Strong light irritates

GLUCOSE REGULATION and METABOLISM

__ Hypoglycemia ☐ w/(+) test
__ Excessive appetite
__ Have to eat frequently
__ Afternoon headaches
__ Eating relieves fatigue
__ Get shaky, lightheaded or heart pounds if hungry or meals delayed.
__ Awaken after a few hours of sleep for no reason
__ Am still hungry even after a large meal
__ Eat when nervous or upset
__ Hungry or irritable between meals
I crave __candy/sweets __chocolate __alcohol __breads __coffee

HEADACHES and DENTAL HISTORY

Location of headaches: | Headaches began

__ Head throbs or pounds (migraines)
__ Car or other major accidents
__ Have had orthodontic work
__ Headaches are "splitting"
__ Headaches are dull/pressure
__ Grind teeth/bruxism
__ Sleep preferentially on 1 side
How long does your headache last
__ Past head/neck injury
__ Jaw pops, locks, grind
__ Neck trigger points
__ Shoulders & upper back ache
__ Clench teeth
__ Carry tension in neck/upper back
__ Stiff neck
____ # of dental fillings
____ # of root canals

What helps | Triggers

BRAIN CHEMISTRY and FUNCTION

__ Restless, uneasy sleep
__ Awaken in the night ____ times
__ Awaken in a.m. unrested
Usual number hours of sleep ____
__ Prominent dreams
__ Depressed, not motivated
__ Suicidal thoughts
__ Withdrawn socially
__ Reduced initiative
__ Tend to procrastinate
__ Anxious, nervousness
__ Highly emotional
__ Worrier or feel insecure
__ Poor school/work performance
__ Attention deficit disorder
__ Moody
__ Irritable or angry
__ Mind races
__ History of seizures
__ Learning Disorder
__ High pain threshold
__ Poor concentration
__ Forgetful/poor memory
__ Cloudy/foggy thinking
__ Hyperactive or very restless

WHAT IS YOUR DOMINANT EMOTIONAL RESPONSE(S): __ Fear __ Worry __ Anxiety __ Anger __ Frustration __ Impatience __Sadness

☐ Check here if you would like to complete a more comprehensive questionnaire regarding brain neurotransmitters and chemistry.

ENDOCRINE GLANDS and HORMONES

__ Thyroid disorder
__ Low body temperature
__ Sensitivity to cold
__ Sensitivity to heat
__ Thick puffy dry skin
__ Swollen or bulging eyes
__ Low sex drive
__ Low sex responsiveness
__ High sex drive
__ Crave salt
__ Can't get weight up to normal
__ Weight loss (_____lbs.)
__ Weight gain (_____lbs.)
WHAT IS YOUR IDEAL WT?_____
When did you last weigh this?_____
__ Always thirsty
__ High blood sugar/diabetes
__ Hot flashes
__ Premenstrual anxiety/irritability
__ Premenstrual bloating/water gain
__ Premenstrual depression/crying
__ Premenstrual acne/skin outbreaks
__ Menses are irregular in interval
Days between periods _____
Days of flow:_____
__ Heavy flow __ Light flow
__ Clots __ Brown flow
__ Menstrual cramps
__ Menopause in _____
__ Night or cold sweats __ Hot flashes
__ Vaginal dryness __ Urinary tract symptoms
__ Mood/mentation changed with menopause
__ Surgical hysterectomy in _____☐ovaries taken
__ Felt great during pregnancy __ Felt bad during
__ Breast tenderness or cysts
__ Have had an abnormal Pap smear ☐HPV positive
__ Ovarian Cysts __Polycystic Ovaries
__ Vaginal itch, discomfort, or discharge

☐ Check here if you would like to complete a more comprehensive questionnaire regarding hormone balance.

SKIN

__ Itching
__ Corners of mouth crack
__ Brittle fingernails
__ White nail spots
__ Dandruff
__ Psoriasis
__ Flushing or blotches
__ Stretch marks
__ Dry skin
__ Rashes
__ Sunburn easily
__ Foot odor
__ Eczema
__ Chapped lips
__ Acne or pimples
__ Thick skin on heels/feet
__ Hives
__ Rough skin on back of arm
__ Oily skin ☐ only on face
__ Hair loss

GASTROINTESTINAL-DIGESTION

__ Burning tongue
__ Burping or belching
__ Heartburn or sour taste
__ Nausea
__ Metallic/bitter taste
__ Stomach pain/upset before meals
__ Stomach pain/upset after meals
__ Coated tongue
__ Bloating after meals
__ Fatty food intolerance
__ Pain between shoulder blades
__ Gallstones
__ Light/clay colored stools
__ Past ulcer or gastritis
__ Bad breath/halitosis
__ Gas/flatulence
__ Acidic foods upset stomach
__ Foul smelling stool
__ Pain/cramps in lower abdomen
__ Black or bloody stools
__ Loose bowel movements (diarrhea) ☐Unformed
__ Parasites __SIBO
__ Intestinal bloating
__ Groin rash or itch
__ Itching around anus
__ Colonoscopy last done
__ Constipation or hard stools
__ Hemorrhoids
__ Elevated liver enzymes
__ Have had hepatitis
__ Have had polyps
Bowels move_____a day

CARDIOVASCULAR

__ Chest pains (Angina)
__ Mitral valve prolapse
__ Palpitations/heart pounding
__ Irregular heart beat
__ Heart beats fast or races
__ Easily winded with slight effort
__ Had a Stress Test when?_____
__ High blood pressure
__ Low blood pressure
__ Low blood count (anemia)
__ Low iron __ Low B12
__ Had a heart calcium scan (CAC)
__ Gums bleed after brushing
__ Bruise easily
__ Prior stroke or TIA
__ Feet swell up
__ Varicose veins ☐ Thrombosed
__ Spider veins
__ Dizzy or light-headed
__ Dizzy when stand up
__ Poor circulation
__ Hands / feet fall asleep
Your highest cholesterol level_____
__ High triglycerides (>100)

MUSCULOSKELETAL & CALCIUM METABOLISM

__ Arthritis LIST locations in order of severity:
__ Painful joints

__ Joints click or creak
__ Stiffness with prolonged sitting
__ Stiff in the morning
__ Low back pain / ache
__ Pain between shoulder blades
__ Neck pain / stiffness
__ Degenerative joint disease
__ Have crushed vertebrae
__ Joints injure easily
__ Heel or Foot pain
__ Tremor or shakiness
__ Numbness or reduced sensation
__ Balance difficulty
__ Poor coordination
__ Tingling
__ Muscle cramps ☐ at night?
__ Muscle spasms or tenderness
__ Muscles weak/fatigue easily
__ Bursitis
__ Carpal Tunnel Syndrome
__ Osteoporosis / Osteopenia / Bone loss
__ Chiropractic adjustments don't stay/hold
__ Get chiropractic care often
__ Kidney stones (type:)
__ Build up dental tartar or plaque rapidly
__ Gingivitis/gum disease/inflammation
__ Loss of gingiva/ gingival recession
__ Dental cavities recently
__ Loss of dental bone
__ Root canals ☐ Painful/sensitive
How many crowns do you have?_____

MISCELLANEOUS

__ Swollen lymph glands
__ Sensitivity to fumes, smoke, EMF smog, chemicals, odors, etc.
__ Sensitivity to most medicines or herbs
__ Significant chemical exposures at work
__ Significant EMF exposure
__ Awaken to urinate ____ times
__ Dribble after urinating
__ Burning with urination
__ Urinate small amount at a time
__ Kidney infections
__ Frequent bladder infections
__ Interstitial Cystitis
__ Stream force is reduced
__ Prostate trouble / Prostatitis
__ Impotency/Trouble with erections
__ Difficulty holding urine
__ Urine incontinence/leakage
__ Kidney disease
__ Glaucoma
__ Reduced Night Vision
__ Macular Degeneration ☐Right ☐ Left
_ Silicone/Saline implants (yr placed:)

MEDICAL and SURGICAL HISTORY

CHILDHOOD: weeks born premature?____ low birth weight?_____ complications of pregnancy or delivery?_____
newborn jaundice?_____ diarrhea?_____ vomiting or regurgitation?_____ breastfed _____ months
formula soy___ milk___ colic?___ croup?___ bronchiolitis/bronchitis?___ (age(s)_____)
Are immunizations up to date?___ normal development?__ ☐ Issues with development In daycare or preschool _____ days/wk

List MAJOR ILLNESSES or INFECTIONS	
List PREVIOUS THERAPIES and YOUR RESPONSE	
List all HOSPITALIZATIONS, OPERATIONS, DENTAL PROCEDURES, CAR & OTHER ACCIDENTS, ETC. (include dates)	

DIETARY PROFILE

Alcohol intake per week _____ Tobacco ___packs/day for ___years (quit 19____) Do you VAPE? ___ Cups of caffeinated coffee per day ___
Colas or sodas _____ cans/day "Sugar-free" products per day ___ ☐ Aspartame Red meat eaten _____/week Fish eaten _____/week
Do you use margarine? __ Do you eat dairy products regularly?___ Do you drink tap water?___ purified?__ distilled?__
Antacids taken _____/week Birth Control Pills for _____years Recreational drug use (THC, etc.) _____
How much fruit juice do you consume/day?_____ How many servings of fruit/day?____ How many servings of vegetables/day?_____

List FOOD RESTRICTIONS:

What Foods do you CRAVE or eat a lot of?

What do you typically eat?	Breakfast
	Lunch
	Dinner

SOCIAL HISTORY

Marital status: How long? years Ages of children: Ages of Siblings:

ACTIVITIES/SPORTS HOBBIES

LIST THE MAJOR SOURCES OF STRESS IN YOUR LIFE	

Rate your satisfaction on a scale from 1 (poor) - 10 (great) of your JOB ____ MARRIAGE____ HEALTH ____ GENERAL LIFE ____

FAMILY HEALTH HISTORY

__ Alcoholism / Addiction
__ Atherosclerosis
__ Allergies
__ Asthma
__ Attention deficit
__ Autism / Asperger's
__ Parkinson's Disease
__ Alzheimer's at what age
__ Autoimmunity
__ Diabetes
__ High blood pressure
__ Obesity/Excessive weight
__ Thyroid disorders
__ Irritable Bowel Syndrome
__ Anxiety
__ Early menopause
__ Emphysema/Lung disease
__ Mood Disorders
__ Osteoporosis
__ Osteoarthritis
__Inflammatory Bowel (Crohn's, UC)
__ Depression
__ Insomnia
__ Heart disease
__ Migraines
__ Strokes
__ Cancer (list types:
List other family conditions
_____
_____
☐Have done 23andme or Ancestry.com

Request for Release of Records to True Health Partners

Patient: _____ Date of Birth:_____

SSN: XXX-XX-__ __ __ __ Medical Record Number:_____

From DOCTOR(s), CLINIC(s) or HOSPITAL(s):

Date faxed

❑_____ fax:_____

❑_____ fax:_____

❑_____ fax:_____

❑_____ fax:_____

Effectively immediately, I hereby authorize and request you to release by mail or facsimile or e-mail to:

True Health Partners
Jeremy E. Kaslow, M.D., F.A.C.P., F.A.C.A.A.I.
Thanh Coughlin, D.O.
720 North Tustin Ave Ste 202
Santa Ana, CA 92705-3606
714-565-1032 FAX 714-565-1035
frontdesk@drkaslow.com

❑ All medical records concerning any aspect of my medical care.
❑ All medical records concerning any aspect of my medical care beginning _____.

❑ Only diagnostic data such as lab, biopsy, radiograph, imaging, spirometric, EKG, skin testing, or other test reports.
  ❑ the beginning of my illness or my first visit with you or your group.
  ❑ since this date only_____.

The medical records requested are only to be used for medical care. They will not be released to another party without specific written authorization. A photocopy or facsimile of this request shall be as valid as the original and remain in effect for 12 months from the date of signature below. I may revoke this authorization in writing effective at any time. My next appointment with Dr. Kaslow and/or Coughlin is _____.

Thank you for your cooperation and rapid response.

Signed:_____ / Witness: _____ Date:_____

PROHIBITION OF RE-DISCLOSURE and CONFIDENTIALITY NOTE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you making any further disclosure without the specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

The information released is intended only for the use of the individual(s) or entity(s) listed above and is confidential and legally privileged.

Jul 2022