Chari Center of Health

Advanced Holistic Medical Healthcare

General Medical Questionnaire

NOTE: This Client Questionnaire MUST be completed prior to your appointment with Dr. Chari. All information that you give on this questionnaire and during any consultation and/or sessions is kept strictly confidential.

CLIENT INFORMATION

First Name_____ Date of Birth_____

Middle _____ Age_____

Last_____

Circle: M F Circle : Mr Miss Mrs Ms.

Circle: Single Married Separated Divorced Widowed

Email_____

Street Address_____

City, State & Zip code_____

Home Phone#_____

Cell Phone#._____

Employer_____

Employer City, State, Zip_____

Work Phone#_____

Who Referred you to the Chari Center? _____

EMERGENCY CONTACT INFORMATION

Name of Local Friend or Relative (not living at same address)_____

Relationship to Client: _____

Best Phone No._____

Address, City, State:_____

DISCLAIMER PLEASE NOTE:

Dr. Chari is NOT a primary healthcare physician. Please consult your primary care physician for your annual physical exam, prescription refills & emergency medical needs. Please sign below to indicate that you understand these terms, and consult Dr. Chari, Deepak Chari and the Chari Center at your own risk/responsibility.

Name:_____ Date:_____

Chari Center of Health

Advanced Holistic Medical Healthcare

Name:	Date:	Age:	Sex:

Please answer the questions below:

Are you currently under the care of a psychiatrist? **Yes** **No**

If yes, what condition(s) are you receiving treatment for? Also, what medications have been prescribed by your psychiatrist (dosage, times per day and how long you have been on the medication(s)? Use additional paper if necessary.

_____

Do you have a Pacemaker? **Yes** **No**

Do you have an implantable defibrillator? **Yes** **No**

History of Seizures/Epilepsy? **Yes** **No**

History of Bi-Polar Disorder? **Yes** **No**

Are you currently being treated with Lithium? **Yes** **No**

Are you currently being treated with Dilantin, Phenobarbital or other anti-seizure medications? **Yes** **No**

Do you have a history of suicide attempts? **Yes** **No**

If yes, when did this occur? (Please provide more details and use additional paper.)

_____

Do you have any history of brain tumors? **Yes** **No**

If yes, when? _____

Do you have any pins/clamps/plates inside your body (i.e. from knee/hip replacement surgery or other joint surgery)?

Do you have a history of high blood pressure? **Yes** **No**

Do you have a history of a heart attack? **Yes** **No**

Have you had angioplasty, stents or bypass Surgery? **Yes** **No**

Do you have a history of a stroke? **Yes** **No**

Are you on the medications Coumadin or Plavix? **Yes** **No**

Do you have a history of migraine headaches? **Yes** **No**

Do you have a history of hypo- or hyperthyroidism? **Yes** **No**

Are you sensitive to bright lights or sounds? **Yes** **No**

If you're a woman, are you currently pregnant? **Yes** **No**

Do you have Incontinence (leaky bladder)? **Yes** **No**

1. **What is the main reason you are here? What do you expect from our services?**

2. **What are your current medical/psychological concerns? Please rank your current concerns and rate their severity (on a scale of 1-10; 10 being the most severe).**

3. **What treatment(s) have you received for each of the conditions mentioned above? (e.g., acupuncture, chiropractic, herbs, supplements, medications, surgery, etc.)**

4. **Do you have any allergies (including medications, food, environmental, pets, supplements such as spirulina, chlorella, blue-green algae, barley greens, etc.)?**

5. **Medications: Please list any prescription and non-prescription (over the counter) medications you are currently taking. Include birth control pills, aspirin, any kind of pain medication, antacids, etc.**
   - **Drugs you are on? Give the dosage (milligrams) & # of times per day.**
   - **How long have you taken each medication (days/weeks/months/years)?**
   - **Why are you on each of the Medications?**

6. **Are you currently or have you in the past experienced any side effects due to the medications?**

7. **What vitamins, herbs, minerals, enzymes, oils, bioidentical hormone replacement therapy and/or other supplements do you take on a regular basis?** Use additional paper if necessary.

8. **Have you had any benefits and/or side effects with natural supplements?**

9. **Do you have a history of …? Highlight or mark your conditions with an X.**

High Blood Pressure		Bronchitis	
High Cholesterol		Prostate issues	
Diabetes		Ovarian cysts	
Arthritis		Uterine Fibroids	
Asthma		Thyroid conditions (hypo or hyperthyroid)	
Cancer	Type	Year Diagnosed	Treatment received

10. **Past Medical History (previously diagnosed illnesses/treatment/hospitalization)**

11. **Do you have a history of HIV/AIDS and/or Hepatitis C?**

    When were you first diagnosed?

    What treatment(s) did you receive and/or are currently receiving?

12. **Past Surgical History (i.e. surgery on the heart, tonsils, appendix, uterus/ovaries, prostate, gallbladder, hip/knee replacements, arthroscopic surgery on joints, etc.) What surgeries or operations have you had? What date(s) were the surgeries?**

13. **Do you have any metal/plastic inside your body? For instance, pins/clamps/plates, etc. from hip/knee replacement/joint surgery**

14. **Have you had elective/cosmetic surgery?** Highlight: face lift, breast implants, rhino-plasty, tummy tuck, liposuction, cheek implants, chin implants, other?

    Have you used Botox injections? Yes No

    If yes: How many treatments?

    How many days or weeks apart were each of the Botox injections?

15. **Do you have tattoos?** Yes No

    If yes, when did you get the tattoos?

16. **Have you had any motor vehicle accidents (i.e. car/motorcycle)?** Yes No

    When did the accident(s) occur?

    Were there any injuries after the accident(s)?

17. **Rate your current stress level** (on a scale of 1-10; 10 being the highest stress)

    What is the main reason(s) for your stress?

    If over Level 5, what step(s) are you taking to reduce your stress level?

18. How is your digestion? Highlight whatever applies…

Adequate	Poor	Acid Reflux	Burping often
Bloating	Heartburn	Stomach	Gas

19. How is your sleep?

Restlessness Hard to get to sleep Wake up often

Other sleep complaints:

What time do you usually go to sleep?

Do you have trouble falling asleep, staying asleep or both?

What time do you usually wake up during the night?

Do you sleep with a clock-radio near your head (within 1-2 ft.)?

Is there a computer/TV in your bedroom?

Is there considerable light in the room when you sleep?

Do you frequently eat dinner after 7:00pm?

Do you eat late night snacks on a regular basis?

Do you drink caffeine (coffee/tea/soda) in the late afternoon or evening?

20. Who is your primary care physician?

Name:

Address:

Phone:

21. Do you consult any specialists?

Name:

Address:

Phone:

Name:

Address:

Phone:

22. On average, how much water do you drink per day? (in fluid ounces)

23. What type of water do you drink? Highlight what applies…

Reverse osmosis	Distilled water	Alkaline water
Tap water	Filtered	Other?

24. How many bowel movements do you have per day or per week?

Do you skip days?

Is there any of the following in your stool? Blood Mucus Foul smell

Consistency of stool: normal too hard very soft diarrhea

Other complaints:

25. Dental History

How many amalgam (mercury) fillings do you have?

How many gold fillings do you have?

Did you have any amalgam fillings removed?

Did you have heavy metal detox after their removal?

If so, what type of detoxification was done?

Have you had any root canals done? How many?

When was each one done?

Have you had any teeth removed, such as wisdom teeth or molars?

If so, when were they removed?

Have you had any other dental surgery (gum or jaw)?.

If so, what type and when?

Do you have dentures? If so, what type – partial or full?

Do you need further dental work? What type?

Who is your dentist?

Name:

Address:

Phone:

26. For Women only

Are you pregnant? If so, when are you due?

Are you breast feeding?

Do you have monthly periods? Date of last period:

Are you going through menopause?

Have your periods stopped? If so, when did they stop?

Have you had your uterus or ovaries removed? If so, when?

Menstrual cycle:

Are your monthly periods regular? How many days between?

How many day does your flow last?

Do you have any of the following symptoms associated with your period? Highlight or X.

Cramping	Bloating	Feeling weak	Mood swings
Heavy bleeding	Back pain	Headaches	Dark clotting blood
Bright red blood	Any other complaints?		

27. Sunlight

Amount of natural sunlight you receive daily outside?

Amount of sunlight you receive through the window?

Number of hours spent under fluorescent lights?

28. Eyewear

Do you wear contact lens? If so, how many hours per day?

Do you wear glasses? If so, for distance or reading?

29. Electromagnetic Exposure: How many hours do you spend daily…

Watching television?

Working on the computer?

Talking on the cell phone?

Using a Blackberry or equivalent?

Wearing a pager?

Wearing a headset?

Wearing a blue tooth?

Carrying your cell phone in a pouch near your waist?

Carrying an electronic device (i.e. blackberry) in a pouch near your waist?

Wearing a wristwatch?

When you sleep is your head within 10 ft. of a plug-in clock?

Do you live or work within ½ mile of a cell phone tower?

Do you live or work near high-power lines?

Do you use an electric blanket while sleeping?

30. What type of cookware do you use?

Stainless steel	Aluminum	Iron or cast iron
Teflon-coated	Glass	Other?

31. Shower Filter: Do you have a shower filter for chlorine protection?

32. Personal Care Products

What household cleaners do you use?

What type of detergents do you use?

What hair products do you use?

What skin-care products do you use?

What toothpaste do you use?

What deodorants do you use?

What cosmetics do you use?

Do you use air-freshening sprays at home?

33. Family History

Age		Age	
	Mother		Aunts
	Father		Uncles
	Siblings		Grandmothers
	Siblings		Grandfathers

Where were you born and raised?

How long have you been in your current location?

Are you currently married or in a committed partnership?

How many times have you been married?

Have you been divorced? How many times? When?

How many children do you have? For each one…

Child's name Age Health conditions

34. Occupation:

35. Are you currently addicted to any of the following? (Info kept in strict confidence.)

Cigarettes	Alcohol	Recreational Drugs
Pain-killers	Prescription drugs	Food / sugar/ chocolate
Cocaine	Crystal meth	Marijuana
Heroin	Sex	Other?

If so, what counseling and/or treatments did you receive?

Have you attended AA and/or other Support Groups?

36. Do you currently smoke?

If so, how much/often do you smoke?

What age did you start?

How long have you smoked?

What do you smoke – cigarettes, cigars, pipe, marijuana, etc.?

When you do you smoke? Socially, alone, after meals, etc.

If you still smoke, have you tried quitting in the past?

If you no longer smoke, when did you quit?

What motivated you to quit smoking?

How did you quit smoking? (e.g., hypnosis, medications)

37. **Do you currently drink alcohol?**

If yes, how much and how often?

What age did you start drinking alcohol?

For how long have you been drinking alcohol?

What type of alcohol do you consume – beer, wine, spirits, etc.?

How much do you typically drink at a time?

When do you drink – socially, alone, with meals?

If you still drink, have you tried quitting in the past?

If you no longer drink alcohol, when did you quit?

What motivated you to quit drinking?

How did you quit drinking?

38. **Do you currently use any recreational drugs** (inc. oral, inhaled, intravenous)**?**

If yes, which type of drugs do you use?

How often? (times per week, day, or month)

When did you start using drugs?

For how long have you used drugs?

Have you tried quitting in the past?

If you no longer take drugs, when did you quit?

What motivated you to quit taking drugs?

How did you quit using drugs? (through hypnosis, medication, etc.)?

39. What is your typical diet? (over the last few weeks) Include the time meals are eaten and all food/beverages. Please go into detail!

Meal	Time	Foods/beverages
Breakfast		
Lunch		
Dinner		
Snacks		

Do you eat out often at restaurants

How many times a week do you eat out?

Where do you usually eat out?

What type of food do you eat at restaurants?

Do you prepare meals at home?

How often do you eat freshly prepared meals at home?

What oils do you use in your cooking? (Olive oil, canola, butter, etc.)

Do you skip meals often?

Do you have irregular eating times?

Do you eat your dinner past 7:00pm?

Do you drink freshly prepared fruit smoothies? If yes how often?

Do you drink freshly vegetable juice (from a juicer)? If yes how often?

How many servings of fruits and vegetables do you eat a day or week?

Is your produce mainly organically grown or commercial?

Do you mainly purchase your produce from the Farmers markets, Health Food Stores or commercial grocery stores?

How much soda/pop do you consume a day/week?

What soda do you drink? Is it in a can or plastic bottle?

How much coffee, black tea or “decaffeinated” coffee or black tea do you consume per day/week? Do you add cream/sugar?

Do you drink Green Tea? If so, how many cups per day/week?

Do you drink herbal teas? What type and how often?

How long have you been drinking this amount of coffee, tea or soda?

Do you drink any diet drinks or eat diet foods that contain artificial sweeteners such as Apartame, Nutrasweet and/or Splenda?

How much dairy do you consume per day/week?

For example, milk, eggs, cheese, yogurt, ice cream, cottage cheese, pudding…

Is it organic or commercial? What brand?

How much meat do you consume per day/week?
This includes beef, chicken, pork, turkey, lamb, fish, all seafood, all game animals.

Does your meat come from animals raised naturally or commercially?

Where do you usually buy your meat?

Farmer's market Health food store Grocery store

40. Exercise

What type of exercise do you do?

How long do you exercise at a time?

How many times a week do you exercise?

For how long (weeks/months/years) have you been exercising?

41. Relaxation:

What do you do to relax? (e.g., meditation, yoga, reading, etc.)

How many times a week do you take to take time out to relax?

What are your hobbies? What do you enjoy doing?

42. Parents and Upbringing

Please describe the personalities of <u>both</u> of your parents and/or step-parents. Also describe how your parents treated each other while you were growing up. If your parents divorced, why did they divorce and how old were you when they divorced? (Use additional paper if necessary.)

Mother:

Father:

Stepmother:

Stepfather:

Relationship:

Divorce:

43. **Describe your childhood and what it was like growing up in your household with your parents, siblings and other significant relatives (who had an impact on your life. Were they loving & close, supportive, distant, abusive, traumatic, fearful, estranged, other? In addition, which parent(s) or siblings are you closest to?**

    Childhood conditions:

    Siblings or other relatives

44. **Describe the personalities of your current spouse/partner, and ex-spouses/partners:**

    Current:

    Significant Ex:

    Significant Ex:

45. **Describe your relationship with your current spouse and significant previous relationships** (e.g., loving, supportive, abusive, traumatic, other?):

    Current:

    Significant Ex:

    Significant Ex:

46. **If you have been divorced, what led to the divorce(s)? With previous significant relationships, what led to the break-up? (e.g., incompatibility/ jealousy/abuse)**

47. **If you are with someone, how happy are you in this relationship?**

    What would you like to change?

48. **What is your relationship like with your children and/or stepchildren – loving, distant, estranged, other?**

Describe your children's personalities, their health and/or emotional concerns?

What traumatic events have significantly impacted your life, such as divorce, illness, death of a loved one, accident/injury, serious health issue, or problems with your career or business? When did those events occur?

50. Do you have a history of having experienced abuse? What kind(s)?

Physical abuse Sexual abuse Verbal abuse Emotional abuse

If yes, please answer the following in the lines next to the question and any write any additional information in the paragraph below, using additional paper if necessary.

How old you were when the abuse started?

How long (days/months/years) did the abuse continue?

What occurred during the abuse? By whom were you abused? (For example, parents or step-parents, parent's boyfriends or parent's girlfriends, relatives, neighbors, friends, spouses, significant relationships, other?)

51. What treatments for the abuse (i.e. counseling/medications) did you receive?

52. How many months/years of counseling did you receive?

53. How long were or are you treated with medication(s)?

54. What support did you receive (i.e. other family members, friends or teachers) to help you at the time of the abuse?

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Advanced Holistic Medical Healthcare

Name:		**Date:**	
Age:	**Birthdate:**	**Date of last exam?**	

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Injury
- ☐ Back ☐ Hips
- ☐ Neck ☐ Legs
- ☐ Shoulder ☐ Knees
- ☐ Arms ☐ Feet
- ☐ Hands ☐ Other

Genito-Urinary
- ☐ Blood in urine
- ☐ Cystitis
- ☐ Frequent urination
- ☐ No bladder control
- ☐ Painful urination

Gastro-Intestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling ankles
- ☐ Varicose veins

Ear/Nose/Throat/Eyes
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficult swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hayfever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that don't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other?

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Blood spotting
- ☐ Breast lump
- ☐ Cramps
- ☐ Menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other?

Last period _____

Last pap smear _____

Mammogram?_____

Pregnant? _____

No. of kids? _____

CONDITIONS and DISEASES, past or present – check ALL that apply.

- ☐ AIDS/HIV positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chem. dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ MS / ALS
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric issues
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Suicide attempts
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Bleeding disorders
- ☐ Tuberculosis
- ☐ Typhoid / Typhus
- ☐ Ulcers
- ☐ Vaginal infections

MEDICATIONS	**ALLERGIES**	

Chari Center of Health

Advanced Holistic Medical Healthcare

INFORMED CONSENT

Patient Name: _____ Date: _____

I UNDERSTAND THE FOLLOWING:

1. I understand that Roopa Chari, M.D. is a California licensed medical doctor qualified to diagnose, treat, prevent and cure any of my medical, physical, emotional, mental or psychological diseases, disorders or conditions while practicing under the scope of practice defined by her license. I also understand Dr. Chari is qualified in providing nutritional counseling and is a biofeedback and sound therapist. I further understand Dr. Chari is qualified to supervise biofeedback and sound therapy practitioners and interventions to help me achieve my health goals.

2. I understand Mr. Deepak Chari is a Certified Biofeedback Specialist. He is qualified to help me identify the causes of my stress and pain and to assist me in reducing my stress, managing my pain, enhancing the quality of my life and improve my peak performance. I also understand Mr. Deepak Chari is a qualified sound therapist. I further understand Mr. Chari performs these therapies under the supervision of Dr. Roopa Chari.

3. I understand that I am responsible for my health and well being; and I am interested in taking care of my body, resolving my emotional issues, reducing my stress and enhancing the quality of my life.

4. I further understand alternative healing is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.

5. I understand certain services provided by Dr. Roopa Chari and Mr. Deepak Chari are contraindicated for women during pregnancy, people with a pacemaker, implantable defibrillator or insulin pump, people with certain allergies and people with certain medical and psychiatric conditions. I also understand all healing may cause me some minor discomfort in the form of aches and pains, headaches, emotional release or increased emotionality. If I have any concerns about these things, I will keep Dr. Roopa Chari and Mr. Deepak Chari fully advised about my concerns so the intervention may be terminated if necessary or revised to minimize any harm to me.

6. I understand both Dr. Roopa Chari and Mr. Deepak Chari will keep all information they learn about me completely confidential unless I release them in writing or as specifically required by law. I further understand both Dr. Roopa Chari and Mr. Chari will not discuss anything with me publicly unless I initiate the conversation and the topics of discussion.

7. I have disclosed all of my known drug and food allergies.

8. I have disclosed all prescription and over the counter medications, supplements, vitamins, minerals, enzymes, herbal remedies and/or other remedies I am currently taking.

9. I have disclosed other therapies, such as medical, chiropractic, acupuncture, homeopathic, or other treatments that I am currently undertaking.

10. I understand that the recommendations given by Dr. Chari are not intended as substitute for conventional medical care.

11. I further understand that Dr. Chari and the Chari Center of Health, Inc. does not make any claims medical, or otherwise or any guarantees on their work and in return services all clients to the best of their ability.

12. I further understand that all therapeutic procedures whether natural alternative treatments or procedures or conventional medicine treatments or procedures involve possibilities of unsuccessful results from both known and unknown causes.

13. I further understand that in medical practice, (whether alternative or conventional), no warranty or guarantee can be made as to result or cure.

14. I understand that I have the opportunity at any time to obtain a second opinion regarding any treatments or procedures.

15. I understand that services such as laboratory work, x-rays and/or referrals to specialists may be necessary and I agree to see my primary care physician for follow up care if necessary.

16. I have the right to consent to or to refuse any recommended treatment or procedure anytime prior to its performance.

17. I understand that Dr. Roopa Chari and Mr. Deepak Chari will discuss their fees with me prior to administering any therapies or conducting any medical services.

18. I understand that all fees are due and payable in full at the completion of each appointment. I understand the Chari Center of Health charges a fee for all services which is payable by cash, credit cards (Master Card & VISA), debit cards, money order or check at the time services are delivered. In the event my check is not honored by my bank, I agree to pay an additional fee of $35.00 for this inconvenience. The charges for the consultations and sessions are subject to change.

19. I understand that the Chari Center of Health, Inc. does not accept insurance as payment for services nor does it submit claims to insurance carriers. Patients will be given receipts upon payment of services rendered. The Chari Center of Health does not participate in any insurance programs, whether government and private.

20. I understand that Dr. Chari will not be my primary care physician and I must have another primary care physician other than Dr. Chari.

21. I understand that Dr. Chari is not affiliated with any hospital or Medical Management company.

22. I understand that Dr. Chari does not provide emergency services or after hours care and should an emergency arise, I will need to contact my primary care physician and/or seek medical attention from an Urgent Care Center or Emergency Room.

23. I understand that Dr. Chari has the legal right to refuse to treat me either before, during or after the initial consultation based on Dr. Chari's assessment of her comfort level in treating my medical condition. I understand that if Dr. Chari does not feel comfortable treating my medical condition, she may refer me to another Medical Doctor and/or Medical Specialist or other health care practitioners. I also understand that I do have a primary care physician who is other than Dr. Chari.

24. I understand that the Zyto EVOX, Zyto Balance Scan, Metabolic Analyzer, AmpCoil technologies, the mind/body techniques, ancient healing techniques, natural remedies, supplements, herbal remedies, natural health programs and detoxification programs are not intended to diagnose, treat or cure any medical condition.

25. I understand that Dr. Roopa Chari will not call or write letters on my (patients) behalf to Insurance companies for any correspondence including reimbursement, Diagnosis codes, CPT codes, etc. for any medical consultations, treatments with any of Chari Center technologies (Zyto Balance, Zyto EVOX, Metabolic Analyzer, AmpCoil). Dr. Chari will also not write letters or send Medical Records to Government Agencies, Workman's Compensations, Disability Claims and other Agencies regarding my (patient) medical evaluation, condition, treatment and progress.

26. I understand that I must give 24-hour notice for the cancellation of my consult or I will be charged the full price of the consultation for which I was scheduled.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Dr. Roopa Chari, M.D. & Mr. Deepak Chari from and against any and all claims of liability of whatsoever kind or nature arising out of or in connection with my session(s). The Chari Center of Health agree to settle any disagreements I have with the Chari Center of Health, Dr. Roopa Chari or Mr. Deepak Chari. If this is not possible, then I agree to turn to engage the services of Peacemaking and Conflict Resolution Services (PMCRS.com) to mediate an agreement acceptable to both myself and the Chari Center of Health, Dr. Roopa Chari and Mr. Deepak Chari.

By signing below, I acknowledge that I have read and understand this form. I agree to allow Dr. Roopa Chari, Mr. Deepak Chari and any other qualified employees of the Chari Center of Health to provide the natural healing services, techniques and modalities I agree to receive.

Patient Name

Patient Signature Date:

Physician's Signature Date

Chari Center of Health

Advanced Holistic Medical Healthcare

DIRECTIONS TO THE CHARI CENTER

Coming from South of Encinitas, CA

- Take I-5 N/San Diego Fwy N toward Los Angeles
- Take the Manchester Ave exit, (EXIT 39)
- Turn left onto Manchester Ave (this will turn into El Camino Real)
- Turn right onto Manchester Ave
- **4401 MANCHESTER AVE is on the left side (Landmark is our building is next to Rite Aid and on the driveway is a sign that says "Office Condomiums")**

* When you come into the driveway, our building #4401 is the first building on the left hand side. We are in the back of this building.

* To park, go to the second driveway on the left and make a left turn and park in the back of the building. Walk down the ramp and take the elevator to the second floor. Make a left out of the elevator and walk towards the back balcony and turn right. Our Suite is #201 (next to Accupuncture4U).

Coming from North of Encinitas, CA

- Merge onto I-5 S/San Diego Fwy S toward San Diego.
- Take the Encinitas Blvd exit (EXIT 42) towards Encinitas.
- Turn left onto County Hwy-S9/Encinitas Blvd.
- Turn right onto Manchester Ave.

- **4401 MANCHESTER AVE is on the right side. (Landmark is our building is next to Rite Aid and on the driveway is a sign that says "Office Condomiums")**

* When you come into the driveway, our building (4401) is the first building on the left hand side. We are in the back of this building.

* To park, go to the second driveway on the left and make a left turn and park in the back of the building. Walk down the ramp and take the elevator to the second floor. Make a left out of the elevator and walk towards the back balcony and turn right. Our Suite is #201 (next to Accupuncture4U).