Debra Sax Annes RsHom, CCH, BA

Minnesota Center for Homeopathy
4126 York Ave So, Minneapolis, MN 55410

Client Bill of Rights

We are pleased to provide you with this Client Bill of Rights, in accordance with Minnesota laws governing complementary and alternative health care practices.

1. **Degrees, training, and experience.**

   Debra Sax Annes, RsHom, CCH, BA in Psychology and Education s a graduate of the Northwestern Academy of Homeopathy, Class 1 1998. She is certified in classical homeopathy by the Council for Homeopathic Certification and the North American Society of Homeopaths. She has practiced classical homeopathy for over 20 years and is on the faculty of the Northwestern Academy of Homeopathy in Minnesota. She is also an adjunct professor at eh University of Minnesota, Center for Spirituality

   The current care you receive will be of a homeopathic nature and ***not*** *allopathic (conventional medicine). Patients are advised to have and receive allopathic care from their primary care physician or provider. Our care recommendations should be considered in consult with your physician. We will be pleased to coordinate your health care with your primary physician according to your wishes.*

   In accordance with Minnesota law, I am 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. Also, 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

3. **Fees for unit of service.** Fees are payable at the time of service by cash, check, or credit card.

Medical Care. We do not accept partial payment or waive payment. (See our Payment Policy).

4. **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.
5. **Description of Services.** Please see the article "What is Homeopathy," provided to you in your clinic information packet, and available in our reception room.
6. **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.
7. **Courteous treatment.** You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.
8. **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.
9. **Access to client records.** You are allowed access to records and other written information, in accordance with Minnesota Statutes, section 144.335.
10. **Other available services.** If you are interested in other available services in the community, you may wish to consult the Minnesota Homeopathic Association.
11. **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.
12. **Coordinated transfer.** If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.
13. **Refusing services.** You have the right to refuse services or treatment, unless otherwise provided by law.
14. **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**

_____ _____

Witness **Date**

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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 (if client is under age 18):_____ **Date:** _____

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

_____

_____

_____

_____

_____

_____

Vitamin and Mineral Supplements

Type and dosage

_____

_____

_____

_____

_____

_____

Allergies

I am allergic to the following medications:

_____

_____

_____

_____

_____

_____

Food allergies and method of testing

_____

_____

_____

_____

_____

_____

Please turn page.

Personal History

Lifestyle

List your favorite foods or cravings:

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

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 _____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Fees for Service

Adult and Children Initial Consultation. $400 (2-21/2 hours)

Follow-ups for all age groups $135- $150 depending on length

Acute Phone Calls, E-mails or Texts: $65

Urgent calls after hours or on week-ends may be accessed a higher charge.

There is no charge to clarify instructions or to order a remedy or a remedy refill by phone or text.

Hours:
Monday 10am – 2:30pm
Tuesday - Wednesday 10am – 6pm
Some evenings and Saturdays, on request

Debra takes office, phone and video appointments

Scheduling: Call 877-207-4801

Please give a 24 hours notice if possible for a cancellation of an appointment.

Payment is due at time of service