Welcome to the Practice of Ayurvedic Medicine at Om Shanti Wellness LLC!

Informed consent/Bill of Rights

Om Shanti Wellness LLC takes a unique seat in the team of Healthcare Professionals whom you have chosen to work with; whether you have current medical issues or are interested in optimizing your health as you go through life. Our most important guiding principle is that of client-centered care. The unique story of each individual is honored in the process of unraveling and clarifying the interwoven fabric of your health issues by careful history-taking, physical examination, and Ayurvedic medicine diagnostic evaluation.

What is Ayurvedic Medicine?

Ayurveda, a traditional medical science that originated in Ancient India, has been practiced for thousands of years and has treated millions of people worldwide. The emphasis of this medical system is on preventive health measures that are customized to the client's inborn normal physical and mental constitution (prakruti) as well as current imbalances (vikruti). Ayurvedic recommendations include but are not limited to: Yoga Therapy, Meditation, Pranayama (breathing exercises), Dinacharya (daily routine recommendations), Aromatherapy, Dietary Recommendations, Customized Herb and/or Spice Regimens.

Understanding of Ayurvedic recommendations offered by Om Shanti Wellness LLC

1. Intention of Program: To educate you about your individual constitution and assist you in bringing yourself back to balance and harmony with the laws of nature. As you begin to move towards balance, you become more conscious and your natural, innate intelligence wakes-up - you begin to naturally make choices that are nurturing, healing, and balancing. You will be educated and empowered to take charge of your own health and begin to develop the awareness to bring balance and health to each moment of your life, restoring you to your true joyful nature and present to the beauty and magic of life.

2. Outline of Services: An initial consultation, lasting 2-3 hours, is an opportunity to assess your current physical, mental and spiritual routines, your prakruti (fundamental state of balance) and

your vikruti (current imbalance). I will begin to educate you on your individual constitution and the basics of Ayurveda. You will be introduced to new practices as part of your plan for achieving balance. Practices may include first and foremost diet and lifestyle adjustments, but depending on your individual needs may also include herbal therapy, meditation, yoga, breathing exercises, or more all designed to further your education, awareness and ability to bring balance to your life. Periodic (~ monthly is suggested) 60 min. follow-up sessions will be recommended to monitor and support your progress. In this way you can integrate lifestyle changes over time and we can make any adjustments needed in your program. Ayurveda is not about instantaneous results, although you will see many immediate benefits. In accordance with the laws of nature, it will take time to gently restore full balance. Life is dynamic and we are part of life. We continually need to modify our lifestyle to the changing seasons, emotions, stresses etc. to achieve balance. Ayurveda is not a passive form of therapy but rather asks each individual to take responsibility for his or her own daily living. Using the ancient wisdom of Ayurveda I will educate, empower and support you as a dynamic individual, but it is up to you to bring this into your daily life. It is a simple, natural science that takes time, as it takes time for the stream to wear the stone smooth, but gently, over time it changes form completely. It is amazing the difference a small adjustment in your diet or lifestyle can make to create greater well-being. I am excited and honored to assist you in discovering your uniqueness and create a balanced life with radiant health and a peaceful mind.

Om Shanti Wellness LLC

Informed consent/Bill of Rights, cont'd

I understand that this is an educational Ayurvedic consultation for the purpose of helping me improve my health and wellness. I understand that Tiffany Reinitz of Om Shanti Wellness LLC is an Ayurvedic Practitioner who provides me with information on the Ayurvedic approach to health care, which may affect my diet and health in a positive way. I agree that I am interested in enhancing my own abilities to heal and establish health in mind and body, and this is the reason I have sought Ayurvedic consulting services. I agree that I should consult a licensed physician for any concern, at any time, about any disease or pathology that now exists or arises during my professional relationship with her. Furthermore, I understand that Tiffany Reinitz of Om Shanti Wellness LLC encourages regular medical check-ups from a licensed medical professional of my choice, and that any medication that I am now taking it upon my licensed physician's advice, or will take in the future, is taken strictly according to my licensed physician's directions. Only a licensed physician of my choice can advise on medication dosages or the discontinuation of medications My signature below acknowledges the above statements as fully read and understood.

Patient Name: (Please print name):_____
Signature of Patient or Guardian:_____Date:_____
Signature of Witness: _____ Date: _____

Waiver of Liability I, the undersigned, hereby confirm that I am consulting with Tiffany Reinitz of Om Shanti Wellness LLC, of my own free will. I understand that there will be no diagnosis made, nor pharmaceutical prescription given, but that Tiffany Reinitz of Om Shanti Wellness LLC will offer an assessment of my general health based on Ayurvedic methods, and will make dietary, herbal and physical exercise recommendations to support my health. I understand the importance of frequent monitoring by my Medical practitioner and Ayurvedic practitioner for necessary treatment modifications.

Patient Name: (Please print name):_____
Signature of Patient or Guardian:_____Date:_____
Signature of Witness: _____ Date: _____

All patient history, exam and progress notes recorded will be kept strictly confidential. Information contained herein will not be released to any person or agency except with your authorization or where required by law.

HIPAA - Notice of Privacy Practices

We are required by federal law to provide you with a "Notice of Privacy Practices." This notice describes how health information that we maintain about you may be used or disclosed. It provides a description of your rights and our obligation under federal and state privacy laws.

The confidentiality of patient information has always been a high priority for us. Our employees are constantly reminded of its importance. This ethic will not change.

The Federal Government has passed a law – the Health Insurance Portability and Accountability Act (**HIPAA**). The law formally protects your Protected Health Information (**PHI**), which includes your demographics (address, phone number, etc.) and all your health information.

Under the law you have specific rights – subject to certain exceptions and

limitations: 1. To receive a paper copy of this "Notice of Privacy Practices"

2. To review your medical records with your Ayurvedic Practitioner and to request an amendment of the health information in your file, if you believe it is inaccurate. If your request to amend your health information is denied, you may submit a written statement to Om Shanti Wellness LLC disagreeing with the denial which we will keep on file and distribute with all future disclosures of the information to which it relates.

3. To an accounting of certain disclosures made by this office of your PHI made during the 6 yr. period preceding the date of your request. Exceptions include, disclosures regarding diet and lifestyle recommendations, disclosures made to you as a client, payment, or health care operations purposes: disclosures to your family or close friends involved with your care; or for notification purposes.

4. To examine and copy your protected health information. To arrange access to your records or to receive a copy of your records a written request should be submitted to our privacy officer or to the medical records office.

5. To request restrictions, other than regarding emergency circumstances, on the allowable uses and disclosures of your PHI. Such restrictions may include prohibitions on disclosure of certain types of PHI or certain persons you do not wish to have access to your PHI. Om Shanti Wellness LLC is not required to agree with these restrictions. To request a restriction, submit a written request to our privacy officer.

Om Shanti Wellness LLC complies with the privacy law.

Om Shanti Wellness LLC:

- May use your PHI, without separate consent or authorization from you for recommendations, payment or facility operations in connection with services rendered by us, to you. For example we may provide your past medical history to a provider you've been referred to or we may provide your personal health information to your insurance plan or to support our request for reimbursement. We may also, with your consent, disclose your PHI to family members and close friends involved in your care.
- Will download your complete medication history into our electronic medical records, as part of your PHI (if applicable)

- May be required to disclose your PHI, without your consent or authorization, if required by law. For example, the law requires that certain PHI be disclosed in connection with protection of the public health, for governmental health oversight activities, in response to a valid subpoena or other judicial process, in response to certain law enforcement inquiries, or to lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures other than those specifically referenced above or otherwise allowed by law, will be made only with your written authorization and you may revoke such authorization, in writing, at any time.

We may contact our clients by phone or e-mail to provide appointment reminders. A message about the appointment reminder may be left on your answering machine or on your work voicemail. Please alert us if you do not want this done.

Marketing Materials: You will not receive any marketing materials from us, unless we first receive a separate written consent form, executed by you, allowing us to provide you with such information.

Changes to the Notice: Om Shanti Wellness LLC may change the terms of this written notice and may make the new notice provisions effective for all protected health information that we maintain. If we do so, we will provide you with a copy of the revised notice upon request, and we will post the notice, with the effective date, in a visible location in this office. This notice may at some point in time also be posted on our website.

Complaints: If you believe your privacy rights have been violated you may complain to us and to the Secretary of the United States Department of Health and Human Services. If you have any questions about this, or wish to file a complaint with this office, please file a written complaint with our designated privacy officer. You will not be retaliated against in any way for the filing of the complaint.

Designated Contacts:
Om Shanti Wellness LLC, C/O Tiffany Reinitz
PO Box 727, Henderson, MN 56044

Effective date of this notice 8/4/2021; Reviewed: March 2023

Demographics

Name (Last, First, MI):_____

Date of Birth (MM/DD/YYYY):_____

How do you prefer to be addressed? (Please Circle): Ms. Mr. Mrs. Dr. First Name

Pronoun: He/She/They/_____

Mailing Address:

_____

City: _____ State: _____ Zip Code: _____

Shipping Address (if different):

_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) -_____
Cell Phone: (_____) -_____
Work Phone: (_____) -_____
Fax: (_____) -_____

Do I have your permission to leave any messages on: Day Phone? (Circle): YES NO Do I have your permission to leave any messages on: Evening Phone? YES NO

Email: _____
Employer: _____
Occupation:_____
Physician: _____ Date of last Physical: _____

Dentist: _____ Date of last Visit: _____

Emergency contact name: _____; Phone: _____

Who referred you to the Clinic: _____

Acknowledgement

I acknowledge full responsibility for the payment of services and agree to pay for them, in full, at the time of service unless other arrangements have been made with the office in writing.

Client's or Guardian's Signature: _____

Client's Name (Please Print): _____

Credit Card Authorization (optional)

I give my permission to Om Shanti Wellness LLC., to keep my credit card on file. This card is to be used only when I approve the charges and in the event of appointment cancellations 48 hours or less before the time of the appointment.

CC# _____ Exp. _____

CVV#_____ Client's or Guardian's Signature:

_____ Client's Name (Please Print):

_____

Om Shanti Wellness LLC - Client Medical History

Name: _____ **DOB**: _____ **Date**: _____

As a new client, we first would like you to answer the questions below so that we can get an idea of your past medical history. On the last page of this form, you will have an opportunity to write a "free-write summary" in which you can tell us your story in your own words.

Present Age: _____ **Height**: _____**Ft** _____ **Inches**; **Present Weight**: _____

Are you currently under the care of any providers of alternative medicine? YES ☐ NO ☐ Practice Type: _____
Provider Name: _____ Phone Number: _____
If in the past you had seen providers of alternative medicine/healers, please list the type of work they did (e.g. Acupuncture, Reiki, Energy Healing, etc.): _____
_____

Are you allergic to any medications? YES ☐ NO ☐
If yes, please list the names of the medications and your reactions to them:_____
_____
Are you allergic to any materials, food, or environment? (Example: Latex, Cat Dander, Peanuts) If yes, please list the substances and your reactions to them: _____

_____

<u>For Women</u>:

Are you currently pregnant? Y/N If yes months/weeks along _____, due date _____
Are you currently trying to conceive? Y/N
If sexually active, what is your method of birth control? _____
Number of pregnancies:_____ Number of Live Births:_____
Age when periods started: _____ Age when periods ended (if applicable):_____
Are your periods regular or irregular? _____
Pain or heavy bleeding during periods?_____
Premenstrual Symptoms?_____

Do you have a present or past history of:

Y N Anemia. If yes, list type:

Y N Arthritis. If yes, list type:

Y N Asthma

Y N Depression

Y N Anxiety

Y N Autoimmune Disorders. If yes, list type:

Y N Cancer.

Y N COPD

Y N Heart disease - please circle (CHF, Coronary Artery disease, Congenital Heart Disease, heart attack, arrhythmia, heart murmur, valve disorder, pacemaker)

Y N Diabetes. If yes, circle type: Type I Type II

Y N Eczema

Y N Glaucoma

Y N Inflammatory Bowel Disease

Y N Hepatitis or Liver Disease

Y N High Blood Pressure

Y N Hypothyroidism

Y N Hyperthyroidism

Y N Hay Fever/Seasonal Allergies

Y N Lyme's Disease

Y N Migraines

Y N Multiple Sclerosis

Y N Peptic Ulcers

Y N Psoriasis

Y N Rheumatic Fever

Y N Seizure Disorders

Y N Sleep Apnea

Y N Stroke or Transient Ischemic Attacks

Y N Tuberculosis

Y N Prolonged Steroid Therapy or other Immune Deficiency State?

Y N Issues with Prolonged Bleeding?

Please circle if you have been diagnosed with any of the following: Irritable Bowel Disease, Chronic Fatigue/CFIDS, Fibromyalgia, or Environmental Sensitivity

Any other current or past medical problems? *including illnesses, diseases, injuries, trauma, mental illness, addictions, changes in weight, or any information you believe will help clarify your health history*

1. _____
2. _____
3. _____
4. _____
5. _____

Surgeries: What was done? Date of surgery Any Complications?

1. _____
2. _____
3. _____
4. _____

Please list any hospitalizations that you have had (do not include visits to the ER):

_____
_____

Family History

Still Alive? Age now or age of death? Cause of Death or Medical Problems:

(include any cancers, heart issues, mental health issues, substance abuse etc)

Father yes/no _____

Mother yes/no _____

Brother yes/no _____

Brother yes/no _____

Sister yes/no _____

Sister yes/no _____

Child yes/no _____

Child yes/no _____

Additional_____

Family of Origin: *Where you grew up, what your family was like growing up, any information you think important about your family*

_____

_____

_____

Please list all current doctor-prescribed medications: **Name, Strength, Dosage**
(Example: **Name:** Metformin **Strength:** 1000mg **Dosage:** One pill twice daily)

_____
_____
_____
_____
_____
_____
_____
_____

Please list all current herbal or alternative supplements: **Name, Strength, Dosage**
(Example: Arnica 30X, 5 pellets 3 times daily)

_____
_____
_____
_____
_____
_____
_____

Please list all herbal/alternative supplements that you have taken in the past year+ and no longer take:_____
_____
_____
_____
_____

Please list all over-the-counter medications you are currently taking: **Name, Strength, Dosage.**
(Example: Tylenol 500 mg, 1 pill every 8 hours)

_____
_____
_____
_____
_____

Social History

Single _____ Married _____ Divorced _____ Partner/Significant Other _____

Widowed _____ Number of Children: Total _____ How many still living at home? _____

Do you drink alcohol? How much & how often? _____

Do you use tobacco? YES ☐ NO ☐ Former Smoker, Quit year:_____
If yes, how many packs per day?_____ For how many years? _____

Do you use any other drugs (marijuana, cocaine, etc)? How much/often?_____
Caffeine use: (per week) _____ **Type** (i.e. coffee, energy drinks, soda) _____

What is your daily/weekly exercise routine?

_____

Do you practice yoga/meditation/breathwork? If yes, what is your routine?

_____

Dietary Information:

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Snacks _____

Toxic Exposures? (for example asbestos, mercury) Yes/No If yes, what?

_____

Sleep: please circle: Excellent Good Poor Terrible

Work History: Current & past employment/work/how you make your living

_____

Traumatic Events in Your Life: Abuse, significant deaths, accidents, injuries, health conditions

_____

_____

Religious or Spiritual History (past/current)**:**

_____

“FREE WRITE” AREA

What is the primary reason & goals for this consultation & Ayurveda as a modality of health? What are the most important things about you and your life that you feel I should know about (ex. Current health concerns, problems, or anything else you want to share)? Feel free to include a summary of your history, your current diet and lifestyle, or anything you feel is pertinent. You can also use this space to continue answering any of the questions from the history form above.

Printed Name:_____ Signature:_____ Date:_____

Clinical States of Agni --Self-Assessment

Place a Y in any category that is true for you:

____ Appetite changeable

____ Appetite changes with travel or any disruption of routine

____ Sometimes can skip a meal without noticing or without needing to eat

____ Usually appetite is strong, but sometimes it is not

____ Appetite is usually good but sometimes it is weak

____ Energy is variable, comes and goes

____ Coating on the tongue

____ Tendency to have gas/ flatulence

If more than one answer is YES in this category, then digestion is visama, vāta is affecting agni.

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____ Appetite is always strong

____ Need to eat three meals a day

____ Cannot skip. any meal

____ Need to snack between meals.

____ Excessive thirst

____ Hypoglycemic tendencies

____ Irritable if meal is delayed

____ Can eat heavy food any time of day

____ Can eat large meals any time of day

____ Can digest anything

____ Tendency to have diarrhea

____ Have raw or undigested food in stools

____ Can eat often and not gain weight

If more than one answer is YES in this category; then digestion is tiksla and pitta is affecting agni.

____ Appetite is dull

____ Digestion can take 5. - 6 hours per meal.

____ Can skip meals easily

____ Do not eat breakfast and skip other meals regularly

____ Heavy foods are hard to digest

____ Large meals are hard to digest

____ Feeling of heaviness, dullness, lethargy after eating

____ Tendency to gain weight

____ Rarely snack

___ feel cold after eating food

If more than one answer is YES in this category, then digestion is manda and kapha is affecting ägni.

Results of this survey: My agni is: viṣama/variable, tīkṣṇa / sharp, manda/ dull or slow

Clinical States of Ama--Self-Assessment

Circle your response (1 = least; 5= most) to find out your ama score

1. I tend to feel blocked in my body (constipated, congested in the head, general lack of clarity)

1 2 3 4 5

2. In the morning when I wake up, I'm groggy; it takes me quite a while to feel really awake,

1 2 3 4 5

3. I tend to feel weak, physically, for no reason that I can see.

1 2 3 4 5

4. I get colds (or similar conditions) several times each year.

1 2 3 4 5

5. My body tends to have a feeling of heaviness.

1 2 3 4 5

6. I just tend to feel that "something isn't working right" in the body (digestion, breathing, bowel)

1 2 3 4 5

7. I tend to feel lazy. (My capacity to work seems all right, but I have no inclination.)

1 2 3 4 5

8. I commonly have indigestion.

1 2 3 4 5

9. I often have to spit

1 2 3 4 5

10. Often, I just don't have a taste for food. I have no appetite.

1 2 3 4 5

11. I just tend to feel tired, even exhausted in mind or body.

1 2 3 4 5

Add up your scores to arrive at a rating of your level of ama.

45-55: Severe 25-35: Mild 35-45: Moderate 11-25: Minimal

This Questionnaire is taken from the book "The Answer to Cancer", authors Sharma and Meade