



LYMEXICO
DR OMAR MORALES

NEW PATIENT PACKAGE

Welcome to our clinic! We are pleased that you have chosen Lyme Mexico Clinic as your next step for treatment and we thank you for placing confidence in us.

Please review and fill out the following information in this package. After your doctor has explained the treatment to you, you must make a conscious decision whether or not to undergo our therapy, whereby you assume the responsibility for your decision. By no means will we advise you against continuing other conventional medical treatment if you consider this to be appropriate or necessary. In fact, many patients find our treatment beneficial as adjunctive therapy to more conventional treatment plans.

Before your first appointment, please complete and email the completed New Patient Package to: info@lymediseasemexico.com.

If you are unable to email it, please bring the completed New Patient Package to your scheduled initial consultation.

If you have any questions, please do not hesitate to contact us at:
info@lymediseasemexico.com.



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PATIENT AGREEMENT

Patient Information

Patient name _____ Date of birth _____

Name of Parent or Authorized Guardian and Relationship (If Applicable):

Current residence _____

Phone _____

Social Security # _____

Please list all known allergies:

I have provided the following information and documents listed below:

- Medical Questionnaire
- List of Medications
- List of Supplements
- Current Symptoms Checklist
- Consent to Disclose/Release Health Information to Dr. Omar Morales
- Informed Consent for Treatment of Persistent Lyme Disease
- IV Treatment Consent Form
- Information and Consent on the Settlement of Costs
- Patient Declaration

I hereby authorize and accept Lyme Disease Mexico to provide the required services and products and agree to their terms and conditions:

Patient Signature _____ Date _____

(Or Patient Representative)

(Indicate Relationship If Signing for Patient _____)

Office Signature _____ Date _____



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MEDICAL QUESTIONNAIRE

Please fill out the following information completely. Your answers on this questionnaire are important for the planning of our therapies. Please take your time and answer as accurately as possible. If there is not enough space for your entries, please add a separate page.

Personal Information

Last Name _____ First Name _____
Date of Birth _____ Place of Birth _____

Sex M F Family (To Child Under 18 Years) _____

Mailing Address (If Different from Previous Page)

City _____ Country _____
Zip Code _____ Home Phone _____
Mobile Phone _____ Work Phone _____
Fax Number _____ Email _____
Skype _____
Contact Preference Email Phone _____
If phone, best time to call _____

Relationship Status Married Single

Occupation _____
Children Number _____ Sex(M/F) _____ Age(s) _____

Emergency Contact Person

Name _____ Phone _____
Address _____ Email _____

Contact Information for Stay in Puerto Vallarta

Hotel/Residence Name _____
Address _____
Telephone Number _____

Primary Care Physician

Name _____ Address _____
Phone _____ Email _____



MEDICAL BACKGROUND

Please briefly state your reason for the visit to our office.

Medical History (Chronic Illnesses and Injuries):

Date	Illness	Treatment

Surgical History (Operations and Procedures):

Please list in chronological order, from the oldest to the most recent.

Month & Year	Type of Surgery

Have you ever needed a transfusion of blood or blood products: Yes No
If yes, briefly explain why.

Please explain any adverse reactions?

Does your family have a history of any illnesses? Yes No
If so, please explain:



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LIFESTYLE

Height _____ cm in Weight in _____ kg lbs

Please select the appropriate answer and make comments where necessary.

	Normal	Too Little	Too Much	Comments
Appetite/Thirst				_____
Digestion/Bowel Movement				_____
Exercise				_____

	Comments
Sleep Disturbances	_____
Dental Problems	_____
Do you have amalgam fillings?	_____
Do you have root canals?	_____
Heart Problems/Heart Illnesses	_____
Breathing Problems, Asthma	_____
Unrest, Concentration Problems, Tiredness	_____
Problems of the Bladder or Genital Area	_____
Vomiting, Nausea, Flatulence	_____
Back Problems, Joint Problems	_____
Do you have difficulty climbing stairs?	_____
Do you need a wheelchair?	_____
Allergies	_____
Emotional Problems	_____
Are you on a special diet?	_____
Do you smoke? If so, how often?	_____
Do you drink? If so, how often?	_____
Do you have pets? If so, what type and how many?	_____

Any other important information about your lifestyle, occupation and/or environment?
(ie. exposure to mold, heavy metals, etc)



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INFORMED CONSENT FOR TREATMENT OF PERSISTENT LYME DISEASE

There is considerable uncertainty regarding the diagnosis and treatment of Lyme disease. No single diagnostic and treatment program for Lyme disease is universally successful or accepted. Medical opinion is divided, and two schools of thought regarding diagnosis and treatment exist. Each of the two schools of thought is described in peer-reviewed, evidence-based treatment guidelines. Until we know more, patients must weigh the risks and benefits of treatment in consultation with their doctor.

My Diagnosis

The diagnosis of Lyme disease is primarily a clinical determination made by my doctor based on my exposure to ticks, my report of symptoms, and my doctor's observation of signs of the disease, with diagnostic tests playing a supportive role. Doctors differ in how they diagnose Lyme disease.

Some physicians rely on the narrow surveillance case criteria of the CDC for clinical diagnosis even though the CDC itself cautions against this approach. These physicians may fail to diagnose some patients who actually have Lyme disease. For these patients, treatment will either not occur or will be delayed.

Other physicians use broader clinical criteria for diagnosing Lyme disease. These physicians believe it is better to err on the side of treatment because of the serious consequences of failing to treat active Lyme disease. These physicians sometimes use the antibiotic responsiveness of a patient to assist in their diagnosis. Since no treatment is risk-free, use of broader clinical criteria to diagnose disease could in some cases expose patients to increased treatment complications. This approach may result in a tendency to over diagnose and over treat Lyme disease.

My Treatment Choices

The medical community is divided regarding the best approach for treating persistent Lyme disease. Many physicians follow the treatment guidelines of the Infectious Diseases Society of America (IDSA) that recommend short-term treatment only and view the long-term effects of Lyme disease as an autoimmune process or permanent damage that is unaffected by antibiotics. [1] Other physicians believe that the infection persists, is often associated with other tick-borne co-infections, is difficult to eradicate, and therefore requires long-term treatment with intravenous, intramuscular, or oral antibiotics, frequently in high and/or combination or pulsed dosing. These physicians follow the guidelines promulgated by the International Lyme and Associated Diseases Society (ILADS), which recognize that commercial diagnostic tests may be insensitive and that diagnosis and treatment must be based on the physician's clinical judgment and that the risk/ benefit of any treatment must be individualized. [2]

Potential Benefits of Treatment

Some clinical studies support longer term treatment approaches, while others do not. The experience in this office is that although most patients improve with continued treatment, some do not.



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Risks of Treatment

There are potential risks involved in using any treatment, just as there are in foregoing treatment entirely. Some of the problems with antibiotics may include (a) allergic reactions, which may manifest as rashes, swelling, and difficulty with breathing, (b) stomach or bowel upset, or (c) yeast infections. Severe allergic reactions may require emergency treatments, while other problems may require suspension of treatment, or adjustment of medication. Other problems such as adverse effects on liver, kidneys gallbladder, or other organs may occur.

Factors to Consider My Decision

No one knows the optimal treatment of symptoms that persist after a patient is diagnosed with Lyme disease and treated with a simple short course of antibiotic therapy. The appropriate treatment may be supportive therapy without the administration of any additional antibiotics. Or, the appropriate treatment might be additional antibiotic therapy. If additional antibiotic therapy is warranted, no one knows for certain exactly how long to give the additional therapy. By taking antibiotics for longer periods of time, I place myself at greater risk of developing side effects. By stopping antibiotic treatment, I place myself at greater risk that a potentially serious infection will progress. Antibiotics are the only form of treatment shown to be effective for Lyme disease, but not all patients respond to antibiotic therapy. There is no currently available diagnostic test that can demonstrate the eradication of the Lyme bacteria from my body. Other forms of treatment designed to strengthen my immune system also may be important.

Some forms of treatment are only intended to make me more comfortable by relieving my symptoms and do not address any underlying infection.

My decision about continued treatment may depend on a number of factors and the importance of these factors to me. Some of these factors include (a) the severity of my illness and degree to which it impairs my quality of life, (b) whether I have co-infections, which can complicate treatment, (c) my ability to tolerate antibiotic treatment and the risk of major and minor side effects associated with the treatment, (d) whether I have been responsive to antibiotics in the past, (e) whether I relapse or my illness progresses when I stop taking antibiotics, and (f) my willingness to accept the risk that, left untreated, a bacterial infection potentially may get worse.

For example, if my illness is severe, significantly affects the quality of my life, and I have been responsive to antibiotic treatment in the past, I may wish to continue my treatment. However, if I am not responsive to antibiotics, I may wish to terminate treatment. I will ask my doctor if I need any more information to make this decision and am aware that I have the right to obtain a second opinion at any time if I think this would be helpful.



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I realize that the choice of treatment approach to use in treating my condition is mine to make in consultation with my physician. After weighing the risks and benefits of the two treatment approaches, I have decided: (Please check one)

To treat my Lyme disease through a treatment approach that relies heavily on clinical judgment and may use antibiotics until my clinical symptoms resolve. I recognize that this treatment approach does not conform to IDSA guidelines and that insurance companies may not cover the cost of some or all of my treatment.

Only to treat my Lyme disease with antibiotics for thirty days, even if I still have symptoms.

Not to pursue antibiotic therapy

*The IDSA guidelines are available free at:
http://www.cdc.gov/ncidod/dvbid/lyme/IDSA_2000.pdf

*The ILADS guidelines are available free at:
http://www.iladds.org/files/ILADS_Guidelines.pdf

I understand the benefits and risks of the proposed course of treatment, and of the alternatives to it, including the risks and benefits of foregoing treatment altogether. My questions have all been answered in terms I understand. All blanks on this document have been filled in as of the time of my signature.

Patient's Signature _____ Date _____

Print Name _____

For more information on the treatment approaches used in diagnosing and treating Lyme disease, see:

1. Wormser GP, RJ Dattwyler, ED Shapiro, AJ Halperin, AC Steere, MS Klempner, PJ Krause, JS Bakken, F Strle, G Stanek, L Bockenstedt, D Fish, JS Dumler, and RB Nadelman. The clinical assessment, treatment, and prevention of Lyme disease, Human Granulocytic Anaplasmosis, and Babesiosis: Clinical practice guidelines by the Infectious Disease Society of America. Clin Infect Dis. 2006; 41 (November): 1089.

Available at <http://cid.oxfordjournals.org/content/43/9/1089.full>

2. The International Lyme and Associated Diseases Society. ILADS Evidence-based guidelines for the management of Lyme disease. Expert Rev. Anti-infect. Ther. 2004; 2(1): S1-S13.

Available at http://www.ilads.org/files/ILADS_Guidelines.pdf



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INTRAVENOUS TREATMENT CONSENT

In certain situations, intravenous (IV) medications are preferred or may be used to supplement oral medications. IV treatment is sometimes recommended when there is neurological involvement, heart problems, severe joint inflammation, or inadequate response to oral medications. Because the GI system is bypassed, IV dosing greatly increases the probability of adequate medication blood levels and reduces gastrointestinal symptoms. IV antibiotics also may penetrate the blood brain barrier more effectively.

There are additional risks associated with IV treatment. IV treatment usually involves the installation of an intravenous line in my vein or a vascular catheter to allow easier IV treatment. PICC lines and vascular catheters may result in local infection, or if unchecked, systemic infection. If signs of skin inflammation occur, the line or catheter may need to be removed. Rarely, PICC lines break off when they are being removed and may then require surgical removal. There is also a chance that, upon insertion, a nerve near the vein could be damaged. There is a risk of blood clots from PICC line or vascular catheter insertion. If a clot forms, the PICC line or vascular catheter may be removed and I may be hospitalized for the initiation of anti coagulation therapy. The risk of clot development is decreased, although not eliminated, by flushing the PICC line or vascular catheter twice daily with saline and heparin and by avoiding vigorous repetitive motion activity of the arm in which the PICC line or vascular catheter is placed.

My questions have been answered in terms I understand. I am aware of the risks foregoing IV treatment as well as the potential side effects if I undergo this treatment, and I consent to the use of IV treatment.

Patient's Signature _____ Date _____

Print Name _____

To my knowledge, I am not allergic/intolerant to any antibiotics, supplements, vitamins and minerals except those listed below:



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INFORMATION AND CONSENT ON THE SETTLEMENT OF COSTS

Due to patient inquiries placed to our accounting office, the following provides answers to some of the more common questions, which are: general charges associated with organizing your stay, making a down payment, cancellation fee and final bill.

Administrative Costs

The administrative costs associated with coordinating a patient's visit is included in our price list; additional delegated services that may be suggested outside of the clinic are not included (specialist appointments, alternative detoxification treatments, etc.).

Deposit

Once you have agreed to receive treatments at Lyme Mexico Clinic, a \$500 non-refundable deposit is due at the time your appointment is scheduled. This amount will be applied to the total cost of your care.

50% Down Payment

Once your treatment plan and schedule are finalized, we require half of your bill to be paid before your first day of treatment. If you do not complete this transaction, Lyme Disease Mexico will pause treatments until payment is completed.

Final Bill:

Your bill must be paid in full one week prior to your final day of treatment.

Consent:

I accept these terms of payment as outlined above.

Patient's Signature _____ Date _____

Print Name _____



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PATIENT DECLARATION

I hereby consent to an integrative medical assessment and treatment. This means that the treatment may go beyond conventional therapy. Treatments may utilize such substances as herbs, homeopathic remedies, vitamins, minerals, and various other therapeutic modalities, which will be determined by the physicians of Lyme Mexico Clinic. Medication, supplements and other treatments approved in Mexico may be adapted to treat specific needs for uses other than the intended label indications. Assessment findings and treatment plans will be discussed in full before implementation.

I am responsible for the decision to seek a therapeutic program that includes the physical, psychological, environmental, and spiritual aspects of my illness.

I recognize the possibility that this treatment may not prove successful.

I am fully informed that this approach to healing differs from, and may not be recognized by, traditional medical standards. I also understand that many of the therapies used at Lyme Mexico Clinic may not be acceptable to doctors practicing traditional medicine.

I hereby waive any claims and demands that I might now or hereafter have against Lyme Mexico Clinic, its affiliates, business partners and licensees, and their owners, employees, agents or the Biomedical Clinic and their owners that may arise, or be deemed to arise, from treatment at Lyme Mexico Clinic, its affiliates, business partners and licensees, and their owners, employees, agents and all liability of whatsoever kind or nature arising out of or in any way their relating to the treatment I receive at Lyme Mexico Clinic.

My medical files are strictly confidential. They are intended to be read only by myself and the clinical staff, based on my right to privacy. These files will not be transmitted to anyone else without written permission. Regardless of the jurisdiction in which this Patient Declaration is signed by me, it shall be deemed to have been signed by me in Mexico. Any dispute arising from, out of or as a consequence of this Patient Declaration or the treatment given by Lyme Mexico Clinic shall be subject to the laws of Mexico and this Patient Declaration shall be interpreted and construed in accordance with the laws of that jurisdiction. I hereby submit to jurisdiction of the courts, in Puerto Vallarta, Mexico, for resolution of any dispute arising out of or relating to this Patient Declaration and the treatment performed by Lyme Mexico Clinic.

This Patient Declaration was given to me, read by me and signed by me before any payment of fees were made by me for this treatment.

Confirmation of Agreement

I have read the description of the most important aspects of your therapy concept and have taken note of its content. I wish to receive treatment according to the principles of medicine as described above and kindly request a consultation.

Patient's Signature _____ Date _____

Print Name _____