Welcome to the Riordan Clinic!

On behalf of the entire staff, we would like to welcome you to our family of co-learners who come to us from every state and more than 58 countries.

We are pleased to have the opportunity to assist you on your health journey. We are committed to helping you attain your goals while striving to meet our motto, “Achieving Excellence in Patient Care”. It is our goal to provide you with outstanding service.

Our approach is to focus on Real Health and understanding each co-learner individually. We do this by using seven core precepts/principles:

1. The privacy of the doctor/patient relationship
2. Identify and correct the underlying causes
3. Characterize the biochemical uniqueness of the patient as co-learner
4. Care for the whole person
5. Let food be thy medicine
6. Cultivate healthy reserves
7. The healing power of nature

We can set a course for you in the right direction by being able to measure, detect, and correct what is necessary for each co-learner. This allows you to reach your best possible health on your journey towards Real Health

This involves a discovery process of getting to know each other and encouraging you to become what we call a co-learner. Educating our co-learners is the cornerstone of the Riordan Clinic. Some of our educational tools include our monthly Health Hunters newsletter with decades of past issues archived on our website at Riordanclinic.org/health-hunters-news. We have hundreds of videos with over 2.1 million views available to you. You can find links to all of our social media accounts at RiordanClinic.org/social-media.

We look forward to serving you and helping to restore you to your optimum health and well-being.

In Health,

Dr. Ron Hunninghake, Chief Medical Officer

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Thank you for choosing the Riordan Clinic in your journey towards Real Health.

Filling out the new patient forms:

Enclosed in this packet you will find several forms. **Please complete and bring the accompanying forms (pages 5 to 23) with you** on your first day. These forms MUST be completed *before* your appointment. (Note: you may want to keep a copy for your own records.)

STEP 1

- Fill out the *New Patient Intake Forms* starting on page 5.
  If you have had a diagnosis of cancer at any point in in your life, please fill out the additional questions starting on page 14. If not, you can skip these questions.

STEP 2

- Fill out the *3-day Diet Diary/Exercise Log* starting on page 17.

STEP 3

- Review and fill out the *Permission to Discuss* and *Regarding Long Term Care* information on page 21.
- Read the *Notice of Privacy Practices* and *Rights and Responsibilities* that start on page 25 then sign page 23. Return pages 5 - 23. Keep pages 25 through 32 for your records.

STEP 4

- Set up a patient portal using the instructions on page 32.

Notes regarding your lab draw: *These steps are necessary to ensure accuracy for your laboratory test results.*

- **Fast for the 12 hours before your initial appointment arrival time.**
- Drink plenty of water!
- Take any medications that are necessary to your health and cannot wait until after your appointment. If you have questions on which are necessary, please consult the doctor who prescribed the medications to you.
- Be prepared to provide a urine sample.
- If you are a female who is still menstruating regularly – it may be best, especially if having hormonal concerns, to run your blood work between days 18- 22 of your menstrual cycle. If this conflicts with your scheduled appointment, please let your doctor know and they will determine if those particular labs should be drawn and run during your next cycle.
- If you are currently taking a Biotin supplement, please do not take it for one week prior to your initial appointment as it may cause a false result of your thyroid lab (TSH).

Other things to know:

- Please bring your current supplements and prescriptions, in their original bottles, with you to your first appointment.
- Please be aware that the Riordan Clinic is a smoke free facility and that due to other co-learner's sensitivities we ask that you refrain from wearing perfumes or scented lotions on the days you visit the clinic.

Thank you in advance for reading through the accompanying welcome packet and arriving with completed forms. We look forward to seeing you soon!

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NEW PATIENT INTAKE FORMS

Thank you for your interest in pursuing Real Health at the Riordan Clinic. As "Co-learners' you will work with the doctors and staff to understand your whole health picture; therefore, we ask for a significant history prior to our initial visit. Thank you for taking the time to thoughtfully complete this form. We look forward to discussing your personal health history from this holistic/detective perspective (looking for root causes.) See you at your first visit! - *Thank you, Riordan Clinic Team*

PATIENT INFORMATION		☐ *Male* ☐ *Female*
Full legal name	*Preferred name*	*Date of birth*

Name of Parent(s) or Guardian(s) if patient is under the age of 18	
Street name	*Apartment/suite number*

City	*State*	*Zip*

Telephone number (home)	*Work phone*	*Cell*

Email Address (as you want used for communications with the Riordan Clinic and for your Patient Portal access, see p. 32 for details.)

Marital status	*Number of children*
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single	

Live with
☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐Friends ☐ Alone

Occupation	*Hours per week*	*Retired*
		☐

How did you hear about The Riordan Clinic and/or who can we thank for referring you?

EMERGENCY CONTACT	
Name	*Relationship*
Address	*Phone*

PHARMACY INFORMATION	
Pharmacy name	*Phone*
Pharmacy address	

THE FOLLOWING QUESTIONS WILL HELP US UNDERSTAND YOUR EXPECTATIONS

1. What are the primary health concerns you are seeking treatment for?

    1. _____ 3. _____

    2. _____ 4. _____

    Comments:

2. Why did you choose to come to the Riordan Clinic?

3. What aspect of holistic / nutritional approach appeals to you?

4. What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle?

    Little Commitment < 1 2 3 4 5 6 7 8 9 10 > 100% Commitment

5. What lifestyle habits do you currently engage in that you believe support your health?

6. What lifestyle habits do you currently engage in that you believe harm your health?

7. What obstacles do you foresee that could undermine your progress?

8. What else is important to you that the Riordan Clinic doctors and staff should be aware of as we begin working together with you as a co-learner?

9. Please tell us your goals in coming to the Riordan Clinic?

FAMILY HISTORY *Leave blank if not applicable*

	Father	***Mother***	***Siblings***	***Maternal Grandparents***	***Paternal Grandparents***	***Spouse***	***Children***
Age if living							
Age at time of death							
Cause of death							
If Cancer, type							

	If present, mark an "X"						
Thyroid disorder							
High blood pressure							
Heart attack							
Asthma / allergies							
Mental Illness							
Autoimmune							
Diabetes							
Osteoporosis							
Other							

DOCTOR, HOSPITALIZATION, SURGERY, IMAGING

Primary care physician	*Primary care physician's address and phone number*
*Date and type of last **X-Ray(s)***	*Date and type of last **MRI/CT Scan(s)***
*Date and type of last **ultrasound(s)***	*Date and type of last **EKG***
*Last **dental visit***	*Last **eye exam***

*Date and brief explanation of previous **surgeries***

ALLERGIES AND SENSITIVITIES

Please list any known allergies or sensitivities and label as such. If none, please mark the section with N/A.

Drug/prescription(s)	*Food(s)*
Substances in the environment/chemicals	
If you have had allergy testing, when and where was the test(s) performed? Please provide as many details as you can.	

CURRENT MEDICATIONS/SUPPLEMENTS

Please list **any** prescription, over the counter medications, or vitamins/supplements you are taking and dosages:

PLEASE BRING YOUR SUPPLEMENTS AND PRESCRIPTIONS, IN THEIR ORIGINAL BOTTLES, WITH YOU TO YOUR FIRST APPOINTMENT

Prescription medications	**Over the counter medications** *(Ibuprofen, antacids, sleep aids, laxatives, etc.)*	**Vitamins/supplements**

CURRENT MEDICATIONS/SUPPLEMENTS - CONTINUED

Please list **any** prescription, over the counter medications, or vitamins/supplements you are taking and dosages:

PLEASE BRING YOUR SUPPLEMENTS AND PRESCRIPTIONS, IN THEIR ORIGINAL BOTTLES, WITH YOU TO YOUR FIRST APPOINTMENT

Prescription medications	**Over the counter medications** *(Ibuprofen, antacids, sleep aids, laxatives, etc.)*	**Vitamins/supplements**

HEALTH ASSESSMENT

GENERAL INFORMATION

Current height	*Current weight*	*Weight one year ago*
Lifetime maximum weight	*When were you at your max weight?*	*Your ideal weight*

Do you have sufficient energy throughout the day?	☐ Yes ☐ No	*Please rate your energy from 1-10 (10 being best)*
		Low Energy < 1 2 3 4 5 6 7 8 9 10 > High Energy

When is your energy best?	*When is your energy worst?*

HABITS/LIFESTYLE

(Y) = Yes (N) = No (P) = in the Past

Do you drink alcoholic beverages?	☐ Y ☐ N ☐ P	*Do you sleep well?*	☐ Y ☐ N
Have you been treated for alcoholism?	☐ Y ☐ N ☐ P	*Do you wake rested?*	☐ Y ☐ N
Have you been treated for drug dependence?	☐ Y ☐ N ☐ P	*How many hours of sleep per night?*	
For any of the above, please explain:		*How much time per day in relaxation?*	
Do you use tobacco?	☐ Y ☐ N ☐ P	*Do you enjoy your work?*	☐ Y ☐ N
How many years and packs/day?		*Do you take vacations?*	☐ Y ☐ N
Do you drink coffee?	☐ Y ☐ N	*Do you have a religious or spiritual practice?*	☐ Y ☐ N
If yes to coffee, quantity per day?		*Do you have a supportive relationship?*	☐ Y ☐ N
Do you drink soda/pop?	☐ Y ☐ N ☐ P	*Main interests and hobbies:*	
If yes to soda, quantity per day?		*Do you exercise?*	☐ Y ☐ N
Do you eat three meals a day?	☐ Y ☐ N	If yes, what kind and how often?	
Do you go on diets often?	☐ Y ☐ N ☐ P	*Do you spend time outside?*	☐ Y ☐ N
Do you eat out often?	☐ Y ☐ N	*How many hours of TV per day?*	

REVIEW OF SYSTEMS *(Y) = Yes (N) = No (P) = in the Past*

MENTAL/EMOTIONAL			
Treated for emotional problems	☐ Y ☐ N ☐ P	Depression	☐ Y ☐ N ☐ P
Mood swings	☐ Y ☐ N ☐ P	Anxiety or nervousness	☐ Y ☐ N ☐ P
Considered/attempted suicide	☐ Y ☐ N ☐ P	Tension	☐ Y ☐ N ☐ P
Poor concentration	☐ Y ☐ N ☐ P	Memory problems	☐ Y ☐ N ☐ P
IMMUNE			
Reactions to immunizations	☐ Y ☐ N ☐ P	Chronic infections	☐ Y ☐ N ☐ P
Chronic fatigue	☐ Y ☐ N ☐ P	Slow wound healing	☐ Y ☐ N ☐ P
Chronically swollen glands	☐ Y ☐ N ☐ P		
ENDOCRINE (HORMONE SYSTEM)			
Underactive thyroid	☐ Y ☐ N ☐ P	Heat or cold intolerance	☐ Y ☐ N ☐ P
Low blood sugars	☐ Y ☐ N ☐ P	Excessive hunger	☐ Y ☐ N ☐ P
Excessive thirst	☐ Y ☐ N ☐ P	Seasonal depression	☐ Y ☐ N ☐ P
Fatigue	☐ Y ☐ N ☐ P	Night sweats	☐ Y ☐ N ☐ P
NEUROLOGIC			
Seizures	☐ Y ☐ N ☐ P	Paralysis	☐ Y ☐ N ☐ P
Muscle weakness	☐ Y ☐ N ☐ P	Numbness or tingling	☐ Y ☐ N ☐ P
Loss of memory	☐ Y ☐ N ☐ P	Loss of balance	☐ Y ☐ N ☐ P
Vertigo or dizziness	☐ Y ☐ N ☐ P	Motion sickness	☐ Y ☐ N ☐ P
SKIN			
Rashes	☐ Y ☐ N ☐ P	Eczema/hives	☐ Y ☐ N ☐ P
Acne	☐ Y ☐ N ☐ P	Itching	☐ Y ☐ N ☐ P
Color changes	☐ Y ☐ N ☐ P	Hair loss	☐ Y ☐ N ☐ P
Lumps	☐ Y ☐ N ☐ P	Brittle	☐ Y ☐ N ☐ P
Dry skin	☐ Y ☐ N ☐ P		
HEAD/NECK			
Headaches	☐ Y ☐ N ☐ P	Jaw/TMJ problems	☐ Y ☐ N ☐ P
Migraines	☐ Y ☐ N ☐ P	Lumps	☐ Y ☐ N ☐ P
Head injury	☐ Y ☐ N ☐ P	Swollen glands	☐ Y ☐ N ☐ P
EYES			
Spots in eyes	☐ Y ☐ N ☐ P	Cataracts	☐ Y ☐ N ☐ P
Impaired vision	☐ Y ☐ N ☐ P	Glasses/contacts	☐ Y ☐ N ☐ P
Blurriness	☐ Y ☐ N ☐ P	Eye pain/strain	☐ Y ☐ N ☐ P
Color blindness	☐ Y ☐ N ☐ P	Tearing or dryness	☐ Y ☐ N ☐ P
Double vision	☐ Y ☐ N ☐ P	Glaucoma	☐ Y ☐ N ☐ P
EARS			
Impaired hearing	☐ Y ☐ N ☐ P	Ringing in the ears	☐ Y ☐ N ☐ P
Earaches	☐ Y ☐ N ☐ P	Dizziness	☐ Y ☐ N ☐ P
NOSE AND SINUSES			
Frequent colds	☐ Y ☐ N ☐ P	Nose bleeds	☐ Y ☐ N ☐ P
Stuffiness	☐ Y ☐ N ☐ P	Hay fever/post nasal drip	☐ Y ☐ N ☐ P
Sinus problems	☐ Y ☐ N ☐ P	Loss of smell	☐ Y ☐ N ☐ P

REVIEW OF SYSTEMS *(Y) = Yes (N) = No (P) = in the Past*			
MOUTH AND THROAT			
Frequent sore throat	☐ Y ☐ N ☐ P	Excessive/copious saliva	☐ Y ☐ N ☐ P
Teeth grinding	☐ Y ☐ N ☐ P	Sore tongue/lips	☐ Y ☐ N ☐ P
Gum problems	☐ Y ☐ N ☐ P	Hoarseness	☐ Y ☐ N ☐ P
Dental cavities	☐ Y ☐ N ☐ P		
RESPIRATORY			
Cough	☐ Y ☐ N ☐ P	Pain on breathing	☐ Y ☐ N ☐ P
Spitting up blood	☐ Y ☐ N ☐ P	Shortness of breath	☐ Y ☐ N ☐ P
Asthma	☐ Y ☐ N ☐ P	Shortness of breath lying down	☐ Y ☐ N ☐ P
Pneumonia	☐ Y ☐ N ☐ P	Bronchitis	☐ Y ☐ N ☐ P
Emphysema	☐ Y ☐ N ☐ P		
CARDIOVASCULAR			
Heart disease	☐ Y ☐ N ☐ P	Swelling in ankles	☐ Y ☐ N ☐ P
High blood pressure	☐ Y ☐ N ☐ P	Chest pain	☐ Y ☐ N ☐ P
Blood clots	☐ Y ☐ N ☐ P	Murmurs	☐ Y ☐ N ☐ P
Phlebitis	☐ Y ☐ N ☐ P	Fainting	☐ Y ☐ N ☐ P
Rheumatic fever	☐ Y ☐ N ☐ P	Palpitations	☐ Y ☐ N ☐ P
GASTROINTESTINAL			
Trouble swallowing	☐ Y ☐ N ☐ P	Heart burn/reflux	☐ Y ☐ N ☐ P
Change in thirst	☐ Y ☐ N ☐ P	Abdominal pain/cramps	☐ Y ☐ N ☐ P
Change in appetite	☐ Y ☐ N ☐ P	Belching or passing gas	☐ Y ☐ N ☐ P
Nausea/vomiting	☐ Y ☐ N ☐ P	Constipation	☐ Y ☐ N ☐ P
Ulcer	☐ Y ☐ N ☐ P	Diarrhea	☐ Y ☐ N ☐ P
Yellow skin	☐ Y ☐ N ☐ P	Black stools	☐ Y ☐ N ☐ P
Gall bladder disease	☐ Y ☐ N ☐ P	Blood in stool	☐ Y ☐ N ☐ P
Liver disease	☐ Y ☐ N ☐ P	Bowel movements per day: _____	
Hemorrhoids	☐ Y ☐ N ☐ P		
URINARY			
Pain on urination	☐ Y ☐ N ☐ P	Increased frequency	☐ Y ☐ N ☐ P
Frequency at night	☐ Y ☐ N ☐ P	Inability to hold urine stream	☐ Y ☐ N ☐ P
Frequent infections	☐ Y ☐ N ☐ P	Kidney stones	☐ Y ☐ N ☐ P
MUSCULOSKELETAL			
Joint pain or stiffness	☐ Y ☐ N ☐ P	Arthritis	☐ Y ☐ N ☐ P
Broken bones	☐ Y ☐ N ☐ P	Weakness	☐ Y ☐ N ☐ P
Muscle spasms/cramps/pain	☐ Y ☐ N ☐ P	Sciatica	☐ Y ☐ N ☐ P
Osteoporosis/Osteopenia	☐ Y ☐ N ☐ P		
BLOOD VESSELS			
Easy bleeding or bruising	☐ Y ☐ N ☐ P	Anemia	☐ Y ☐ N ☐ P
Deep leg pain	☐ Y ☐ N ☐ P	Cold hands/feet	☐ Y ☐ N ☐ P
Varicose veins	☐ Y ☐ N ☐ P		

REVIEW OF SYSTEMS *(Y) = Yes (N) = No (P) = in the Past*			
MALE REPRODUCTIVE			
Hernias	☐ Y ☐ N ☐ P	Discharge or sores	☐ Y ☐ N ☐ P
Testicular pain	☐ Y ☐ N ☐ P	Sexually transmitted disease	☐ Y ☐ N ☐ P
Are you sexually active?	☐ Y ☐ N ☐ P	If yes, which sexually transmitted diseases have you been diagnosed with and when?	
Impotence	☐ Y ☐ N ☐ P		
Testicular mass(es)	☐ Y ☐ N ☐ P		
Prostate disease	☐ Y ☐ N ☐ P		

FEMALE REPRODUCTIVE/BREASTS			
Are you sexually active?	☐ Y ☐ N ☐ P	Sexually transmitted disease	☐ Y ☐ N ☐ P
Discharge or sores	☐ Y ☐ N ☐ P	If yes, which sexually transmitted diseases have you been diagnosed with and when?	
Age of first menses		*Age of last menses (if menopausal)*	
Length of cycle (days)		*Duration of menses (days)*	
Are cycles regular?	☐ Y ☐ N ☐ P	Heavy or excessive flow	☐ Y ☐ N ☐ P
Painful menses	☐ Y ☐ N ☐ P	Bleeding between cycles	☐ Y ☐ N ☐ P
Pain during intercourse	☐ Y ☐ N ☐ P	Breast lumps	☐ Y ☐ N ☐ P
Endometriosis	☐ Y ☐ N ☐ P	Nipple discharge	☐ Y ☐ N ☐ P
Ovarian cysts	☐ Y ☐ N ☐ P	PMS	☐ Y ☐ N ☐ P
Birth Control	*What type?*	If yes to PMS, what are your symptoms?	
☐ Y ☐ N ☐ P			
Number of pregnancies	*Number of live births*	*Number of miscarriages*	*Number of abortions*
Last pap smear		*Last mammogram*	
Have you had a bone density scan?	☐ Y ☐ N ☐ P	*Results:*	

IF YOU HAVE EVER BEEN DIAGNOSED WITH CANCER, PLEASE COMPLETE THE FOLLOWING QUESTIONS:

WHAT CANCER DIAGNOSIS DO YOU HAVE OR HAVE HAD? *Please check all that apply*								
	Have	*Had*		*Have*	*Had*		*Have*	*Had*
Breast			Ovarian			Esophageal		
Colon			Uterine			Small Intestine		
Prostate			Cervical			Testicular		
Lung			Skin			Stomach		
Liver			Bladder			Gallbladder		
Bone			Lymphoma			Eye		
Brain			Leukemia			Thyroid		
Pancreas			Sarcoma/Soft tissue			Parathyroid		
Adrenal			Metastatic			Esophageal		
Other/not listed: *(please name)*								

WHAT STAGE OF CANCER HAVE YOU BEEN MOST RECENTLY DIAGNOSED WITH?				
☐ Stage I	☐ Stage II	☐ Stage III	☐ Stage IV	☐ I don't know

PLEASE CHECK ALL OF THE DOCTORS YOU ARE CURRENTLY WORKING WITH *Not including Riordan Clinic*			
☐ Oncologist	☐ Radiation Oncologist	☐ Primary Care Physician	☐ M.D. or D.O.
☐ Naturopath	☐ Integrative/Functional Medicine Doctor		☐ Chiropractor
☐ Other (please list):			

Has your current doctor(s) cleared you for travel? ☐ Yes ☐ No ☐ I need to ask my doctor

Have you been hospitalized in the past three months? ☐ Yes ☐ No

If so, why: _____

HAVE YOU HAD ANY OF THE FOLLOWING SUPPORTIVE THERAPIES FOR CANCER? *Please check all that apply*			
☐ Chemotherapy	☐ Radiation	☐ Surgery	☐ Natural Medicine/ Integrative Medicine
☐ Acupuncture	☐ Chiropractic	☐ IV Vitamin therapies	
☐ Other: *(please list)*			

PLEASE TELL US YOUR WILLINGNESS TO MAKE MAJOR DIETARY, NUTRITIONAL, AND LIFESTYLE CHANGES

On a scale of 0-10, with zero being unwilling to make these changes and 10 being most ready and willing to make these changes, I anticipate being at a…

Little Commitment < 1 2 3 4 5 6 7 8 9 10 > 100% Commitment

These diet and lifestyle changes may include, but are not limited to, items such as:

- Eating more plants including vegetables and fruits
- Eliminating fried foods, fast foods, soda, sugar, wheat, milk/dairy, and soy
- Cooking more meals at home rather than eating out
- Increasing water intake

TELL US ABOUT YOUR ABILITY TO EAT *Please check all that apply*		
☐ I eat by mouth	☐ I eat by feeding tube	☐ I am not eating
☐ I can eat at least three platefuls of food and finish them completely each day	☐ I am nauseated often	☐ I am vomiting regularly

TELL US ABOUT YOUR ABILITY TO WALK *Please check all that apply*		
☐ I can walk by myself without any assistive devices such as a cane or walker	☐ I can walk with the aid of a cane	☐ I can walk with the aid of a walker
☐ I can walk some and require a wheelchair for part of the day	☐ I require a wheelchair to get around	☐ I am bed bound

TELL US ABOUT YOUR ABILITY TO BREATHE AND GET OXYGEN *Please check all that apply*		
☐ I can breathe on my own and do not require oxygen	☐ I require oxygen only during sleep	☐ I require oxygen when walking
☐ I require oxygen 24 hours a day	☐ I think I need oxygen, but have not been tested	Please list how many liters of oxygen you require: _____

ARE YOU CURRENTLY REQUIRING BLOOD TRANSFUSIONS? *Please check one*		
☐ I am currently receiving blood transfusions weekly	☐ I am currently receiving blood transfusions once a month	☐ I am currently receiving blood transfusions twice a month
☐ I am currently receiving blood transfusions once every few months	☐ I do not currently need blood transfusions	

LIST ALL OF THE DAILY ACTIVITIES YOU CAN DO UNASSISTED *Please check all that apply*			
☐ Walking	☐ Climbing stairs	☐ Getting dressed	☐ Taking a bath or shower
☐ Grocery shopping	☐ Balancing your checkbook	☐ Doing laundry	☐ Cooking

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3 Day Diet Diary / Exercise Log

Name:

Provide Info For:
2 weekdays +
1 weekend day

Please complete your "Diet Diary/ Exercise Log" every day.

1. Make note of the time you wake up.
2. List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list *everything* you eat or drink, including any condiments used (i .e. mayonnaise. mustard. relish, etc.).
3. Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.
4. Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.
5. Note any periods of relaxation and what kind of relaxation it was.
6. Note the time you go to sleep.

Day 1	
Date	
Wake Up Time	
Breakfast	*Time:*
Snack	*Time:*
Lunch	*Time:*
Snack	*Time:*
Dinner	*Time:*
Water *(ounces)*	
Other Drinks *(not listed with meals or snacks above)*	
Activity/Exercise	*How Long:*
Relaxation Type	*How Long:*
Bedtime	

3 Day Diet Diary / Exercise Log

Name:

Provide Info For:
2 weekdays +
1 weekend day

Please complete your "Diet Diary/ Exercise Log" every day.

1. Make note of the time you wake up.
2. List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list *everything* you eat or drink, including any condiments used (i .e. mayonnaise. mustard. relish, etc.).
3. Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.
4. Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.
5. Note any periods of relaxation and what kind of relaxation it was.
6. Note the time you go to sleep.

Day 2	
Date	
Wake Up Time	
Breakfast	*Time:*
Snack	*Time:*
Lunch	*Time:*
Snack	*Time:*
Dinner	*Time:*
Water *(ounces)*	
Other Drinks *(not listed with meals or snacks above)*	
Activity/Exercise	*How Long:*
Relaxation Type	*How Long:*
Bedtime	

3 Day Diet Diary / Exercise Log

Name:

Provide Info For:
2 weekdays +
1 weekend day

Please complete your "Diet Diary/ Exercise Log" every day.

1. Make note of the time you wake up.
2. List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list *everything* you eat or drink, including any condiments used (i .e. mayonnaise. mustard. relish, etc.).
3. Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.
4. Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.
5. Note any periods of relaxation and what kind of relaxation it was.
6. Note the time you go to sleep.

Day 3	
Date	
Wake Up Time	
Breakfast	*Time:*
Snack	*Time:*
Lunch	*Time:*
Snack	*Time:*
Dinner	*Time:*
Water *(ounces)*	
Other Drinks *(not listed with meals or snacks above)*	
Activity/Exercise	*How Long:*
Relaxation Type	*How Long:*
Bedtime	

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PERMISSION TO DISCUSS OR RELEASE CONFIDENTIAL INFORMATION

By completing this form, you will allow the staff of the Riordan Clinic to communicate with family members, health care providers, or others as deemed medically appropriate. If someone other than yourself is responsible for payment of your services, you will need to include their name on this list.

I, _____, grant permission to the Riordan Clinic to discuss or release confidential information related to my care with the following individuals:

NAME	RELATIONSHIP

REGARDING LONG TERM TREATMENT:

Over the next several months it will be important to implement the nutrition and lifestyle changes, supplement recommendations, follow-up appointments and clinic services that your treatment plan outlines.

For patients with cancer or chronic illnesses it is likely that your treatment plan will include ongoing nutritional IV infusions after your initial appointment at the Riordan Clinic. Please expect to receive nutritional infusions up to three times per week for the first three months or until your provider adjusts your treatment plan.

If you are not able to travel to the Riordan Clinic for each treatment**, it will be necessary for you to find a provider near your home to receive the IVC treatments.** The Riordan Clinic does not have a list of providers to refer you to outside of our three clinics in Wichita, Hays and Overland Park (Kansas).

Please initial: **I understand that if I live too far from the Riordan Clinic to return for regular infusions, it will be my responsibility to find a doctor or nurse near my home who could administer IV Vitamin C up to three (3) times a week depending on my treatment plan.** ***Initials:*** _____

PATIENT'S NAME (PLEASE PRINT)	DATE OF BIRTH
SIGNATURE OF PATIENT OR GUARDIAN	**TODAY'S DATE**

[Page left intentionally blank]

STEP 3

NOTICE OF PRIVACY PRACTICES

And

RIGHTS AND RESPONSIBILITIES

Please read through the following pages and retain for your records.
When you are done, please initial each of the following boxes, sign and date.

Please initial each statement

☐ I have been presented with a copy of the *Notice of Privacy Practices* detailing how confidential information may be used and disclosed as permitted under federal and state law. I have read, acknowledge and understand this notice as explained on pages 25 -28.

☐ I have read, acknowledge and understand and agree to the *Cancellation Policy* outlined on page 31.

☐ I have read, acknowledge and understand and agree to the *Rights and Responsibilities* on pages 29 – 31.

PATIENT'S NAME (PLEASE PRINT)	DATE OF BIRTH
SIGNATURE OF PATIENT OR GUARDIAN	**TODAY'S DATE**

THANK YOU FOR FILLING OUT THE *NEW PATIENT INTAKE FORMS*. THIS WILL ALLOW YOUR DOCTOR AND MEDICAL TEAM TO PROVIDE YOU WITH THE BEST POSSIBLE CARE. **PLEASE BRING THE COMPLETED PAGES (5-23) WITH YOU TO YOUR FIRST APPOINTMENT.** WE LOOK FORWARD TO MEETING YOU!

[Page left intentionally blank]
Keep all pages after this for your records.

NOTICE OF PRIVACY PRACTICES

Please read and retain for your records.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. WE HAVE A LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We are committed to treating and using personal health information about you responsibly and with the utmost respect for your privacy. We are required by law to protect the privacy of health information about you and that can be identified with you, which we call "protected health information," or "PHI" for short. We must give you notice of our legal duties and privacy practices concerning PHI:

- We must protect PHI that we have created or received about your health condition; health care we provide to you; and payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.

This Notice describes the types of uses and disclosures that we may make and gives you some examples. In addition, we may make other uses and disclosures, which occur as a byproduct of the permitted uses and disclosures described in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by first:

- Posting the revised notice in our offices and on our website (riordanclinic.org)
- Making copies of the revised notice available upon request.

B. WE MAY USE AND DISCLOSE PHI ABOUT YOU WITHOUT YOUR AUTHORIZATION IN THE FOLLOWING CIRCUMSTANCES

1. We may use and disclose PHI about you to provide health care treatment to you.

We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services.

2. We may use and disclose PHI about you to obtain payment for services.

Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services provided to you by us or by another provider. We may also share portions of medical information about you with the following:

- A billing company;
- Collection departments or agencies, or attorneys assisting us with collections;
- Insurance companies, health plans and their agents which provide you coverage;
- Consumer reporting agencies (e.g., credit bureaus).

3. We may use and disclose PHI about you for health care operations.

We may use and disclose PHI in performing business activities, which we call "health care operations". These "health care operations" allow us to improve the quality of care we provide. Examples of the way we may use or disclose PHI about you for "health care operations" include the following:

- *Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills.*
- *Cooperating with outside organizations that assess the quality of the care we and others provide.*
- *Cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities in a particular field or specialty.*
- *Assisting various people who review our activities. For example, PHI may be seen by doctors reviewing the services provided to you, and by accountants, lawyers, and others who assist us in complying with applicable laws.*
- *Conducting business management and general administrative activities related to our organization and the services it provides.*
- *Resolving grievances within our organization.*
- *Complying with this Notice and with applicable laws.*

4. We may use and disclose PHI under other circumstances without your authorization or an opportunity to agree or object.

We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

- *When the use and/or disclosure is required by law.* For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- *When the use and/or disclosure is necessary for public health activities.* For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- *When the disclosure relates to victims of abuse, neglect or domestic violence.*
- *When the use and/or disclosure is for health oversight activities.* For example, we may disclose PHI about you to a state or federal health oversight agency that is authorized by law to oversee our operations.
- *When the disclosure is for judicial and administrative proceedings.* For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- *When the disclosure is for law enforcement purposes.* For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- *When the use and/or disclosure relates to decedents*. For example, we may disclose PHI about you to a coroner or medical examiner for the purposes of identifying you should you die.
- *When the use and/or disclosure relates to organ, eye or tissue donation purposes.*
- *When the use and/or disclosure relates to medical research.* Under certain circumstances, we may disclose PHI about you for medical research.
- *When the use and/or disclosure is to avert a serious threat to health or safety.* For example, we may disclose PHI about you to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- *When the use and/or disclosure relates to specialized government functions.* For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- *When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations.* For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

5. You can object to certain uses and disclosures.

Unless you object, we may use or disclose PHI about you in the following circumstances:

- Using our best judgment, we may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care.
- We may share with a public or private agency (for example, American Red Cross) PHI about you for disaster relief purposes. Even if you object, we may still share the PHI about you, if necessary for the emergency

circumstances. If you would like to object to our use or disclosure of PHI about you in the above or other specific circumstances, please call or write our office using the contact information at the end of this Notice.

6. We may contact you to provide appointment reminders.
We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

7. We may contact you with information about treatment, services, products or health care providers.
We may use and/or disclose PHI to manage or coordinate your healthcare. This may include telling you about treatments, services, products and/or other healthcare providers. We may also use and/or disclose PHI to give you gifts of a small value.

EXAMPLE: If you are diagnosed with diabetes, we may tell you about nutritional and other counseling services that may be of interest to you.

ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION: Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing by our office. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation; except for disclosures which were being processed before we received your cancellation.

C. YOU HAVE SEVERAL RIGHTS REGARDING PHI ABOUT YOU

1. You have the right to request restrictions on uses and disclosures of PHI about you.
You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection B.4 of the previous section of this Notice. You may request a restriction in writing at the address listed below.

2. You have the right to request different ways to communicate with you.
You have the right to request how and where we contact you about PHI. For example, you may request that we contact you at your work address or phone number. Your request must be in writing. You may request alternative communications by writing to the address listed below.

3. You have the right to see and copy PHI about you.
You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. You may request to see and receive a copy of PHI by requesting this in writing at the address listed below.

4. You have the right to request amendment of PHI about you.
You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us

a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment. You may request an amendment of PHI by writing to the address listed below.

5. You have the right to a listing of disclosures we have made.
If you ask us in writing, you have the right to receive a written list of certain disclosures of PHI about you (not including disclosures made prior to April 14, 2004). The period of time for which the accounting is requested may not exceed six (6) years from the date of the request. We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or requested by you, or that you authorized
- Occurring as a byproduct of permitted uses and disclosures
- Made to individuals involved in your care, or for other purposes described in subsection B.5 above
- Allowed by law when the use and/or disclosure relates to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations (please see subsection B.4 above) and
- As part of a limited set of information which does not contain certain information which would identify you (for example: research purposes)
- The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You may request a listing of disclosures by writing to the address listed below.

6. You have the right to a copy of this Notice.
You have the right to request a paper copy of this Notice at any time by contacting our office. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services, and then we will provide the Notice to you as soon as possible).

D. YOU MAY FILE A COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have a question or concern regarding our privacy practices, please contact:

Medical Records
Riordan Clinic | 3100 N. Hillside Avenue | Wichita, KS 67219 USA
Phone 316-682-3100 Extension 300 | Fax 316-618-8537
medicalrecords@riordanclinic.org

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. Complaints must be filed within 180 days of when you became aware of the privacy concern, unless this time limit is waived by the Secretary. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

E. EFFECTIVE DATE OF THIS NOTICE

This Notice of Privacy Practices is effective on April 14, 2004.

RIGHTS AND RESPONSIBILITIES

Please read and retain for your records.

Since 1975, Riordan Clinic has served its patients as unique co-learners who are striving to create real and lasting health in their lives by identifying and correcting hidden root causes that would otherwise perpetuate their illnesses. This process of co-learner care was instituted by Riordan Clinic's founder, Dr. Hugh Riordan. The Riordan Clinic staff has created the following guidelines which aid in the day to day delivery of this ideal vision of patient care. We strive to make these ideals living realities in each patient's experience at the Riordan Clinic.

The following rights and responsibilities are offered as a template for the expression of this co-learner care. We ask you to bear in mind that co- as a prefix to co-learner implies mutuality. Riordan Clinic patients should expect to be treated with dignity and compassion. Similarly, Riordan Clinic staff will expect you and your family/friends/advocates to show us the same reasonable and responsible behavior as we strive together to achieve excellent results.

Riordan Clinic is a specialty healthcare provider used in conjunction with medical care and therefore cannot take the place of a primary care doctor.

CO-LEARNER RIGHTS AND RESPONSIBILITIES

As a Riordan Clinic co-learner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

- Provide my Riordan Clinic provider(s) with information that is relevant to my health.
- Be willing to sort through my health-related challenges.
- Ask questions related to information that is provided by my practitioner, including treatment options.
- Take mutually agreed upon supplements, as part of my treatment plan, only according to directions given to me and discontinue use if side effects ensue and report this to my Riordan Clinic practitioner(s).
- Work together with Riordan Clinic health professionals to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and spiritual health.
- Make conscious decisions to nurture intrinsic healing and promote balance in my life.
- Evaluate the effectiveness of my plan of care.
- Participate in all scheduled treatment sessions.
- Be willing and open to investigate my health-related challenges, understanding that the treatment we provide is not a quick fix to your health challenges.
- To provide complete health information asked of the Riordan Clinic prior to my first and each appointment.
- To have all your health information be kept in compliance with all confidently laws.
- To have the complete attention of all Riordan Clinic health professionals during my appointments.

PRACTICE POLICIES

As a reminder: Riordan Clinic is a specialty healthcare provider used in conjunction with medical care and therefore cannot take the place of a primary care doctor.

APPOINTMENTS

- Please arrive promptly at the "arrival time" given to you when scheduling your first new patient appointment.
- Please arrive 15 minutes before all subsequent appointments.
- If you arrive more than 15 minutes late for an appointment we reserve the right to reschedule your appointment to avoid inconveniencing other patients and you will be charged for a missed appointment per the *Cancellation Policy* as outline on page 31.

LABORATORY/OTHER RESULTS

- When test results are received they are placed into our EHR ("Electronic Health Record") and the doctor will review the results. The doctor often waits for all of your tests to come back so they can review the whole picture.
- An appointment is required to review lab testing results so you as a co-learner can have a complete understanding of the results and, with your Riordan Clinic provider, can formulate an updated treatment plan.
- Please keep copies of all test results that are mailed or given to you.
- Self-referred laboratory results cannot be reviewed with recommendations by a Riordan Clinic doctor without a doctor's visit.
- Any laboratory testing covered by traditional Medicare will be filed directly.
- Copies of your test results will be provided to you via the Patient Portal (see page 32.), in person, mailed or emailed.

CLINIC THERAPIES

- All co-learners receiving any therapies by Riordan Clinic medical staff (IVs, injections, PEMT, UBI, Chelation, etc) must be seen by a Riordan Clinic doctor **every six (6) months**.
- IV and injection appointments must be cancelled at least 24 hours in advance.
- Same day cancellations will be charged a $50 USD no-show fee as that IV time slot was reserved for you.

PRESCRIPTIONS

- All co-learners receiving pharmaceutical prescriptions by a Riordan Clinic doctor must be seen by a Riordan Clinic doctor **every six (6) months**.
- Certain prescriptions (thyroid, hormone therapy, blood pressure, chelation and IVs) require follow-up lab work and must be checked **every six (6) months**.
- Please make sure that all prescription renewal requests are made at least **one (1) week before** your prescription runs out.
- Our doctors often must review your chart and authorize the renewal before it can be sent in. In addition, compounding is sometimes required. Allow **24 hours** before calling to see if we have received your request. Please plan accordingly.

HOME IV INFUSIONS

- All Home IV infusions performed off-site must be administered by a licensed medical professional.

- All co-learners receiving home IV infusions must follow up with a Riordan Clinic doctor **every three (3) months**.
- A maximum of three (3) months' supply of IVC kits can be purchased at a time and must fall within the 3-month window of a scheduled follow up visit.
- **All home IV products purchased are non-refundable, non-returnable and cannot be brought back into the clinic to be rendered for services at our clinic.**

CANCELLATIONS/RESCHEDULING

- New Patient Appointments: We require your cancellation notice no later than two **(2) business days** (Monday – Friday) prior to your scheduled appointment. If notice is not received two (2) business days prior to your scheduled appointment we will charge you a non-refundable $150 USD non-cancellation fee.
- Follow-up Appointments: Follow-up visits require cancellation notice of **one (1) business day** (Monday – Friday). If notice is not received one (1) business day prior to your scheduled appointment, we will charge you a non-refundable $50 USD cancellation fee.

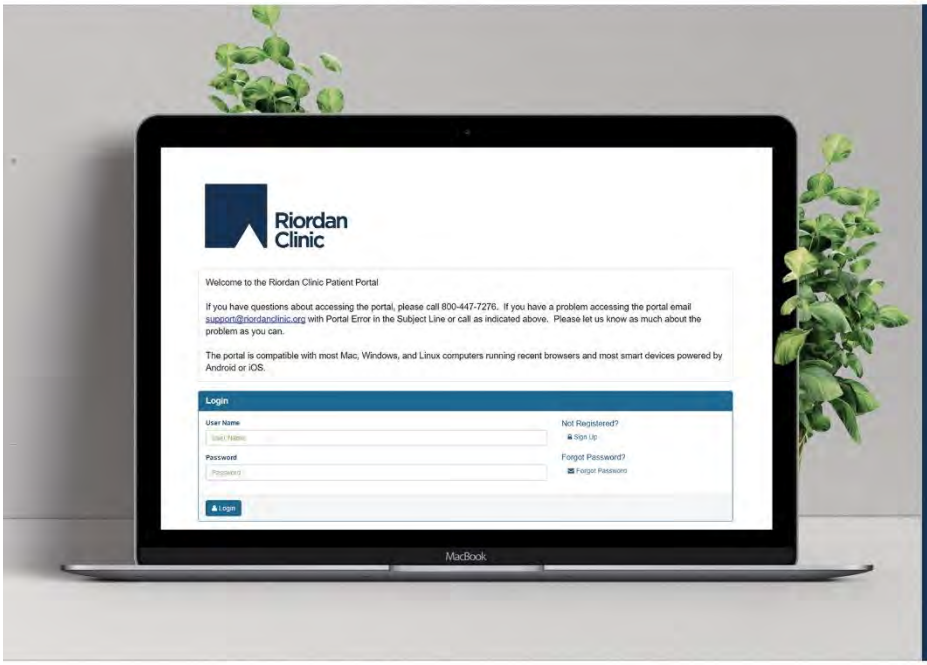
INSURANCE

- As of September 1st, 2014, Riordan Clinic has opted out of Medicare. No clinic services will be filed by Riordan Clinic.
- Services are paid for at the time of your visit. We will give you an itemized bill that you can submit directly to your commercial insurance company. Please keep in mind that many of the services we offer are not considered medically necessary by traditional insurance companies.
- We cannot change any diagnosis or coding on the sole basis of insurance coverage.
- We do not contract with any commercial insurance company. Therefore, reimbursement would be sent to you directly and would be paid at a non-network level as this relationship is between you and your insurance company.
- If your insurance company requires prior authorization for any services our doctors order, it is your responsibility to make sure that this is done prior to such services being performed.
- Any laboratory testing covered by traditional Medicare will be filed directly.

OTHER

- Form(s) Completion: Disability, Insurance Forms, Travel Forms, Release from Work, Prior Authorizations, and other forms are not required by all insurance plans or employers. If you require a doctor to complete these forms, you will be required to schedule an office visit at an additional charge.
- Paper Records: We will provide to you, upon written request, a paper copy of your medical record. We charge a base fee of $25 USD. Please submit this request to:

Medical Records
Riordan Clinic | 3100 N. Hillside Avenue | Wichita, KS 67219 USA
Phone 316-682-3100 Extension 300 | Fax 316-618-8537
medicalrecords@riordanclinic.org



SIGN UP FOR OUR PATIENT PORTAL

- Secure Communication
- Online Forms
- Education Resources
- Access Records
- View Lab Results

CREATING YOUR PORTAL ACCOUNT

1. Visit **HTTPS://MY.RIORDANCLINIC.ORG.**
2. If you have not yet registered, click SIGN UP.

This information MUST match the data on your Riordan Clinic account.

Much of this information can be found on your last Riordan Clinic invoice given at checkout.

3. Create a username to use each time you log in.
4. Enter the email address you provided to the Riordan Clinic. Enter your first and last name as well as your birth date.
5. Click SUBMIT.
6. After clicking submit, you will receive an email with a link to verify your account and to set up a unique password.

Passwords must contain at least one uppercase letter, one lowercase letter and one numeric character.

If you have trouble creating a portal account, please call Riordan Clinic and verify your patient information: 1 (800) 447-7276

WICHITA
3100 N Hillside Ave
Wichita, KS 67219

OVERLAND PARK
6300 W 143rd Street, Suite #205
Overland Park, KS 66223

HAYS
1010 E 17th St.
Hays, KS 67601

Riordan Clinic