CONSULTATION AGREEMENT

NATURE OF WORK PERFORMED BY PRACTITIONER

I understand that my practitioner evaluates my entire condition based on a holistic, homeopathic approach, and seeks to assist me to stimulate my body's own healing mechanisms with the use of substances prepared according to the guidelines of the Homeopathic Pharmacopoeia of the U.S, as regulated by the FDA. I understand that my practitioner may also discuss with me the use of other integrative therapeutics to improve my health, and that these are within his scope of practice to the extent that he incorporates them. I agree that I am interested in enhancing my own abilities to establish health in mind and body.

TRAINING AND CREDENTIALS OF PRACTITIONER

I have reviewed the training and credentials of the practitioners listed below. I understand that my practitioner is not a medical doctor, has not presented himself as such, and does not seek to diagnose, treat, or prescribe for disease, disorder or other pathological conditions.

> **Randy Fruchter, CCH, CIHC** attended the University of Michigan where he received a Bachelor of Business Administration in 1998, and the Bloustein School at Rutgers University, where he received a Master of City and Regional Planning in 2006. He completed a 3-year certificate program at the Academy of Homeopathy Education in NYC (now located in Philadelphia), and a 1-year certificate program with the Institute for Integrative Nutrition. He is nationally certified in Classical Homeopathy by the Council of Homeopathic Certification, and internationally certified in Health Coaching by the International Association for Health Coaches.

COST AND POLICIES OF CONSULTATION

I have reviewed the fee statement. I agree to pay these fees at the time that services are provided, by cash, credit card, or Paypal. I agree to the office policies and charges as described in the policy statement below.

PROFESSIONAL CONDUCT AND CONSULTATION

Practitioner agrees to honor confidentiality and assures professional conduct as defined by the Code of Ethics of the Council for Homeopathic Certification; Client grants permission for my practitioner to discuss details of his/her health in conferral with professional colleagues without additional confidentiality waiver. This agreement becomes part of client's case records. Client agrees to consult a licensed physician for any medical concern that now exists or arises at any time during the term of this agreement, and to inform Practitioner of any physician's assessment in so far as it applies to the client's work with Practitioner.

____

Client Name

____

Client Signature Date

FEES AND POLICIES FOR CONSULTATION

Fees can be found on the website here: fee statement

Fee includes email support and brief check in calls as required to track response. Remedies are to be purchased by the client; I offer at least one recommendation to clients as to where to purchase.

GENERAL POLICIES REGARDING SCHEDULING, PAYMENT, AND CLIENT SUPPORT:

Scheduling and Cancellations: We understand that occasional unexpected circumstances arise that can disrupt your schedule, and require a change of appointment.

- If it is necessary to cancel / reschedule an appointment, notification of schedule change must be made at least 24 hours in advance.
- Appointments that are missed or cancelled late represent time that was scheduled for the client, and this time is unlikely to be rebooked in a late cancellation or missed appointment.
- Each client is offered one ‘first miss’ or late cancel that is not charged. A second or later event will be charged at the full fee.

Virtual Office Consultation: Clients can schedule consultation by web conference using Zoom.

Payment: The client is responsible for payment of all fees at time of service.

- Payment may be made with cash, credit card (Visa, MasterCard, AmEx, or Discover) or Paypal.
- Clients who have off-site consultations are asked to keep a credit card on file with the office to simplify payment.
- Our office does not file any forms for insurance or reimbursement.
- Clients are encouraged to investigate all options for insurance reimbursement or use of plans such as Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA), which allow reimbursement of payment with pre-tax funds.

Homeopathics: The client will obtain the selected remedy from a licensed homeopathic pharmacies or a reputable distributor.

- Many common homeopathics in lower potencies can be obtained locally by the client at health food stores (Whole Foods, Sprouts, Wegmans, etc). For some clients, it is recommended to have a homeopathic kit on hand with a ready set of common options.
- We understand that it may be frustrating to be waiting for a package to arrive. In several other countries, wide selections of homeopathics are available at any local pharmacy. Unfortunately this is not true in much of North America. Patience is required.

CONTINUED...

Interim Support: For scheduling, brief check-ins, questions about symptoms, their therapeutic plan, their remedy response, or acute complaints, please email me at randy@hilltop-homeopathy.com or hilltop.homeopathy@gmail.com. There is no charge for continued, reasonable email contact. I check email regularly, multiple times daily. I will respond promptly if need be, or within a day or two if not an emergency. I will let you know if I believe a specific issue requires an acute or follow-up appointment. I do not guarantee a response on weekends or holidays, nor do I see clients on weekends or holidays.

In emergencies, you must call a doctor or hospital first. I may be able to assist you after you have reached out for medical assistance, but I am not a first responder to any emergency.

If there is any concern that requires prompt response, or you have not gotten a reply from an email in the timeframe you require, please call.

Ultimately, you, the client, are responsible for your own health. You are responsible for maintaining regular, frequent contact with your practitioner, particularly when there are any changes in your health or symptoms. Taking a remedy on a regular basis requires regular, frequent contact with your practitioner. If you no longer maintain contact with your practitioner, please stop taking your remedy.

Complaints and Recourse: Randy maintains certification in Classical Homeopathy by the Council for Homeopathic Certification (CHC), a national accredited credentialing board. This certification requires that each practitioner abide by CHC guidelines for professional and ethical conduct. As with any of the healing professions, each client must have a mechanism of public recourse in the event that he or she feels that unethical or unprofessional interactions have taken place with the certified practitioner. For certified homeopaths, the mechanism of recourse is through the CHC.

The following is a statement from the CHC:

- Each CHC certificant represents the homeopathic profession in the eyes of the public and is expected to uphold the highest standards of professional conduct as described in the CHC Code of Professional Ethics and the Client Healthcare Rights.
- Any client who believes he or she has a valid complaint regarding a CHC credentialed homeopath may submit a letter to the CHC office describing his or her concerns in detail.
- Following receipt of the letter, a member of the Standards and Ethics Committee informs the complainant in writing (through postal or email correspondence) within 10 business days that the complaint has been received and requests an interview to discuss the nature and veracity of the complaint.
- The Standards and Ethics Committee notifies all parties concerned, conducts interviews, and thoroughly investigates each complaint received.
- The letter should be e-mailed to: chcinfo@homeopathicdirectory.com.

Homeopathics: The client will obtain the selected remedy from a licensed homeopathic pharmacies or a reputable distributor.

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- We understand that it may be frustrating to be waiting for a package to arrive. In several other countries, wide selections of homeopathics are available at any local pharmacy. Unfortunately this is not true in much of North America. Patience is required.

CREDIT CARD AUTHORIZATION FORM

HILLTOP
HEALTH & HOMEOPATHY

Please use this form if you plan on credit card payment. We can also accept PayPal and are open to other payment arrangements.

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

CREDIT CARD INFORMATION

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other: ____________________

Cardholder Name (as shown on card)

Card Number Exp Date (mm/yy) CVV/CVV2 Billing Zip

I, ____, authorize **Hilltop Health & Homeopathy** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Client Signature Date

HEALTH INVENTORY FORM

Name | Date

Address

Date of Birth | Age | Gender | Height

Email | Education (circle years completed) Elem HS Coll Voc Prof

Primary Phone | Secondary Phone

Occupation | Employed/ Retired | Hours/Wk

Emergency Contact (name & phone)

If under 18, parent's Name/Address/Phone

Children | Gender(s) | Age(s)

Legal Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Domestic Partner

Living Arrangement: ☐ Alone ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends

Are you currently receiving healthcare? If yes, where and from who? ____________________

Top 3 health concerns: | Intensity of Symptom:

1. ____________________ **Very Mild** 1 2 3 4 5 6 7 8 9 10 **Unbearable**

2. ____________________ **Very Mild** 1 2 3 4 5 6 7 8 9 10 **Unbearable**

3. ____________________ **Very Mild** 1 2 3 4 5 6 7 8 9 10 **Unbearable**

Date of last physical exam

Date of last blood tests | Date of any other applicable testing

CONTINUED...

Please check ALL that apply currently or previously and list approximate dates:

Women:
- ☐ irregular menses
- ☐ PMS
- ☐ endometriosis
- ☐ fibroids
- ☐ pelvic infection
- ☐ miscarriage(s)
- ☐ abortion(s)
- ☐ sickness during pregnancy
- ☐ prolapse of uterus
- ☐ breast lumps

Men:
- ☐ prostate problems
- ☐ ED
- ☐ low testosterone

Acute/Chronic Infections:
- ☐ typhoid
- ☐ cholera
- ☐ dysentery
- ☐ measles
- ☐ german measles
- ☐ polio
- ☐ chickenpox
- ☐ smallpox
- ☐ mumps
- ☐ whooping cough
- ☐ cold-fever
- ☐ pneumonia
- ☐ rheumatic fever
- ☐ scarlet fever
- ☐ tuberculosis
- ☐ diphtheria
- ☐ malaria
- ☐ AIDS
- ☐ meningitis
- ☐ sepsis
- ☐ bronchitis
- ☐ otitis media (ear)
- ☐ sinusitis
- ☐ food poisoning
- ☐ colitis
- ☐ cystitis (bladder)
- ☐ yeast infection
- ☐ candida
- ☐ recurrent infections

Venereal Disease:
- ☐ chlamydia
- ☐ condylomata
- ☐ gonorrhea
- ☐ herpes
- ☐ syphilis

Skin Diseases:
- ☐ acne
- ☐ boils
- ☐ carbuncles
- ☐ hives (urticaria)
- ☐ moles
- ☐ warts
- ☐ ulcers on body parts
- ☐ eczema
- ☐ fungus
- ☐ herpes
- ☐ ringworm
- ☐ scabies

Other Chronic Conditions:
- ☐ allergies
- ☐ arthritis
- ☐ rheumatism
- ☐ gout
- ☐ backache/problems
- ☐ any lumbar puncture
- ☐ anorexia/bulimia
- ☐ binge eating
- ☐ overweight
- ☐ malnutrition
- ☐ rickets
- ☐ insomnia
- ☐ nightmares
- ☐ sleep disorder
- ☐ chronic fatigue
- ☐ chronic headaches
- ☐ migraines
- ☐ chemical sensitivity
- ☐ periodontal disease
- ☐ glaucoma
- ☐ hearing problems
- ☐ hemorrhoids
- ☐ diarrhea
- ☐ worms
- ☐ hernia
- ☐ jaundice
- ☐ any liver, spleen or gall bladder disease
- ☐ hepatitis
- ☐ diabetes
- ☐ cancer
- ☐ prostate
- ☐ thyroid problem
- ☐ asthma
- ☐ pleurisy
- ☐ kidney stones
- ☐ nephritis
- ☐ numbness
- ☐ cramps
- ☐ fits
- ☐ chill
- ☐ neurological problems
- ☐ seizures/epilepsy
- ☐ convulsions
- ☐ paralysis
- ☐ vaccine reaction
- ☐ alcohol/Drug problems
- ☐ steroid use

Physical Trauma:
- ☐ major accident or injury to body or head
- ☐ occasion of unconsciousness
- ☐ major bleeding from any part of the body

Circulatory:
- ☐ anemia
- ☐ high/low blood pressure
- ☐ heart failure
- ☐ heart murmur
- ☐ heart attack
- ☐ palpitation
- ☐ giddiness
- ☐ varicose veins
- ☐ blood clots
- ☐ phlebitis
- ☐ eosinophilia
- ☐ other:__________________

Operations:
- ☐ cataract
- ☐ lasik
- ☐ tonsils
- ☐ adenoids
- ☐ abdomen
- ☐ appendix
- ☐ hernia
- ☐ uterus
- ☐ renal stones
- ☐ gallstones
- ☐ cosmetic
- ☐ other: __________________

Mode of Anesthesia:
- ☐ general
- ☐ local

Antibiotics:
- ☐ never
- ☐ less than once/yr
- ☐ more than once/yr

Emotional State:
- ☐ serious shock
- ☐ grief
- ☐ disappointments
- ☐ fright
- ☐ mental upset
- ☐ mental illness
- ☐ anxiety
- ☐ depression
- ☐ nervous breakdown
- ☐ panic attack
- ☐ suicide attempt
- ☐ psychotherapy

Past history of illnesses, health challenges and medical/surgical procedures:

Hospitalizations:

Surgeries

Serious Illnesses & Injuries

Accidents, Traumatic Injuries, Broken Bones

CONTINUED...

WOMEN ONLY

Date of last menstrual period ____________________

Date of last pelvic exam ____________________

Date/results of last pap smear ____________________

Ever had abnormal pap smear? ____________________

DES exposure ____________________

Sexually transmitted disease ____________________

History of sexual disease ____________________

Frequent yeast infections ____________________

Frequent bladder infections ____________________

Vaginal discharge ____________________

Age period began ____________________

Regular periods: ☐ Yes ☐ No Flow: ☐ Heavy ☐ Medium ☐ Light

Length of cycle __________ Days of Flow __________

☐ Spotting ☐ Cramps ☐ PMS ☐ Endometriosis ☐ PID ☐ Fibroids

Ever used birth control pills? ____________________

How long for? ____________________

How long ago? ____________________

Present birth control ____________________

Change in sex drive ____________________

Painful intercourse ____________________

Pregnancies (number) ____________________

Childbirth (number) ____________________

Complications ____________________

Miscarriages (number) ____________________

Abortions (number) ____________________

Impaired fertility ____________________

Have you ever had a hysterectomy? ____________________

Age at menopause ____________________

Vaginal dryness ____________________

Hot flashes ____________________

Do you do self breast exams? ____________________

Mammograms (number) ____________________

Date of last Mammogram ____________________

MEN ONLY

Date of last prostate exam ____________________

Prostate enlargement ____________________

Change in force of urine stream ____________________

Difficulty starting urination ____________________

Do you do self testicular exams? ____________________

History of undescended testicles ____________________

Pain / lump in scrotum ____________________

Discharge from penis ____________________

Painful intercourse ____________________

Difficulty with erections ____________________

Change in sex drive ____________________

Impaired fertility ____________________

Sexually transmitted diseases ____________________

History of sexual abuse ____________________

Worry and anxiety: Do you have particular issues that worry you? How does this impact your life?

Healthy relationships: Do you have a supportive family/community?

Unhealthy relationships: Have you been a victim of domestic abuse or troubling relationships?

Anything else you wish to discuss?

CONTINUED...

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe: ____________________

____

____

Do you exercise? Yes No What Type?

Frequency? Are you happy with amount?

Personal Habits:
Please indicate which substances, if any, pertain to you. N = use NOW P = used in the PAST

SUBSTANCE	N/P	HOW MUCH?	HOW LONG?	SUBSTANCE	N/P	HOW MUCH?	HOW LONG?
Tobacco				Soda			
Alcohol				Diet Soda			
Rec Drugs				Artificial Sweeteners			
Coffee				Refined Sugar			
Black Tea				Processed Food			

Do you need guidance/support with a healthy well-balanced diet? ____________________

Do you have specific spiritual practice? ☐ Y ☐ N If so, please describe it: ____________________

Life Changes:
In the past year, what changes have occurred in your:

Personal life: ____________________

____

Family life: ____________________

____

Social life: ____________________

____

Work life: ____________________

____

Sex life: ____________________

____

CONTINUED...

Family History:

	AGE	IF DECEASED, CAUSE OF DEATH
Mother		
Father		

SIBLINGS	AGE	DECEASED?

Check (double click box and select 'checked') items that apply to blood relatives and list relationship:

- ☐ Alcohol/drug problem __________
- ☐ Allergy/asthma __________
- ☐ Anemia __________
- ☐ Arteriosclerosis __________
- ☐ Arthritis __________
- ☐ Binge eating/bulimia __________
- ☐ Bleeding problem __________
- ☐ Cancer __________
- ☐ Diabetes __________
- ☐ Epilepsy/seizure __________
- ☐ Heart disease __________
- ☐ Skin disease __________
- ☐ High blood pressure __________
- ☐ High cholesterol __________
- ☐ Kidney disease __________
- ☐ Liver disease __________
- ☐ Mental illness __________
- ☐ Obesity __________
- ☐ Stroke __________
- ☐ Suicide __________
- ☐ Thyroid disease __________
- ☐ Tuberculosis __________
- ☐ Ulcer __________
- ☐ Syphilis __________
- ☐ Gonorrhea __________

Please list all prescription and over-the-counter medications you are currently taking:

MEDICATION	DOSE	DATE STARTED	PRESCRIBED BY

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking:

SUPPLEMENT	DOSE	DATE STARTED	PRESCRIBED BY

Please list any severe or life-threatening allergies (include method of testing): __________

____