CENTERS FOR ADVANCED MEDICINE

704-895-WELL (9355) | Fax: 877-706-1786
www.DrButtar.com

Welcome to Our Practice

Congratulations on taking the first step! Once your appointment has been confirmed, you will receive two informational DVDs from the Know Your Options™ The Medical Series created by Dr. Rashid A. Buttar. **It is mandatory that you and anyone attending your initial consult watch these DVDs prior to so that you get the most benefit from the appointment.** The two informational DVDs you will receive are titled:

1. **Autism: The Misdiagnosis of Our Future Generations**
2. **Heavy Metal Toxicity: The Hidden Killer**

The following material will finalize your paperwork and should be completed and returned to our office as soon as possible. Please review and complete this material in its entirety. It is important that you answer all questions carefully and accurately so that the medical provider has the correct information. This is essential in order to maximize the outcome of the treatments you may receive.

We thank you for choosing us to provide your medical care and look forward to seeing you in our clinic in the near future.

Sincerely,

Administrative Staff
Centers for Advanced Medicine

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New Patient (Autism) Paperwork Checklist

Prior to Appointment

- ☐ Read Welcome Letter
- ☐ Review all REQUIRED items on Checklist (*this page*)
- ☐ Completed Patient Registration form
- ☐ Read & Sign all Consents & Release for Filming
- ☐ Read & Sign Financial/Appointment Policy
- ☐ Read & Sign HIPPA Notice
- ☐ Complete Release of Medical Records form
- ☐ Read & Sign Evaluation & Examination form
- ☐ Read & Sign Consent for IV therapies
- ☐ Read Autism Treatment Protocol & Misdiagnosis of Our Future Generations. **(You do not have to print these pages.)**

Appointments scheduled ONLY after above items are complete!

After Appointment is Scheduled

Crucial: The items below MUST be accurately completed!

- ☐ COMPLETE **AUTISM** INTAKE FORM
  (no more than 2 weeks prior to appointment)
- ☐ COMPLETE RAP-TD Online
  (no more than 2 weeks prior to appointment)
- ☐ Watch DVD's (**Autism & Heavy Metals**)

Link sent with initial new patient email. Hard copies to be mailed after consult fee is paid.

_____ _____

(Patient / Guardian's Signature) **(Today's Date)**

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Patient Information and Registration

Patient Name: _____ Date: _____
Last First Middle

Sex: ☐M ☐F Date of Birth: _____ Marital Status: ☐S ☐M ☐D ☐W

Patient Social Security #: _____

Primary Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email Address: _____
*used for important administrative & clinical purposes - please list email address you will check often

Names of Parents: _____ Date of Birth: _____
(if patient is minor)

_____ Date of Birth: _____

To Be Filled Out by Financially Responsible Party:

Name of Responsible Party: _____

Driver License #: _____ Social Security #: _____

Employer: _____ Work Phone: _____
Address: _____
Street City State Zip

Relative Not Living with You: _____ Phone #: _____
Address: _____ Relationship: _____

Family Doctor: _____ Phone #: _____
Address: _____ Fax #: _____

Diagnosis/Reason for Visit: _____
_____
_____
_____

How did you hear about us? _____

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Consent for Treatment

I authorize the Medical and Nursing Staff of Centers for Advanced Medicine to perform any diagnostic tests and/or administer treatment plans for allergy, immune and nutritional disorders, as well as cancer, autism or any other chronic medical conditions. I fully recognize and understand that the advanced medical treatments I will receive may include nutrient, herbal, oxidative, functional, integrative, alternative, preventative, traditional, pharmaceutical, dermaceutical, nutraceutical, and/or conventional therapies. I also understand and fully acknowledge that:

1. Almost all the patients coming to Centers for Advanced Medicine have previously been evaluated and treated with limited or no success prior to coming to our practice.
2. The safety and efficacy of many such therapies has not been established with controlled studies (the prevailing, but inadequate methods, of evaluating effective treatments).
3. Specifically, no claim to "cure" cancer or "cure" any other medical condition with these therapies has been made to me.
4. Our medical staff will NOT be providing hospitalized care or emergency care for me from this clinic.
5. The therapies I receive will compliment the care I receive from my primary care physician, and will not replace them.

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature Date

_____ _____
Representative of Centers for Advanced Medicine Date

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Financial/Appointment Policy

We ask that all patients read and sign our Financial/Appointment Policy prior to scheduling their initial appointment. You will be given your choice in seeing one of our medical providers, all of whom review all charts.

We require pre-payment of all initial appointments. Thereafter, payment is due at the time services are rendered. We require a 72 hour cancellation notice for initial appointments. If you must reschedule you may apply the entire payment to a future visit as long as we receive a 72 hour notice. After you have had your initial appointment, we only require a 24 hour cancellation notice. You may be charged for appointments cancelled without the required notice.

Please note that we do not participate with or accept assignment from any insurance companies. Although most treatments are not reimbursable, as a courtesy we will provide you with the CPT codes for the treatments that can be filed to insurance for you to file on your own behalf. We can not provide filing information for Medicare. Treatments that are reimbursable will vary based on your policy. Because we are not contracted with your insurance company, any reimbursements issued to our office will be returned with a letter stating that all payments should be issued directly to you.

1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you, NOT your insurance company. All charges are ultimately your responsibility whether your insurance company chooses to pay on your claims or not.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In most cases, the majority of alternative and preventative medical treatments are not covered by insurance. We are able to bill some lab work to Medicare if that is an option for you.
3. Returned checks will be subject to an additional collection fee and will not be reprocessed.

Thank you for choosing us as your health care provider. Our main goal is to provide you the treatment needed to restore and maintain your health. We sincerely appreciate your trust in us. The opportunity to care for our patients is something we take very seriously.

I have read the above policy and accept full financial responsibility for my medical treatments. I recognize that many of the services rendered to me may not be covered by my insurance company.

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature Date

_____ _____
Representative of Centers for Advanced Medicine Date

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Permission and Release for Filming

In signing this form, I provide all rights to the use of my image, likeness and voice for the filming, editing and duplication of footage by Dr. Rashid A. Buttar, Centers for Advanced Medicine, associated companies and any media outlet authorized by Centers for Advanced Medicine.

I understand that I may be asked questions regarding my health and medical condition. I give my permission for release of this information and understand that it will be videotaped, but may be used in other forms of media, including but not limited to CD-ROM, audio, new publications, broadcasts or internet. I fully understand that I will receive no compensation or royalties for participation. This release is for all purposes including educational and marketing and is all inclusive of the filming done on all occasions in or around the clinic located at 19620 West Catawba Ave., Suite 100, Cornelius, NC 28031.

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature Date

_____ _____
Representative of Centers for Advanced Medicine Date

Please print the following:

Address: _____

_____

Phone: _____

Email: _____

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HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an office procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the visit.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation:
Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

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You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Patient's Name (print): _____

Patient/Guardian's Signature: _____ Date: _____

Employee Signature: _____ Date: _____

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Request for Release of Medical Records

Date: _____

Patient Name: _____ Date of Birth: _____

To (Institution or Physician): _____

Physician's Phone and Fax #: _____

The above named patient has requested to have a copy of their medical records sent to our clinic. Please fax or mail the following records to us as soon as possible:

_____ The last 2 (most recent) EKG's

_____ All recent (last 3 months) lab work

_____ Reports of Vascular Studies if applicable

_____ Stress test / Echocardiogram reports if applicable

_____ Most recent doctor's notes / history and physical if available

_____ _____

_____ _____

Please fax or mail this information to the above address. We greatly appreciate your help and thank you in advance for your prompt attention to this matter.

Patient Request and Consent for Release of Medical Records

I, _____hereby authorize the release of any medical records, diagnostic tests or treatment history requested by Centers for Advanced Medicine. Please send this information to their office as soon as possible. Thank you.

Signature of Patient: _____ Date: _____

Original Date: July 17, 1997 | Last Revised: January 8, 2018

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Learning Tools

The following **FREE** resources may be helpful to you:

MEDICAL REWIND – The Medical Rewind website is a hub of information. On this website you will find: patient video testimonials and link to our Vimeo Video and YouTube Channels, links to all of Dr. Buttar's informational websites, Medical Rewind Radio Show replays, Seminar schedule, and more. Please visit www.MedicalRewind.com

FACTS ON TOXICITY VIDEO SERIES - The Free FACTS ON TOXICITY Video Series is a complete collection of short videos of riveting medical information, which provides the basis of ALL chronic disease. This vital information is crucial for the world to know and has already impacted literally thousands of people around the globe. Please visit www.FactsOnToxicity.com and watch these FREE videos. If you find them to be of immense value has hundreds of people before you have, we only ask you to "Pay it Forward" in return by telling your loved ones about this site.

MEDICAL SECRETS AUDIO SERIES - The Free Medical Secrets Audio Series is a complete collection of over 15 hours of riveting medical information that has been kept secret from the population, primarily presented by one of the top 50 doctors in the USA, along with a few lectures presented from other highly respected physicians or researchers. To sign up for the Medical Secrets Audio Series, visit www.DrButtar.com/audio.php or visit www.FactsOnToxicity.com.

WEEKLY H.O.W. REPORT - Is our weekly Health Optimization and Wellness email newsletter. This newsletter feeds into our blog so you can comment and interact with other intelligent, like-minded people. To subscribe to our newsletter visit: www.drbuttar.com/newsletter_reg.php

DR. BUTTAR TRUTH SITE - Another website you may wish to review, in case you have an interest or questions surrounding the controversy regarding the false accusations against Dr. Buttar from the North Carolina Medical Board, feel free to visit www.DrButtarTruth.org. The truth and supporting evidence are all provided so that you can determine for yourself the true agenda of the North Carolina Medical Board and why we are a threat to them and the standard medical paradigm.

Our office contact information is as follows:

Centers for Advanced Medicine
19620 West Catawba Ave., Suite 100 | Cornelius, NC 28031
(704) 895-WELL (9355) | www.DrButtar.com
Fax (877) 706-1786

To send an **email** to the clinic, simply send it to: mailto:info@drbuttar.com

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www.DrButtar.com

Policy for Evaluation and Examination of Pediatric Patients

I, _____, as the parent and/or legal guardian of _____ have fully read, understand and agree to the following policy regarding the care my child will receive by the medical staff at Centers for Advanced Medicine (clinic).

1. I have sought treatment for my child at this medical clinic of my own accord and after doing extensive research on the most effective course of action to pursue. This is an informed decision made specifically for my child's benefit. I am making this decision freely and it is my own personal choice. _____

2. My child has suffered for _____ years and has been evaluated by _____ physicians and specialists before coming to this particular clinic. It has been clearly explained to me that this clinic does not and will not be providing primary care or routine visits for my child. I will continue to use my own pediatrician and/or primary care provider for routine medical care. _____

3. I have brought my child to this clinic specifically to address the underlying cause of the metabolic, toxic and/or immune disorder from which my child suffers. I am fully aware of the prevailing medical model designed to suppress symptoms with medication. I am coming to this clinic specifically because I wish to address the cause of the problem, not suppress symptoms with medications. _____

4. I understand that this clinic does not have a pediatrician on staff and does not provide physicals for children. I understand that while my child is undergoing treatment at this clinic, I am required to have a physical exam conducted once a year by my child's pediatrician or primary care provider. A copy of the physical exam report should be provided to the clinic before starting treatment. _____

5. I understand all evaluations (blood work, fecal tests, hair tests, urine tests, RAP-TD, follow-ups) for ongoing treatment will be conducted at the clinic and are required to be completed at specific intervals. I fully understand that treatment must be properly monitored with testing and that follow-ups are required to ensure the safety of my child and to direct the course of treatment to maximize efficacy. I also understand that for the protection of my child, failure to comply with any of the above requirements will result in the delay and/or termination of treatment. _____

I am fully aware of and understand all the contents of this document. Furthermore, I have been given adequate opportunity to ask questions and obtain clarification regarding these specific policies.

_____ _____
Parent / Guardian's Name (print) Patient's Name (print)

_____ _____
Parent / Guardian's Signature Date of Signature

_____ _____
Witness / Representative of the Clinic Signature Date of Signature

Original Date: February 8, 2005 | Last Revised: January 8, 2018

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RECURRING CONSENT FOR VARIOUS THERAPIES (Including IV's)

I, _____, acknowledge that Dr. Buttar and his professional medical staff have explained to me in detail the principles and practices of the various IV (intravenous), TD (transdermal), PO (by mouth) and PR (by rectum) treatments, including, but NOT limited to EDTA, DMPS, Oxidative therapies including ozone auto-hemotherapy, UVBI and H2O2, nutritional, Lipoic Acid, Vitamin C, various minerals including but NOT limited to selenium, magnesium, potassium, zinc, manganese, cesium, rhobidium, chromium, germanium, vanadium and molybdenum, homeopathics, ACIS, MTE formulations, DNA Reductase, DNAOR, MISS, UFAM, MSP protein, Glutathione, Myer's drips, Sulfoxime, Dioxychlor, Biorizin, phosphatidylcholine, glycerophosphocholine, and various amino acids including but NOT limited to proline, lysine, argenine, taurine, glutamate, cysteine, alanine, glutamine, tryptophane, tyrosine, phenalnine and glycine. Specifically, I understand that any of these above mentioned therapies that are administered using intravenous administration techniques, are used for various medical reasons and for various indications. I understand that these treatments are designed to optimize the detoxification of my body and/or to provide nutritional and other support for my system as well as to remove persistent organic pollutants and heavy metals from my system. I understand that these various IV therapies are being provided to me according to the guidelines and/or protocols established or presented by the American Board of Clinical Metal Toxicology (ABCMT) in Chicago, IL, the International College of Integrative Medicine (ICIM) in Cincinnati OH, the Institute of Preventive Medicine in Denville, NJ, the American College for Advancement in Medicine (ACAM) in Laguna Hills, CA, the American Academy of Environment (AAEM) in Wichita, KS, the American Association of Integrative Medicine (AAIM) in Springfield, MO and/or the Advanced Medical Education and Services Physician Association (AMESPA) in Lake Tahoe, NV.

✓ Initials: _____

✓ It has been explicitly explained to me that the efficacy of any of these treatments including EDTA therapy for the support of heart and vascular problems, any IV therapies for the nutritional and detoxification support for cancer, and any other IV therapies indicated for any condition that I may be suffering from, have not been proven with the prevailing randomized, double-blind, placebo controlled studies. I acknowledge that I accept any of these therapies as an adjunct therapy to the standard drug therapies prescribed to me by my regular physician, including my cardiologist, oncologist, neurologist and/or other primary care physician. I have discussed conventional and traditionally accepted options of surgery, angioplasty, chemotherapy, radiation therapy, and other various invasive techniques and forms of treatment with my other physicians prior to visiting Dr. Buttar. It is my informed decision that I accept the treatments as discussed with Dr. Buttar and his medical staff as an integrative approach to my medical care in lieu of or in conjunction with the other conventional options presented to me by my other physicians, including but not limited to surgical and other interventional therapies. I fully understand that any of these various therapies as listed above, may not give me appreciable benefits due to the advanced state of my medical condition(s). I also understand that I will most likely have some type of Hertzheimer type reaction. I acknowledge that no guarantees or claims have been made to me regarding the efficacy or results of any of the above various therapies listed.

✓ Initials: _____

✓ I have been informed of the possible adverse effects of all the IV therapies mentioned above, including but NOT limited to the possibility of phlebitis, infections, headaches, dizziness, hypoglycemia, electrolyte imbalance, mineral depletion, fatigue and kidney injury. In extreme rare circumstances, severe side effects such as kidney failure or even death are possible, although these types of issues have never been observed by Dr. Buttar or his medical colleagues. I also clearly understand that although anything could potentially occur, the full spectrum of possible side effects from any therapy I receive from Dr. Buttar's clinics are minuscule when compared to the traditional, conventional medical treatments and therapies provided by the "standard of care" which have been published in the medical literature. Regarding EDTA specifically, I understand that according to published material, there have been over 1,000,000 patients who have received over 8 million intravenous EDTA "chelation" treatments over the past 55 years. Benefits from this particular therapy reported by patients include relief of symptoms of metal toxicity, peripheral, cerebral and coronary vascular disease, diabetes, hypertension, and degenerative joint diseases. This too has not been proven with the prevailing randomized, double-blind, placebo controlled studies. However, these observations are felt to be due to the antioxidant, chelating, anti-lipid peroxidation, detoxification and nutritional support effect of all the above stated IV therapies.

✓ Initials: _____

Initials: _____ I have been informed that all appointments made for any IV (Intra Venous) therapies are final, but are cancelable before 8 AM on the day of the appointment. I will be responsible for 50% of the cost of any IV therapy if I cancel the appointment after 8 AM, OR if I do not arrive for treatment.

✓ **Patient Signature : _____Today's Date_____**

✓ **Spouse / Witness : _____Today's Date_____**

To all patients: Please be aware that the following language is brought to you as a "courtesy" of the North Carolina Medical Board, and is the only action "required" of us after Dr. Buttar's 5 year battle with the North Carolina Medical Board. To get more details on this battle, visit www.DrButtarTruth.org. This form has NOT been changed, modified or amended in any manner and is provided to you EXACTLY in the format as it was provided to us. Any inadequacies, incompleteness, omissions or errors are the sole responsibility of the North Carolina Medical Board.

Signature: _____

Amended April 11, 2010

Informed Consent to Treatment and Therapies

I, [patient name (written by patient)]_____, understand and have been advised that Rashid Ali Buttar, D.O. practices integrative medicine. Integrative medicine is defined by N.C. Gen. Stat. §90-1.1(3) as: a diagnostic or therapeutic treatment that may not be considered a conventionally accepted medical treatment and that a licensed physician in the physician's professional opinion believes may be of potential benefit to the patient, so long as the treatment poses no greater risk of harm to the patient than the comparable conventional treatments.

Initials: _____.

I have been diagnosed with [diagnosis (written by patient)]_____. ***I understand and have been advised that the treatments and therapies that are to be provided by Dr. Buttar have not been proven effective by traditional research studies or conventional clinical trials and may not have been approved by the FDA for my diagnosis. Dr. Buttar makes no specific claims or representations that the treatments and therapies that he will be providing will be effective or cure the condition or diagnosis that I have.*** I have been encouraged to consult with my primary care physician or the specialist who is primarily treating the above designated diagnosis prior to receiving treatment from Dr. Buttar.

Initials: _____.

I, further understand and have been advised that Dr. Buttar's clinic sells health care practice related items from his office. There is a potential, inherent conflict of interest when a physician sells health care practice related items from his office. Sale of practice-related items such as supplements, vitamins, minerals and medications may be acceptable only after the patient has been told those or similar items can be obtained locally from other sources. I am fully aware that as with any product or commodity, the quality, purity, efficacy, concentration, source and numerous other variables will determine the ultimate price. I also recognize that I have the option to pursue my health care needs at any doctor's office I so choose.

Initials: _____.

I, additionally understand and have been advised that Dr. Buttar utilizes the services of a nurse practitioner in his practice. Nurse practitioners may perform medical acts, tasks and functions under the supervision of a licensed physician. This means that physical examinations and diagnosis can be made by a nurse practitioner qualified to make such examinations and diagnosis while acting under the supervision of a licensed physician. Treatments may also be administered by a nurse practitioner working under the supervision of a licensed physician. I understand and have been advised that office visits may be conducted and treatments may be administered by Dr. Buttar's nurse practitioner.

Initials: _____.

I also understand and have been advised regarding possible adverse effects of all treatments and therapies that Dr. Buttar will be providing me, including intravenous (IV) treatments.. The possible adverse effects of the treatments that I may receive from Dr. Buttar include, but are not limited to, infection, phlebitis, headaches, dizziness, hypoglycemia, electrolyte imbalance, mineral depletion, fatigue, kidney failure, or even death.

Initials: _____.

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A few things to know about being a patient:

- Always eat a high protein breakfast before you arrive.
- Bring food to eat while at the clinic if you will be at the clinic for the majority of the day.
- The clinic is equipped with a patient break room and kitchen area where you can have a meal or break. In the Patient Kitchen area there is a full size refrigerator you are welcome to use. Please make sure you mark your name and the date on anything you wish to leave in this refrigerator.
- We **do not** have a microwave in the office. In the Patient Kitchen, there is a blender, small toaster oven and hot plate you are most welcome to use.
- Our IV Suites are equipped with a TV and DVD player. Cable TV service is not available on the TVs. Patients may bring DVDs to watch on the TV, or a portable DVD player of your own may also be brought by patients. There are plenty of electrical outlets in the IV Suites to plug in electronics such as phones and portable entertainment devices. .
- Filtered water is provided in the Patient Kitchen for patients and staff. You are welcome to fill up gallon containers of water to take with you, however, please follow our guidelines of filling only one (1) gallon container every 30 minutes so there will be water for others to drink.
- **Do not** take minerals on the day you will have chelation. For patients with Cancer, Monday's will be the day you will not take your minerals.
- Please **do not** wear any scented toiletries (perfume, lotions, hair products, etc) as we treat many people that are sensitive to these products.
- If Hyperbaric Therapy is a part of your treatment protocol, wear or bring comfortable clothing to wear in the hyperbaric chamber- no metals or electronics allowed in chambers. Complete instructions and guidelines for Hyperbaric Therapy will be given to you before starting this therapy.
- If you are not taking or unable to take your supplements as directed, please inform the nursing staff as they will need to discuss this with a provider. Adjustments may need to be made in your treatment plan.
- Try to be on time for your appointment. If you are late, your IV schedule will have to be adjusted and you may not receive all of your IV's. If you are unable to make your appointment for any reason, please contact us as quickly as possible. Some IV's are mixed ahead of time and must be used the same day they are mixed. 24 hour notice
- Any time you are unsure about your treatment plan, please talk to the nursing staff or your provider.
- When you are scheduled for an Ondamed treatment, bring a gallon of water with you. The Ondamed is a Biofeedback instrument which measures cellular frequency levels. Your water will be charged with the same frequency that you are treated. You may then drink the water as you wish for a boost to the Ondamed treatment.

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A few things to know about being a patient:

Child Patients

- Children must be accompanied by a parent at all times.
- Some toys are available in the IV Suite, however, we encourage parents to bring activities to keep your child occupied during the day.
- An IV reinsertion fee of $25 per incident will be charged in cases when a child is continuously pulling their IV out.

Other Helpful Information

Please view the "Out of Area Patient Information" section of our website for a listing of other helpful information: http://www.drbuttar.com/out-of-state-patient-information.html

- Charlotte, NC area airports
- Lodging near our Clinic
- Fully furnished short & long term housing options
- In home nursing care
- Lake Norman area taxi services
- Wheel chair transport services
- Local organic & gluten-free grocery stores
- Local farmers markets
- Local organic fresh food stores
- Local parks
- Area recreation options
- Area entertainment option