CLIENT BILL OF RIGHTS

Siri Homeopathy LLC

Monica Raina, Classical Homeopath, CCH

4601 Excelsior Blvd, #501, St. Louis Park, MN 55416

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 practicing classical homeopathy since 2007.
She is a member of the Minnesota Homeopathic Association. She is a mentor and clinical instructor at the Northwestern Academy of Homeopathy, Minneapolis, MN.

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.
(Please refer to Fee Structure for 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

Siri Homeopathy

sirihomeopathy.com

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Health History

This information is confidential and will only be released with your signed consent.

Date:

Name:

Date of Birth: Age:

If under age 18, parent name and address:

Sex: Male/Female/Other

Address (street, city, state, zip):

Phone (c): (h):

E-mail:

Marital status: Single/Married/Divorced/Separated/Widowed.

Education (highest completed):

Occupation (Nature of work):
Retired: Yes/No

Emergency Contact (name, phone, relationship):

Referred by:

Family Physician (name, clinic):

Other practitioners (chiropractor, osteopath, physical therapy, etc):

Main health concerns today (please list each concern and when the issue started):

Your past medical history

Indicate any past symptoms/condition and the dates you experienced these symptoms/conditions:

___Acne	___Hemorrhoids
___AIDS	___Hepatitis
___Alcohol/drug problems	___Herpes
___Allergies	___Hiatal hernia
___Animal Bites	___High blood pressure
___Antibiotics>1x/yr	___High cholesterol
___Amalgams/silver fillings	___Hives
___Anemia	___Hypoglycemia
___Anorexia	___Insomnia
___Anxiety	___Kidney infection
___Arteriosclerosis	___Kidney stones
___Arthritis	___Liver disease
___Asthma	___Lyme’s disease
___Back pain/strain	___Menstrual/pre-menstrual problems

___Bad breath	___Mental illness
___Binge eating/bulimia	___Migraines
___Bladder infections	___Nervous condition
___Bleeding problems	___Neurologic condition
___Blood clots	___Overweight (20#)
___Breast lumps	___Panic attacks
___Bronchitis	___Pelvic infection
___Bruising, easily	___Peptic ulcer
___Cancer	___Periodontal disease
___Cataracts	___Pneumonia
___Chemical Sensitivity	___Prostate problems
___Chicken Pox	___Rheumatic fever
___Chronic fatigue	___Scarlet fever
___Colds, frequent	___Shingles
___Colitis	___Sinusitis
___Congenital condition	___Skin problems
___Depression	___Sleep disorder
___Diabetes	___Stroke
___Ear infection, chronic	___Syphilis
___Eczema	___Taken steroids(cortisone/prednisone)
___Endometriosis	___Thyroid problem
___Epilepsy/seizures	___Tonsillitis
___Epstein Barr/Mononucleosis	___Tuberculosis
___Fibrocystic breasts	___Bedwetting
___Fibroids	___Urinary tract infection
___Gallbladder problems	___Vaccination reaction
___Glaucoma	___Vaginitis
___Gonorrhea	___Vision problem
___Gout	___Warts
___Hay fever	___Whooping cough

___Hearing Problems	___Other
___Heart attack	___Other
___Heart problems	___Other

Surgeries (list all surgeries and dates):

Other hospitalizations and dates:

Broken bones, traumatic injuries, concussions, accidents, along with dates:

Check items that apply to blood relatives and list the person(s) indicated (children, parents, siblings, grandparents, aunts, uncles)

___Check if family history is unknown	___ High cholesterol/fat
___Alcohol/drug problems	___ Hormonal imbalance
___Allergy/Asthma	___Hypertension
___Anemia	___Kidney disease
___Arteriosclerosis	___Liver disease
___Arthritis	___Mental illness
___Bleeding problem	___Obesity
___Cancer	___ Sexually transmitted disease
___Diabetes	___ Skin disease
___Eating disorder	___Stroke
___Epilepsy/seizure	___Suicide
___ Gastro-intestinal disease	___Thyroid disease
___ Heart disease	___Tuberculosis
___ High blood pressure	___Other

Your Family

Family Age If deceased, cause of death	Children Age Conditions or N/A
Father	
Mother	
Siblings	

Review of Systems

Please check if you have experienced these symptoms in the last six months.

___Chronic fatigue	___Dry mouth	___Mucus in stool
___Mood swings	___Dental problems	___Blood in stool
___Chronic depression	___Excessive salivation	___Rectal bleeding
___Trembling episodes	___Bleeding gums	___Abdominal pain
___Light-headedness	___Canker sores	___Hemorrhoids
___Food cravings	___Coating on tongue	___Frequent urination
___Frequent infections	___Chronic cough	___Bedwetting
___Night sweats	___Bloody/yellow sputum	___Blood in urine
___Excessive sweating	___Shortness of breath, exertion	___Pain/burning w/urination
___Swollen glands	___Shortness of breath, night	___Foul odor to urine
___Skin rash	___Chest pain with breathing	___Low back pain
___Headaches	___Chest pain/pressure w/ stress	___Loss of urine control

___Seizure/convulsions	___Chest pain/pressure w/ eating	___Other
___Poor memory	___Chest pain/pressure w/sweating	___Other
___Difficulty concentrating	___Chest pain/pressure w/nausea	___Other
___Fainting	___Chest pain/pressure w/anxiety	
___Weakness	___Chest pain/pressure at rest	MEN:
___Insomnia	___Irregular heartbeat	___Decreased urine stream
___Chills/fever	___Heart skips beats	___Dribbling after urination
___Restlessness	___Heart palpitations	___Enlarged prostate
___Irritability	___Fast heart beat	___Pus/drainage from penis
___Dizziness	___Heart murmur	___Genital swelling
___Balance problems	___Swollen hands/feet	___Genital rash
___Numbness/tingling	___Cold hands/feet	___Problem w/sexual function
___Change in skin/nails	___Leg cramps at night	___Abnormal PSA
___Change in mole/wart	___Joint pain	___Low sperm count/infertility
___Abnormal bleeding/bruising	___Pain/fatigue in legs w/exercise	
___Change in hair loss/growth	___Burning feet	WOMEN:
___Blurred vision	___Color change legs/feet	___Spotting between periods
___Double vision	___Color change nails	___Discomfort with periods
___Halos around lights	___Frequent belching	___Change in cycle
___Tearing/itching of eyes	___Pain relieved by eating	___Vaginal discharge
___Eye pain	___Difficulty swallowing	___Painful intercourse
___Loss of vision	___Pain/discomfort w/eating	___Infertility

___Loss of hearing	___Nausea/vomiting	___Problem w/sexual function
___Ringing/buzzing in ears	___Trouble with fried foods	___Vaginal itching
___Sinus trouble	___Bloating of abdomen	___Vaginal pain
___Nosebleeds	___Bowel gas	___Lump in breast
___Bad breath	___Diarrhea	___Abnormal pap smear
___Sore throat/strep	___Constipation	___Premenstrual tension
___Hoarseness	___Black stool	
___Change in voice	___Clay colored stool	

Women

Date of last menstrual period:

Age at start of menstruation:

Number of pregnancies:

Number of live births:

Number of abortions/miscarriages:

Pregnancy complications?

Used birth control pills?

Usual length of cycle:

Usual length of period:

Is flow heavy or light?

Age at menopause:

Date of last pap smear:

Current medication (list all prescriptions and non-prescriptions including dosage):

Supplements (type and dosage):

Allergies to medications:

Food allergies (include method of testing):

List your favorite foods or cravings:

List any foods you especially dislike:

Generally, how is your appetite?

Generally, how is your thirst?

Are you now or have you ever been a smoker/tobacco user?

If so, how many years have you smoked/used tobacco?

How much?

When did you quit?

I estimate my use of coffee to be _______ cups per day.

I estimate my use of tea/other caffeinated beverage to be ______ cups per day.

Do you consider yourself a ___non-drinker ___social drinker ___heavy drinker ___ alcoholic

___ recovering alcoholic

Do you use marijuana?

Other drugs?

Do you exercise regularly?

What is your favorite type of exercise?

Do you find your work rewarding?

What are your favorite activities for relaxation/recreation?

What is your favorite type of weather? Time of year?

Do you worry about money? ____ job? ____ family? ______ relationships? ______
other? ___________

Do you sleep well?
How many hours do you sleep per night?
Do you use sleep aids?

Do you have any fears?

In the past 12 months, have there been any significant changes in your life?

Personal life:

Family life:

Social life:

Work life:

Sex life:

Spiritual life:

Any other significant changes?

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

Remedies are charged separately from the consult, and paid for directly to Minnesota Remedies (homeopathic dispensary of the Northwestern Academy of Homeopathy, Edina, MN). A remedy may range from $15 to $22, including mailing. The remedies can be picked up, or mailed from, the dispensary, after the practitioner puts in a request.

Siri Homeopathy is also a part of a co-operative called Minnesota Center for Homeopathy, 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