Firshein Center

INTEGRATIVE MEDICINE

WELCOME

Thank you for choosing the Firshein Center for Integrative Medicine.

IN PREPARATION FOR YOUR FIRST VISIT, PLEASE NOTE THE FOLLOWING:

- **Allow a minimum of 2 hours for your first appointment.**
  This appointment will include an in-depth initial consultation, a physical exam, and tests that may be necessary to evaluate your current condition (i.e. Laboratory tests, allergy tests, pulmonary function test for those with respiratory problems, or an EKG for those with cardiovascular related symptoms).
- **Preparation for any blood tests- *fasting overnight is preferred.***
  However, if your appointment is later in the day, please fast for a minimum of 6 hours before your visit. Drinking water, tea or coffee (without milk) is acceptable. We suggest you bring a light snack to eat after your blood has been drawn. Children 12 years and younger should not fast.
- **Preparation for any allergy tests- *refrain from using antihistamines.***
  It is important to refrain from using antihistamines such as Claritin, Zyrtec, Allegra or Benadryl 24 hours prior to your visit. However, if you are currently on any other prescribed medication, it is important that you continue taking it.
- **Bring your medical insurance information.**
  Payment is to be made at the time of service. We accept all major credit cards, personal checks and cash. Our practice is out of network, however, we will provide you with assistance and all the forms required when submitting your claim.

  We do not partake in Medicare and supplemental insurance will not apply.
- **Bring any current medical records, lab work or scans.**
- Please complete the enclosed forms prior to your visit at the Firshein Center.
- If you have any special needs for the above requests, please let us know.
- Please call us if you have any further questions prior to your visit.
  We look forward to meeting you and working together to achieve your health goals.

1226 Park Avenue
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NEW PATIENT REGISTRATION FORM

TODAY'S DATE *(Please fill in the lines above)*

PATIENT INFORMATION

❍ MR. ❍ MRS. ❍ MS. ❍ MISS

PATIENT'S LAST NAME | FIRST | MIDDLE

MARITAL STATUS: ❍ Single ❍ Married ❍ Divorced ❍ Separated ❍ Widowed

SEX: ❍ Male ❍ Female

AGE | BIRTH DATE | SOCIAL SECURITY #

INSURANCE | INSURANCE PHONE

ID # | GROUP # | GROUP NAME

NAME OF POLICY HOLDER | POLICY HOLDER PHONE

HOME ADDRESS | CITY | STATE & ZIP

EMAIL ADDRESS | CELL PHONE

OCCUPATION | EMPLOYER | WORK PHONE

WORK ADDRESS | CITY | STATE & ZIP

EMERGENCY CONTACT | EMERGENCY CONTACT PHONE

HOW DID YOU HEAR ABOUT THE FIRSHEIN CENTER?

YOUR PREDOMINANT HEALTH CONCERNS?

INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. However, necessary forms will be completed to help expedite insurance carrier payments. It is also customary to pay for services rendered unless other arrangements are made in advance with our billing.

PERSON RESPONSIBLE FOR PAYMENT | PHONE

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered, I have read and completed the requested information above, and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above.

SIGNATURE | DATE

PARENT SIGNATURE *(If minor)* | DATE

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PATIENT QUESTIONNAIRE

TODAY'S DATE *(Please fill in the lines above)*

PATIENT INFORMATION

PATIENT NAME _____ BIRTH DATE _____ SEX: ❍ Male ❍ Female

ADDRESS _____ PHONE # _____

FAMILY HISTORY: *Please fill in Ages, "G" or "B" for Health & Check boxes for YES*

	FATHER	MOTHER	BROTHER				SISTER				SPOUSE/PARTNER	CHILDREN					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Age *(if living)*																	
Health (G) Good (B) Bad																	
Cancer	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Tuberculosis	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Diabetes	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Heart Trouble	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
High Blood Pressure	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Stroke	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Epilepsy	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Nervous Breakdown	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Asthma, Hive, Hay Fever	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Blood Disease	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Cause of Death																	

PERSONAL HISTORY: *Check boxes for YES or Fill in the blank*

Have You Ever Had...

❍ Scarlet Fever	❍ Neuritis	❍ Migraine Headaches	❍ Frequent Colds	❍ Concussion
❍ Diphtheria	❍ Neuralgia	❍ Tuberculosis	❍ Frequent Sore Throat	❍ Head Injury
❍ Smallpox	❍ Bursitis	❍ Diabetes	❍ Frequent Infections	❍ Knocked Unconscious
❍ Pneumonia	❍ Sciatica	❍ Cancer	❍ Frequent Boils	❍ Latex Sensitivity
❍ Pleurisy	❍ Lumbago	❍ Colonoscopy / Sigmoidoscopy	❍ Broken Bones	❍ Chronic Fatigue Syndrome
❍ Anemia	❍ Polio	❍ High Blood Pressure	❍ Cracked Bones	Weight Now:
❍ Rheumatic Fever	❍ Meningitis	❍ Low Blood Pressure	❍ Food Poisoning	Weight One Year Ago:
❍ Heart Disease	❍ Gonorrhea	❍ Nervous Breakdown	❍ Chemical Poisoning	Maximum Weight:
❍ Arthritis	❍ Syphilis	❍ Hay Fever	❍ Recurrent Dislocations	When:
❍ Rheumatism	❍ HIV	❍ Asthma		
❍ Bone Disease	❍ Jaundice	❍ Hives	❍ Drug Poisoning - Explain:	
❍ Joint Disease	❍ Epilepsy	❍ Eczema	❍ Any Other Deceases - Explain:	

ALLERGIES: *Check boxes for YES or Fill in the blank*

Are You Allergic To...

❍ Penicillin	❍ Morphine	❍ Antitoxin	❍ Adhesive Tape	❍ Nail Polish
❍ Sulfa Drugs	❍ Mycins	❍ Serums	❍ Other Cosmetics - Explain:	
❍ Aspirin	❍ Other Antibiotics	❍ Iodine	❍ Any Other Drug - Explain:	
❍ Codeine	❍ Tetanus	❍ Radiologic Dye	❍ Any Foods - Explain:	

SURGERY: *Check boxes for YES or Fill in the blank*

Have You Had Removed...		***Have You Had...***	***Have You Had a Transfusion...***
❍ Tonsils	❍ Ovary	❍ Had Hernia Repaired	❍ Blood
❍ Appendix	❍ Ovaries	❍ Had Any Other Operations	❍ Plasma
❍ Gall Bladder	❍ Hemorrhoids		
❍ Uterus		❍ Hospitalized for Any Illness - Explain:	

X-RAYS: *Check boxes for YES and Fill in the blank*

Ever Have X-Rays Of...	***Date***	***Disease Present***
❍ Chest		
❍ Stomach		
❍ Colon		
❍ Gall Bladder		
❍ Extremities		
❍ Back		
❍ Mammogram		
❍ Sigmoidoscopy		
❍ Barium Enema		
❍ Other		

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MEDICATION RECORD

TODAY'S DATE *(Please fill in the line above)*

PATIENT NAME BIRTH DATE

PREVIOUS MEDICATION RECORD: *Fill in boxes below*

DATE	NAME	CONDITION	STRENGTH	DOSAGE	HOW LONG

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DISCLOSURE & INFORMATION ACCESS

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.

EFFECTIVE APRIL 14, 2003

The privacy of your medical information is important to us. You may be aware that U.S. Government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

If you have any questions or concerns regarding privacy matters in our office, please contact us at 212.860.0282.

USE AND DISCLOSURE OF PROTECTED INFORMATION

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test date to that specialist (subject to more stringent New York laws, such as restrictions on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our service without further specific notice to you, or written authorization by you. For example: under your health plan, we are required to provide them with a diagnosis code for your visit an a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example: our accountants may see your name, dates of treatments and procedure codes during audits of our books. We also may use your information for financial service, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required for law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious health or safety risk;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States.

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on your answering device or with any person who answers the phone at your residence.

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DISCLOSURE & INFORMATION ACCESS

USE AND DISCLOSURE OF PROTECTED INFORMATION - *Continued*

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS THAT YOU HAVE

You have the right to request restrictions on certain uses or disclosures as described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the rights to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the request amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45CFR § 164.502, or for emergency notification purposes, or for national security or intelligence purposes as permitted by law. Or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures Made before April 14, 2003.

OBLIGATIONS THAT WE HAVE

We are required by law to maintain the privacy of protected health information and to provide individual with notice of our legal duties and privacy practices.

We are required by law to abide by terms of this notice as long as it is currently in effect. We reserve the right to revise this notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violation of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States.

I have received a paper copy of this notice.

PRINT NAME *(Please fill in the line above)* SIGNATURE DATE

I make the following special request for confidential communications:

PRINT NAME *(Please fill in the line above)* SIGNATURE DATE

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