

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 agrees to discontinue use of any homeopathic remedy or other recommended treatment if regular contact (for example, every two weeks) is not maintained with the 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.

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.

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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 _____

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
- gonorrhoea
- 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

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?

HEALTH INVENTORY FORM 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: _____

Family History:

	AGE	IF DECEASED, CAUSE OF DEATH	SIBLINGS	AGE	DECEASED?
Mother					
Father					

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

- | | |
|---|---|
| <input type="checkbox"/> Alcohol/drug problem _____ | <input type="checkbox"/> High cholesterol _____ |
| <input type="checkbox"/> Allergy/asthma _____ | <input type="checkbox"/> Kidney disease _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Liver disease _____ |
| <input type="checkbox"/> Arteriosclerosis _____ | <input type="checkbox"/> Mental illness _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Obesity _____ |
| <input type="checkbox"/> Binge eating/bulimia _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Bleeding problem _____ | <input type="checkbox"/> Suicide _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Epilepsy/seizure _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Syphilis _____ |
| <input type="checkbox"/> Skin disease _____ | <input type="checkbox"/> Gonorrhea _____ |
| <input type="checkbox"/> High blood pressure _____ | |

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): _____
