CLIENT BILL OF RIGHTS

Siri Homeopathy LLC
Monica Raina, Classical Homeopath, CCH

4601 Excelsior Blvd, #331, St. Louis Park, MN 55416

www.sirihomeopathy.com

952-393-9192

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

1. Degrees, training, and experience:

Monica Raina has studied homeopathy at the four-year program of Northwestern Academy of Homeopathy, Minneapolis, MN. She had the opportunity to study with internationally known teachers such as Valerie Ohanian, Laurie Dack, Eric Sommerman. and Rajan Sankaran.
She has been practising classical homeopathy since 2007.
She is a member of the Minnesota Homeopathic Association. She is also a mentor and clinical instructor at the Northwestern Academy of Homeopathy, in Minneapolis.

In accordance with Minnesota law, I am providing you with the following notice:

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

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

provider, the client may seek such services at any time.

2. Right to file a complaint. If you have any concerns, you may file a complaint with the following office:

Office of Unlicensed Complementary and Alternative Health Care Practice
Health Occupations Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, Minnesota 55164-0882

3. Fees for unit of service.

Please see attached fee statement.

I do not accept Medicare, Medical Assistance, or General Assistance Medical Care.
I do not accept partial payment or waive payment. (Please refer to Payment Policy).

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

5. Summary of Practices/Services. Please review the attached document that provides a detailed description of classical homeopathy. If you have any questions, please ask.

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

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

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

9. Access to client records. You are allowed access to records and other written information, in accordance with Minnesota

Statutes, section 144.335.

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

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

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

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

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

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

_____ _____

Client Signature **Date**

_____ _____

Parent or Guardian Signature **Date**

_____ _____

Witness **Date**

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HOMEOPATHIC SERVICES NOTICE

CLIENT NAME: _____
(please print)

The homeopathic services you have requested are directed at strengthening your constitution and vitality. They are not directed at identifying, treating or preventing specific diseases. Monica Raina is a homeopathic practitioner but is not a licensed physician. Current laws prohibit homeopathic practitioners from diagnosing or treating disease.

If you have a medical complaint or question about your health, you should consult with a physician.

Many insurance companies do not pay for homeopathic services, and Siri Homeopathy will not be sending a bill to your insurance carrier.

CLIENT ACKNOWLEDGEMENT:

It is my personal preference to use the homeopathic services of Monica Raina. I understand that homeopathic services are NOT MEDICAL treatments and that Monica Raina is not a licensed physician.

Signature: _____ **Date**: _____
Client or Guarantor of Client

HEALTH INVENTORY

[THIS INFORMATION IS CONFIDENTIAL AND WILL ONLY BE RELEASED WITH YOUR SIGNED CONSENT]

Name _____ (LAST / FIRST / MIDDLE INITIAL)

Address _____ (COUNTY)

_____ (CITY / STATE / ZIP)

Phone: WORK: _____ HOME: _____

Emergency contact: Name: _____

Phone #: _____ Relationship _____

If under 18, parents' name/address _____

Referred by _____

Address _____

Family Physician _____

Address _____

Today's date _____

Birthdate _____

Age ____ Sex ____ Height ____ Weight ____

Legal status: S M D Sep W

Education (yrs. completed):
Elem ____ HS ____ Coll ____ Voc ____ Prof ____

Occupation _____

Retired: ☐ Yes ☐ No

FAMILY HISTORY

☐ *Check if family history is unknown.*

	Age	If deceased, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

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

YES		RELATIONSHIP
☐	Alcohol/drug problem	
☐	Allergy/asthma	
☐	Anemia	
☐	Arteriosclerosis	
☐	Arthritis	
☐	Binge eating/bulimia	
☐	Bleeding problem	
☐	Cancer	
☐	Diabetes	
☐	Epilepsy/seizure	
☐	Heart disease	
☐	Skin disease	
☐	Endocrine/hormonal imbalance	

YES		RELATIONSHIP
☐	High blood pressure	
☐	High cholesterol/fat	
☐	Kidney disease	
☐	Liver disease	
☐	Mental illness	
☐	Obesity	
☐	Stroke	
☐	Suicide	
☐	Thyroid disease	
☐	Tuberculosis	
☐	Gastro intestinal disease	
☐	Syphilis	
☐	Gonorrhea	

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all surgery and approximate dates

Other hospitalizations and dates

Broken bones and/or traumatic injuries
(include all car accidents or concussions)

Current health problems
Example: High blood pressure - 10 yrs.

PAST HISTORY

YES		WHEN
☐	Acne	
☐	AIDS	
☐	Alcohol/drug problem	
☐	Allergies	
☐	Amalgams/silver fillings	
☐	Anemia	
☐	Antibiotics more than once a year	
☐	Anorexia	
☐	Anxiety	
☐	Arteriosclerosis	
☐	Arthritis	
☐	Asthma	
☐	Back pain/strain	
☐	Binge eating	
☐	Bladder infection	
☐	Blood clots	
☐	Breast lump	
☐	Bronchitis	
☐	Bulimia (self-induced vomiting)	
☐	Cancer	
☐	Cataract	
☐	Chemical sensitivity	
☐	Chicken pox	
☐	Chronic fatigue	
☐	Colds, frequent	
☐	Colitis	
☐	Congenital defect	
☐	Counseling	
☐	Depression	
☐	Diabetes	
☐	Ear infection	
☐	Eczema	
☐	Endometriosis	
☐	Epilepsy	

YES		WHEN
☐	Epstein Barr/ infectious mono	
☐	Fibrocystic breasts	
☐	Fibroids	
☐	Gallbladder problem	
☐	Glaucoma	
☐	Gonorrhea	
☐	Gout	
☐	Hay fever	
☐	Hearing problem	
☐	Heart attack	
☐	Heart failure	
☐	Heart problem	
☐	Hemorrhoids	
☐	Hepatitis	
☐	Herpes	
☐	Hiatal Hernia	
☐	High blood pressure	
☐	High cholesterol/ triglycerides	
☐	Hives	
☐	Hypoglycemia	
☐	Insomnia	
☐	Kidney infection	
☐	Kidney stones	
☐	Kidney problem	
☐	Liver disease	
☐	Menstrual problem	
☐	Mental illness	
☐	Migraine	
☐	Nervous condition	
☐	Neurologic problem	
☐	Overweight (20 lbs)	
☐	Panic Attacks	
☐	Pelvic infection	
☐	Peptic ulcer	

YES		WHEN
☐	Periodontal disease	
☐	Phlebitis	
☐	Pneumonia	
☐	Premenstrual tension	
☐	Prostate problem	
☐	Psychotherapy	
☐	Reactions to vaccinations	
☐	Rheumatic fever	
☐	Root canal	
☐	Scarlet fever	
☐	Sexually transmitted disease	
☐	Sinusitis	
☐	Skin problem	
☐	Sleep disorder	
☐	Stroke	
☐	Suicide attempt	
☐	Syphilis	
☐	Taken steroid (cortisone/prednisone)	
☐	Thyroid problem	
☐	Tonsillitis	
☐	Tooth problems	
☐	Tuberculosis	
☐	Urine problem	
☐	Vaginitis	
☐	Vision problem	
☐	Warts	
☐	Other problems	

REVIEW OF SYSTEMS

Answer "yes" if you have had these symptoms ***in the last 6 months.***

YES

- ☐ Chronic fatigue
- ☐ Mood swings
- ☐ Chronic depression
- ☐ Trembling episodes
- ☐ Light-headedness
- ☐ Food craving
- ☐ Frequent infection
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Skin rash
- ☐ Chills/fever
- ☐ Change in skin/nails
- ☐ Change in wart or mole
- ☐ Abnormal bleeding/bruising
- ☐ Change in hair loss/growth
- ☐ Irritability
- ☐ Restlessness
- ☐ Headaches
- ☐ Dizziness
- ☐ Balance problem
- ☐ Head injury
- ☐ Seizure/convulsion
- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Fainting
- ☐ Weakness
- ☐ Numbness/tingling
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of any vision
- ☐ Halos around lights
- ☐ Excessive tearing/itching
- ☐ Eye pain
- ☐ Dark circles under eyes
- ☐ Date last eye exam _____
- ☐ Loss of hearing
- ☐ Ringing/buzzing in ears
- ☐ Sinus trouble
- ☐ Nosebleed
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Change in voice
- ☐ Dental problem
- ☐ Dry mouth
- ☐ Excessive salivation
- ☐ Bleeding gums
- ☐ Mouth breather

YES

- ☐ Chronic cough
- ☐ Bloody/yellow sputum
- ☐ Shortness of breath
- ☐ with exertion
- ☐ at night
- ☐ Bronchitis
- ☐ Chest pain with breathing
- ☐ High blood pressure
- ☐ Chest pain or pressure
- ☐ at rest
- ☐ with exertion
- ☐ with stress
- ☐ with eating
- ☐ down left arm, neck or back
- ☐ accompanied by nausea, sweating, anxiety
- ☐ Irregular heartbeat
- ☐ Skip beats
- ☐ Palpitations
- ☐ Fast heart beat
- ☐ Heart murmur
- ☐ Swelling feet/legs
- ☐ Cold hands/feet
- ☐ Leg cramps at night
- ☐ Joint pain
- ☐ Pain or fatigue in legs with exercise
- ☐ Burning feet
- ☐ Sore legs/feet
- ☐ Color change legs/arms
- ☐ Difficulty swallowing
- ☐ Pain/discomfort when eating
- ☐ Bad teeth
- ☐ Belching
- ☐ Coating on tongue
- ☐ Canker sores
- ☐ Pain relieved by eating
- ☐ Nausea/vomiting
- ☐ Trouble with fried foods
- ☐ Bloating of abdomen
- ☐ Bowel gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stool
- ☐ Clay-colored stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Rectal bleeding

YES

- ☐ Abdominal pain
- ☐ Change in diet
- ☐ Pain/burning urination
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Blood in urine
- ☐ Foul odor to urine
- ☐ Low back pain
- ☐ Loss of control of urine

MEN

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

WOMEN

Last menstruation period _____

Age menstruation began _____

Age at menopause _____

Number of pregnancies _____

Number of live births _____

Number of abortions/miscarriages _____

- ☐ Complication of pregnancy
- ☐ Used birth control pills
- ☐ Used IUD
  type: _____

Usual length of cycle _____

Usual length of period _____

- ☐ Change in cycle
- ☐ Spotting between periods
- ☐ Discomfort with periods
- ☐ Premenstrual tension
- ☐ Vaginal discharge
- ☐ Painful intercourse
- ☐ Itching
- ☐ Self breast examination
- ☐ Problem w/sexual function
- ☐ Lump in breast
- ☐ Abnormal pap smear
- ☐ Infertility

Date of last pap smear _____

Please turn page.

PERSONAL HISTORY

Current medications

List all prescriptions and non-prescriptions including dosage

Vitamin and mineral supplements

Type and dosage

Allergies

I am allergic to the following medications:

Food allergies and method of testing

Lifestyle

List your favorite foods or cravings

I am now or have been a smoker. ☐ yes ☐ no

How many years have you smoked? _____

How much? _____

When did you quit? _____

I estimate my use of:

coffee: _____ cups/day decaf: _____ cups/day

I use ☐ beer ☐ wine ☐ "hard" liquor.

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

I use ☐ marijuana ☐ other drugs _____

I have participated in an exercise program. ☐ yes ☐ no

I exercise on a regular basis. ☐ yes ☐ no
_____ Times _____ Week/Month

I think this is enough exercise. ☐ yes ☐ no

I would like to do more exercise. ☐ yes ☐ no

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

My sex life is satisfactory. ☐ yes ☐ no

I do the following for relaxation/recreation: _____

I sleep well. ☐ yes ☐ no

I worry about ☐ money ☐ job ☐ family life
☐ relationships ☐ other _____

I currently see a psychotherapist or other mental health professional. ☐ yes ☐ no

I have had a therapeutic massage. ☐ yes ☐ no

I currently see a chiropractor, osteopath, or other physical therapy person. ☐ yes ☐ no

I have been arrested. ☐ yes ☐ no

I have been in the military service. ☐ yes ☐ no

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

My spiritual life is satisfactory. ☐ yes ☐ no

I am currently involved in a regular spiritual program
☐ yes ☐ no

My last physical exam was _____

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Hours & Scheduling:

Appointments are available Monday through Friday, 9am to 5pm.

Please allow for 2 to 3 hours for an adult initial consultation, and up to 2 hours for a child. Follow-up appointments are usually half hour to 45 minutes, but can occasionally take up to an hour.

Fee Schedule:

Initial Consultation:

– adult (18 yrs & over): $285

– child (over 5 yrs): $235

– child (under 5 yrs): $200

Follow-up consult: $80

Acute consult: $45

You may use any method of payment that is convenient for you - cash, check, credit card, or venmo, if that is a phone application you use. For credit card payments, invoice

will be sent by email through Square.

(Please check with practitioner before the appointment, for waiver/discount in case of financial constraints.)

No charge for phone calls with questions.

For cancelation, a 48-hour notice is requested. There is a cancelation fee of $45 for an initial appointment, and $25 for a follow-up.

Remedies are charged separately from the consult, and may range from $14 to $22 a remedy, including mailing. The remedies are mailed out from the homeopathic pharmacy of Jacob Kiakahi, in Minneapolis.

Siri Homeopathy is also a part of a co-operative called Minnesota Center for Homeopathy. www.minnesotacenterforhomeopathy.com

You can also find Siri Homeopathy on Facebook, with tips for using some readily available, and commonly-used remedies: www.facebook.com/SiriHomeopathy