PATIENT INFORMATION - page 1

Name: _____ Date of Birth: _____ Date: _____

Address:_____

_____

city, state. Zip code _____

Phone Number: (home)_____ (work)_____

Emergency Contact: _____

Email address: _____ Social Security #:_____

Occupation: _____

Medical insurance company & plan: _____
Card #:_____ Group # _____

Primary care physician (name, location & phone number):
_____
_____

Permission to contact you regarding reminder calls, laboratory results, and supplement pick up information (please indicate preferred method)_____

Allergies:_____
_____

Have you been under the care of a Naturopathic doctor or Acupuncturist before?
_____
_____

Referred by:_____

What are your chief health concerns and reasons for this visit?
_____
_____
_____
_____
_____
_____

Please list current medical conditions with dates of diagnosis:
_____
_____
_____
_____
_____

Current medications & supplements (Please include dosages):
_____
_____
_____
_____
_____

Name: _____ Date of Birth: _____ Date: _____

PAST MEDICAL HISTORY: (check boxes if yes and include date)

☐ Cancer_____ ☐ Diabetes (Type I or II) _____
☐ High blood pressure _____ ☐ Heart disease _____
☐ Hepatitis _____ ☐ HIV/AIDS _____ ☐ Lung disease _____
☐ Arthritis _____ ☐ Rheumatic fever_____
☐ Thyroid disease_____ ☐ Seizures_____ ☐ Ulcers_____
☐ Other_____.

Occupational stresses (physical, psychological, chemical exposure, etc.):
_____
_____
_____

Date of last physical examination: _____

Date of last Pap smear: _____ Date of last mammogram: _____

Last laboratory/Blood work (date and significant results):
_____
_____

Social History:

Married_____ Divorced _____ Any relationship stressors _____

Do you have children?: _____ If yes, number of children: _____

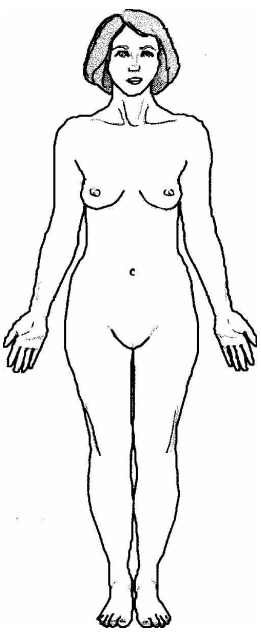
Significant physical traumas (auto accidents, etc.):
_____
_____
_____
_____

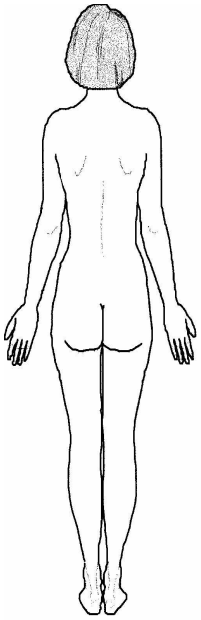
☐ Cigarettes _____(packs per day) ☐ coffee ☐ Tea ☐ Cola
☐ Alcohol_____(number of glasses or bottles per week)
☐ Recreational Drugs ☐ Sweets ☐ Salt

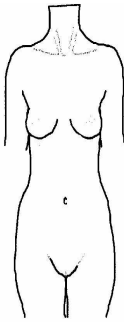
Surgeries (include dates):
_____
_____
_____
_____
_____

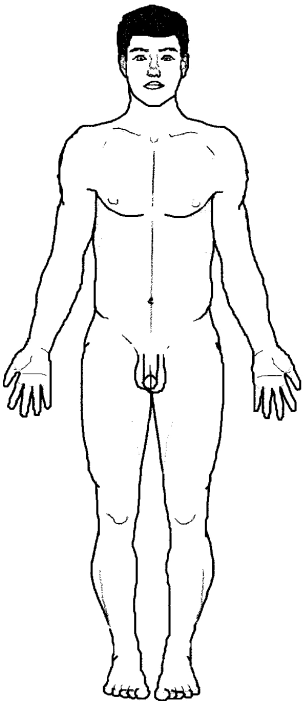
Patient Name: _____ Date of Birth:_____ Date: _____

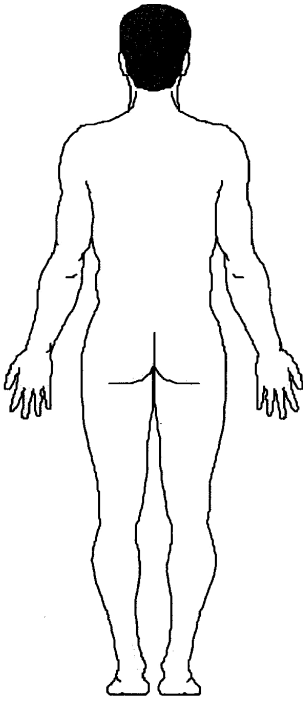
Please circle any current areas of pain on the following diagrams:

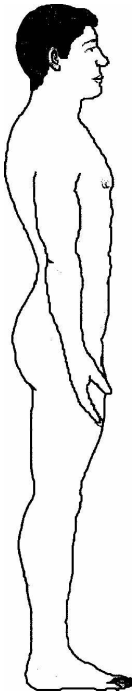












Patient Name :_____ Date of Birth:_____ Date: _____

FAMILY HISTORY:

[Please check the box if a family member (mother, father, brother, sister, aunt, uncle, grandmother, grandfather, or child) has one of the following conditions]

☐ Cancer_____ (type) ☐ Diabetes (Type I or II) ☐ High blood pressure
☐ Heart disease ☐ High cholesterol ☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies
☐ Alcoholism ☐ Mental illness ☐Arthritis ☐ Inherited blood disorder
☐ Autoimmune disorder ☐ Other

_____
_____

DIET:

Please list a typical day and any food restrictions or food sensitivities

_____
_____
_____
_____
_____
_____
_____

EXERCISE:

Please list physical activities and the number of times per week you do them

_____
_____
_____

What would you like to change about your health and/or life? What are your goals?

_____
_____
_____
_____
_____
_____

BIG APPLE HEALTH CENTER, LLC

Dr. Marina Yanover, ND, LAc

PAYMENT POLICY

If unable to keep your appointment, 24 -hour notice of cancellation is required. **Missed appointments or cancellations with less than 24 hours notification will be billed at 50% of the regular office visit charge. Please note that this charge *WILL NOT* be billed through insurance. PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE**. We accept cash, checks, and credit cards.

Patient Name _____ Date _____

RELEASE OF INFORMATION

I authorize the physician to provide from my records any and all information requested by my insurance Company, Medicare, Medicaid, or other third party payer, in connection with payment for my incurred charges. I also authorize the physician to provide any Quality Review organization affiliated with my insurer the information it requests for use in Utilization Management/Review.

ASSIGNMENT OF BENEFITS

I understand I am always responsible for payment regardless of the insurance coverage I may have. I assign any insurance benefits to which I may be entitled to the physician providing the services. I understand that I am responsible for any charges not covered by this assignment. I authorize release of any medical or other information necessary to process my insurance claims**. I agree to pay one half (50%) of the regular office visit charge for any appointment I miss, or cancel with less than 24 hours notice. Medicare** does not cover naturopathic care. Co-payments are due at the time of visit. Some plans may require a referral from your primary care physician and is the patient's responsibility. Reimbursement from other insurance companies is the responsibility of the patient for which a bill receipt will be provided upon request. I authorize disclosure of records to my insurance carrier, lawyer, or referring practitioner.

PATIENT PRIVACY AGREEMENT

I give the physician the authority to share with any consultant all information deemed necessary to coordinate my medical care. This includes sharing/mailing/faxing information such as office notes, EKGs, laboratory results, x-ray reports, medication lists and other consultant's notes to physicians, hospitals, pharmacists and insurance companies. The signature below also gives informed consent for the holistic treatment (Naturopathic medicine, Acupuncture, Craniosacral therapy, herbal medicine, and supplementation) of the individual or the minor for whom they are legally in charge.

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Signature denotes understanding and agreement with all statements above.

AFTER-HOURS CALL POLICY

If you have questions regarding your treatment/condition, we encourage you to phone our office at (203) 255-5005 during business hours. There will be no charge for these calls. However, if you feel that your situation is urgent, and you must contact Dr. Yanover on her cell phone ***after office hours*** (Sun/Mon after 5 PM; Tues/Weds after 7 PM; Fri after 6 PM, and all day Sat), ***she will return your call within 24 hours, and you will be billed $65 for an after-hours consultation.***

SUPPLEMENT RETURN POLICY

We try to provide natural medications to ensure the highest quality products. Unopened supplements may be exchanged, or returned for full reimbursement within 30 days of purchase; returns of opened bottles (**only with at least 2/3 of contents remaining)**, will be reimbursed at 50% of retail cost, also with 30 days. **No returns or exchanges will be made after 30 days.** Special orders or tinctures specifically made for a patient cannot be returned.

_____ _____

(PATIENT SIGNATURE) (DATE)

BIG APPLE HEALTH CENTER,LLC
Marina Yanover, ND, LAc

INFORMED CONSENT FOR TREATMENT

I,_____, hereby authorize Dr. Marina Yanover,

to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:
Common diagnostic procedures: e.g., physical examination, venipuncture, Pap smears, laboratory tests.
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplements.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, or suppositories.
Oriental medicine: acupuncture, applications of heating/burning herbs, cupping with suction, electro acupuncture, acupressure.
Physical medicine: hydrotherapy, physiotherapy, massage/body work, spinal manipulation.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Psychological Counseling
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, contraception
I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, puncturing blood vessels with acupuncture needle, braking of the needle, bruising from leakage of blood under the skin with acupuncture and cupping, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.
Potential benefits: restoration of health and the body's maximum functional capacity without the use of pharmaceutical drugs or surgery, relief of pain or symptoms of disease, assistance in injury and disease recovery, and prevention of disease and its progression.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.
I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all medical conditions that I may have. Also, I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient---------- Date----------

Physician/Witness---------- Date----------

CREDIT CARD AUTHORIZATION

This is our office policy to keep credit card authorizations on file just in case you have any outstanding balances (copay or uncovered charges). We will not share this information with any third party. It will be kept confidential. We will inform you of any balances or charges before we applied them to your credit card.

I, _____, hereby authorize Big Apple Health Center LLC, to utilize my credit card on file for any outstanding balance.

_____ _____
Patient's Name (print) Date

Credit Card Type: _____ Visa
_____ Mastercard

_____ _____ _____
Credit Card Number CVVI (3 last digit on back) Exp. Date

_____ _____
Authorized Signature Date

_____ _____
Witness Signature Date