CLIENT BILL OF RIGHTS

Teresa Stewart, Classical Homeopath, CCH, C.HP.
4601 Excelsior Blvd, Suite 501
St Louis Park, MN 55416

612-720-2332

1. Degrees, training, and experience of practitioners:

Teresa Stewart is a graduate of Northwestern Academy of Homeopathy (NAH), in the Twin Cities. She is certified by the Council for Homeopathic Certification. She has studied with internationally known teachers such as Valerie Ohanian, Laurie Dack, Eric Sommerman. Louis Klein and Rajan Sankaran. And has been practicing classical homeopathy since 2007

Teresa has a background in finance, working in corporate America from many years while pursuing her passion for health and healing. She fell in love with homeopathy in 1993, while raising her family in Australia. She works with families locally and remotely.

The current care you receive will be of a homeopathic nature and **not** allopathic (conventional medicine). Client's are advised to have and receive allopathic care from their primary care physician or provider. We will be pleased to coordinate your health care with your primary physician according to your wishes.

In accordance with Minnesota law, we are providing you with the following notice:

> **THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY.**

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

2. Right to file a complaint. Our names and address are listed above. You have a right to file a complaint with us, by writing a letter with details of the nature of the complaint.

If you have any concerns, you may file a complaint with the following office:

Office of Unlicensed Complementary and Alternative Health Care Practice
Minnesota Department of Health Occupations Program
85 East 7th Place, Suite 300, PO Box 64882
St. Paul MN 55164-0882
651-282-3823, 1-800-657-3957, Fax 651-282-3839

4. Fees for unit of service. Fees are payable at the time of service by cash, check, or credit card. We do not accept Medicare, Medical Assistance, or General Assistance Medical Care. We do not accept partial payment or waive payment.

5. Change in services or charges. You have a right to reasonable notice of changes in services or charges, and we will provide prior notice of any changes.

6. Description of Services. Please see the article "What is Homeopathy," provided to you in your clinic information packet, and available in our reception room.

7. Information about assessment and recommended service. You have a right to complete and current information concerning any assessment and recommended service, including the expected duration of the service to be provided. If you have any questions, please ask.

8. Courteous treatment. You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.

9. Confidentiality of client information. Your records and other information about you are confidential. This information will not be released, unless you authorize release in writing, or unless release is required by law.

10. Access to client records. You are allowed access to records and other written information, in accordance with Minnesota Statutes, section 144.335.

11. Other available services. If you are interested in other available services in the community, you may wish to consult the Minnesota Homeopathic Association.

12. Change practitioners. You have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

13. Coordinated transfer. If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.

14. Refusing services. You have the right to refuse services or treatment, unless otherwise provided by law.

15. No retaliation. You may assert your rights without retaliation.

I hereby acknowledge receipt of the Client Bill of Rights and the attached documents incorporated therein and I have had a full opportunity to ask any questions I have about this document and my rights as a client. I understand my rights as a client.

____

Client Signature **Date**

____

Parent or Guardian Signature **Date**

4601 Excelsior Blvd, Suite #501
St Louis Park, MN 55416

Stewart Homeopathy
Teresa Stewart CCH, C.HP
612-720-2332

Client Registration

Name of Client: ______________________________ Birth Date:____________

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Client Address: ____

Home phone: _______________________ Cell phone: ___________________

Email address: ____

Emergency Name & Phone: ____

____

Physician's Name, Address, & Phone: ____________________________________

____

I acknowledge that I am the responsible party for (client) ____________________, and I understand that payment of homeopathic services is due at time of service.

Signature of Responsible Party: ________________________________ Date: ______________

Homeopathic Services Notice

The homeopathic services you have requested are directed at strengthening your constitution and vitality. They are not directed at identifying, treating or preventing specific diseases. Our practitioners are qualified homeopaths but are not licensed physicians. They are prohibited by law from diagnosing or treating disease.
If you have a medical complaint or question about your health it is important that you consult with a physician.
Many insurance companies do not pay for homeopathic services and our office will not be sending a claim to your insurance carrier.

CLIENT ACKNOWLEDGEMENT:

It is my personal preference to use the homeopathic services of the homeopaths at Minnesota Center for Homeopathy. I understand that the homeopathic services are NOT MEDICAL treatments and that these homeopaths are not licensed physicians.

Client Signature: ____________________________________ **Date:** __________________

Parent Signature____________________________________ **Date:** ____________
(if client is under age 18):

Minnesota Center for Homeopathy
Health Inventory Sheet
(This information is confidential and will only be released with your signed consent)

Name: ______________________________ Birth date:______________
Last First Initial

Address:______________________________ Age____Sex____Height_____Weight_____

City: ____________________ State/ZIP__________ Legal Status: S M D Sep W

Phone: W__________ H__________ C__________ Email:______________

Okay to leave a message by phone? Home________ Cell_______ Work________ Occupation:______________

If under 18, parent's name/address______________________________

Emergency Contact: Name____________________ Phone______________ Relationship______________

Main Concern(s):______________________________

____

____

FAMILY HISTORY

☐ *Check if family history is unknown*

Relative	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

YES	RELATIONSHIP
☐ Alcohol/Drug problem	
☐ Allergy/Asthma	
☐ Anemia	
☐ Arthritis	
☐ Binge eating/Bulimia	
☐ Cancer	
☐ Diabetes	
☐ Epilepsy/Seizure	
☐ Gastro Intestinal	
☐ Gonorrhea	
☐ Heart Disease	
☐ High Blood Pressure	

YES	RELATIONSHIP
☐ High Cholesterol	
☐ Hormonal Imbalance	
☐ Kidney/Liver Disease	
☐ Mental Illness	
☐ Obesity	
☐ Skin Disease	
☐ Stroke	
☐ Suicide	
☐ Syphilis	
☐ Thyroid Disease	
☐ Tuberculosis	

Please turn page.

Past History of Illness and Medical Problems

Surgery: List all surgery and approximate dates		Other hospitalizations and dates	

Broken bones and/or traumatic injuries *(include all car accidents or concussions/head injuries)*		Current health problems *(example: high blood pressure—10yrs)*	

Past History

YES	WHEN	YES	WHEN	YES	WHEN
☐ Alcohol/Drug problems		☐ Gonorrhea		☐ Respiratory problems	
☐ Allergies/Hay fever		☐ Gout		☐ Rheumatic fever	
☐ Amalgams/silver fillings		☐ Headaches/Migraine		☐ Root canal	
☐ Anemia		☐ Hearing problems		☐ Scarlet fever	
☐ Antibiotics (frequent use)		☐ Heart problems		☐ Seizure/Convulsions	
☐ Anxiety		☐ Hemorrhoids		☐ Sexual dysfunction	
☐ Arthritis		☐ Hepatitis		☐ STDs	
☐ Asthma		☐ Herpes		☐ Sinusitis	
☐ Back pain/strain		☐ Hives		☐ Skin problems	
☐ Bladder infections		☐ High/low blood pressure		☐ Sleep disorder	
☐ Blood clots		☐ High cholesterol		☐ Steroid use	
☐ Bowel problems		☐ HIV/AIDS		☐ Stroke	
☐ Breast lump		☐ Hypoglycemia		☐ Suicide attempt	
☐ Cancer		☐ Insomnia		☐ Syphilis	
☐ Chemical sensitivity		☐ Kidney problems		☐ Thyroid problems	
☐ Chicken pox		☐ Liver disease		☐ Tooth problems	
☐ Chronic fatigue		☐ Measles		☐ Tuberculosis	
☐ Congenital defect		☐ Menstrual problems		☐ Urinary problems	
☐ Dental problems		☐ Mental Illness		☐ Vaginitis	
☐ Depression		☐ Mumps		☐ Vascular problems	
☐ Diabetes		☐ Nervous condition		☐ Vision problems	
☐ Digestive problems		☐ Neurologic problems		☐ Warts	
☐ Eating disorders		☐ Over/under weight		☐ Other problems	
☐ Ear infection		☐ Panic attacks			
☐ Eczema		☐ Peptic ulcer			
☐ Endometriosis		☐ Phlebitis			
☐ Epilepsy		☐ Pneumonia/Bronchitis			
☐ Eye/vision problems		☐ Premenstrual tension			
☐ Fibroids		☐ Prostate problems			
☐ Gallbladder problems		☐ Reaction to vaccinations			

Review of Systems

Check if you have had these symptoms in the last 6 months

- ☐ Mood swings
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart/mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Dizziness
- ☐ Balance problems
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Excessive tearing/itching
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ Pain/discomfort while eating
- ☐ Nausea/vomiting
- ☐ Change in diet

Women

Last menstrual period: ____________________

Usual length of cycle ____________________

Usual length of period ____________________

Age menstruation began ____________________

Age at menopause ____________________

Number of pregnancies ____________________

Number of live births ____________________

Number of abortions/miscarriages ____________________

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD; Type: ____________________
- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem with sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility

Date of last pap smear ____________________

Men

- ☐ Enlarged prostate
- ☐ Decreased urine stream
- ☐ Unable to interrupt stream
- ☐ Dribbling after urination
- ☐ Pus or drainage from penis
- ☐ Genital swelling/rash
- ☐ Problem with sexual function

Do you believe you have had an adverse reaction to a vaccination? If so, please list which vaccination(s) and approximate dates:

____

____

____

Current Medications

List all prescription and non-prescription medications including dosage

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Vitamin and Mineral Supplements

Type and dosage

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Allergies

I am allergic to the following medications:

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Food allergies and method of testing

____

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Please turn page.

Personal History

Lifestyle

List your favorite foods or cravings:

____

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____

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I am now or have been a smoker. ☐Yes ☐No

If yes:

How many years have you smoked? ____________

How much? ____________

When did you quit? ____________

I estimate my use of:

coffee:__________ cups/day decaf:__________ cups/day

I consider myself a ☐non-drinker ☐social drinker ☐heavy drinker ☐alcoholic ☐recovering alcoholic

I use: ☐marijuana ☐other drugs:______________

I have participated in an exercise program. ☐Yes ☐No

I exercise on a regular basis. ☐Yes ☐No

__________times __________week/month

I currently see a chiropractor, osteopath, or other physical therapy practitioner: ☐Yes ☐No

My last physical exam was______________________

I find my work ☐too demanding ☐boring ☐satisfactory ☐very satisfactory

Interests/Hobbies

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My sex life is satisfactory ☐Yes ☐No

I do the following for relaxation/recreation: ____________

____

____

My spiritual life is satisfactory. ☐Yes ☐No

I am currently involved in a regular spiritual program: ☐Yes ☐No

I sleep well. ☐Yes ☐No

I worry about: ☐money ☐job ☐family life ☐relationships ☐other______________

I have been a victim of abuse. ☐physical ☐sexual ☐emotional

Are you fearful of: ☐animals ☐people ☐being alone ☐darkness ☐death ☐diseases ☐robbers ☐sudden noises ☐thunder ☐the future ☐high places ☐the unknown ☐other ____________

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Any additional information about yourself that you feel we have missed:

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Fees for Service

$350 Adult Initial Consultation

$285 Child Initial Consultation (Children 12 and under)

$95 Follow up

Consultation virtual, phone, or office visit

$35- $60 Brief/ Acute Consultation

$45-$60 After hours or weekend calls

Location, Hours & Scheduling

Teresa offers in person, phone or virtual appointments at the Minnesota Center for Homeopathy in St Louis Park, MN.

Hours are by appointment.
To schedule a consultation, contact Teresa at 612-720-2332 or email teresastewarthomeopathy@gmail.com