

Revive Wellness Center
867 Whalley Avenue
New Haven, CT 06515
203-387-1540



www.revivewellnesscenter.com

87 Cherry Street
Milford, CT 06460
203-783-9802

Naturopathic Medicine & Functional Medicine: Holistic primary care & general check-ups. Therapies may include nutritional counseling, individualized natural supplement plan, homeopathy, herbal medicine, and lifestyle counseling.

First visit (1 hour to 1 1/2 hours) \$280.00

Return visit (15-45 mins) \$160.00

Insurance plans accepted: Anthem BC/BS, Aetna, Connecticare, Cigna, United and Oxford. Coverage varies based on policy and practitioner.

Naturopathic visit add ons: 30 minutes.

- Add **Acupuncture** to your naturopathic visit for an additional fee of only \$25 (\$70 of the cost of Acupuncture is absorbed by Revive).
- Add **Craniosacral therapy** to your naturopathic visit for an additional fee of only \$50 (\$65 of the cost of craniosacral is absorbed by Revive).

Acupuncture and Chinese Herbal Medicine:

May include cupping, moxa, electroacupuncture, and gua sha.

First visit (1 hour) \$195.00 Return visit (45 min-1 hour) \$95.00

Craniosacral Therapy: A physical therapy & energetic technique that uses light touch to balance the muscular and nervous system. Very relaxing.

1 hour session \$115

Facial Rejuvenation Acupuncture: Includes constitutional acupuncture, facial rejuvenation acupuncture, nutritional counseling, personalized supplement, skin care recommendations, and facial massage with organic aromatherapy.

First and subsequent visits (1 hour) \$165

12 sessions recommended for maximal benefit. Not covered by insurance.

Homeopathic Constitutional Consultation: Insurance coverage may apply.

First visit (2 hours) \$280.00 Return visit (45 min-1 hour) \$160.00

Personalized Nutritional Genotype plan: Your blood type, serotype, and body measurements are assessed and used to determine what your genotype is and what specific foods and nutrients produce inflammation in your body and which ones will help you to feel and look your best. Utilizing cutting edge software developed by Dr. D'Adamo, our expert counselors will provide you with a personalized and detailed dietary plan to reduce inflammation and help with disease prevention.

First and subsequent visits (1.5 hours) \$550 Not covered by insurance

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Laboratory testing for blood type and serotype is not included and can be ordered through our practitioners subsequent to the visit.

Nutrigenomic consult: Unlock the secrets to genetic influences on your health throughout your lifetime with our nutrigenomic experts. By analyzing your genetic markers obtained from tests, such as, 23andme we can determine what specific nutrients and dietary strategies are needed to minimize your genetic risk factors using this personalized medical science. The future of medicine.

First and subsequent visits (1.5 hours) \$550 Not covered by insurance.
Nutrigenomic testing through 23andme not included. Nutrigenomic data must be submitted at least one week prior to visit along with 3 chief complaints in order to prepare for your personalized and detailed visit.

Phone consults Naturopathic Medicine/Functional Medicine/Nutrition:

First office visit 60 minutes	\$280.00
Return office visit 31-45 min	\$160.00
30 minute phone consult	\$80
15 minute phone consult	\$40

Phone consults 5 minutes or less- free of charge.

FREE for New Patients: 15 minute consultation.

INSURANCE. Providers of Anthem BC/BS, Aetna, Connecticut, Cigna, and Oxford for Naturopathic Medicine. Specialty co-pays apply for visits if covered by these insurance plans. Be aware that some plans have deductibles. Please be advised that having these plans does not guarantee that visits will be covered. You are responsible for any and all fees not covered by insurance. We are not providers of MEDICARE/MEDICAID PLANS.

For patients with other insurance plans: We will be happy to provide you with a bill that you can submit to your insurance company for reimbursement of services if you have out-of-network benefits.

SERVICES GENERALLY NOT COVERED BY INSURANCE:

Specialty Lab Test Kits: \$25.00 or as priced

Specialty test blood Draws \$20.00

Nutritional Supplements and herbal medicines are not covered by insurance. **Return policy:** Chinese herbs, tinctures, opened supplements and special order products are non-refundable. Unopened supplements and products may be returned with full refund within one week after purchase.

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PAYMENT POLICY:

YOU ARE RESPONSIBLE FOR ANY CHARGES AND SERVICES NOT COVERED BY INSURANCE. If unable to keep your appointment, 24-hour notice of cancellation is required.

Fee for missed appointments or cancellations with less than 24 hours notification is \$90.00 per visit.

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. We accept cash and checks, MasterCard and Visa.

ASSIGNMENT OF BENEFITS

The patient is responsible for any and all payments that are not covered by insurance 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,** including but not limited to additional services (Acupuncture, labs, craniosacral therapy, supplements and herbs). I authorize release of any medical or other information necessary to process my insurance claims. **I agree to pay \$90 for any appointment I do not cancel within 24 hours notice.** Medicare/Medicaid are not covered plans alone or in combination with other insurance plans. Co-payments are due at the time of visit. Some plans may require a referral from your primary care physician and/or additional paperwork, and is your 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.

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.

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.

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INFORMED CONSENT TO TREAT

The signature below also gives informed consent for the treatment using the therapies below for the individual or the minor for whom they are legally in charge.

- Naturopathic medicine/Functional Medicine/Family Practice Medicine that may include nutritional and lifestyle counseling, dietary supplement recommendations herbal medicine, specialized testing, homeopathy, flower essence therapy, and natural therapy advice.
- Acupuncture and oriental medical techniques, that may include cupping, tui na, electroacupuncture, guasha, ear acupuncture and retention of needles, chinese herbal medicine, nutritional and lifestyle counseling, and facial rejuvenation acupuncture. I understand that with acupuncture, cupping, gua sha, tui na and facial rejuvenation acupuncture there may be minor bleeding, bruising, skin irritation, and retention of needles and that there is a minuscule risk of pneumothorax in some patients. Only disposable, sterile, acupuncture needles are used and our acupuncturists follow clean needle techniques.
- Body Healing Therapies/Physical Medicine techniques that may include massage, Craniosacral therapy, therapeutic stretches, chiropractic adjustments, and constitutional hydrotherapy.

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.

(PATIENT SIGNATURE or parent of minor)

(DATE)

Physician _____ Date _____

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PATIENT INFORMATION - page 1

Name: _____ Date of Birth: _____ Date: _____
Address (city, state, zip code):

Phone Number: (mobile) _____ (home) _____
Work phone number: _____

Email address (required so we can allow you to access your records):

I would like to receive updates on schedule changes, weather-related cancellations, programs, specials and coupons, free monthly newsletter, and join your Facebook group: Y N

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

Email (include address or same as above) _____

Text (include phone number or same as above) _____

Phone call (include phone number or same as above) _____

Social Security (optional) #: _____

Occupation: _____

Medical insurance company & plan:

Card #: _____ Group # _____

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

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?

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Please list current medical conditions with dates of diagnosis:

Current medications & supplements (Please include dosages):

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):

Your personal birth & childhood history (prolonged labor, forceps delivery, breast feeding, chronic infections, antibiotic history, etc.)

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Social history: Married_____ Divorced _____ Sexual orientation_____

Any relationship stressors?

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

Any history of infertility or pregnancy losses? _____

Significant physical traumas (auto accidents, brain injuries, etc.):

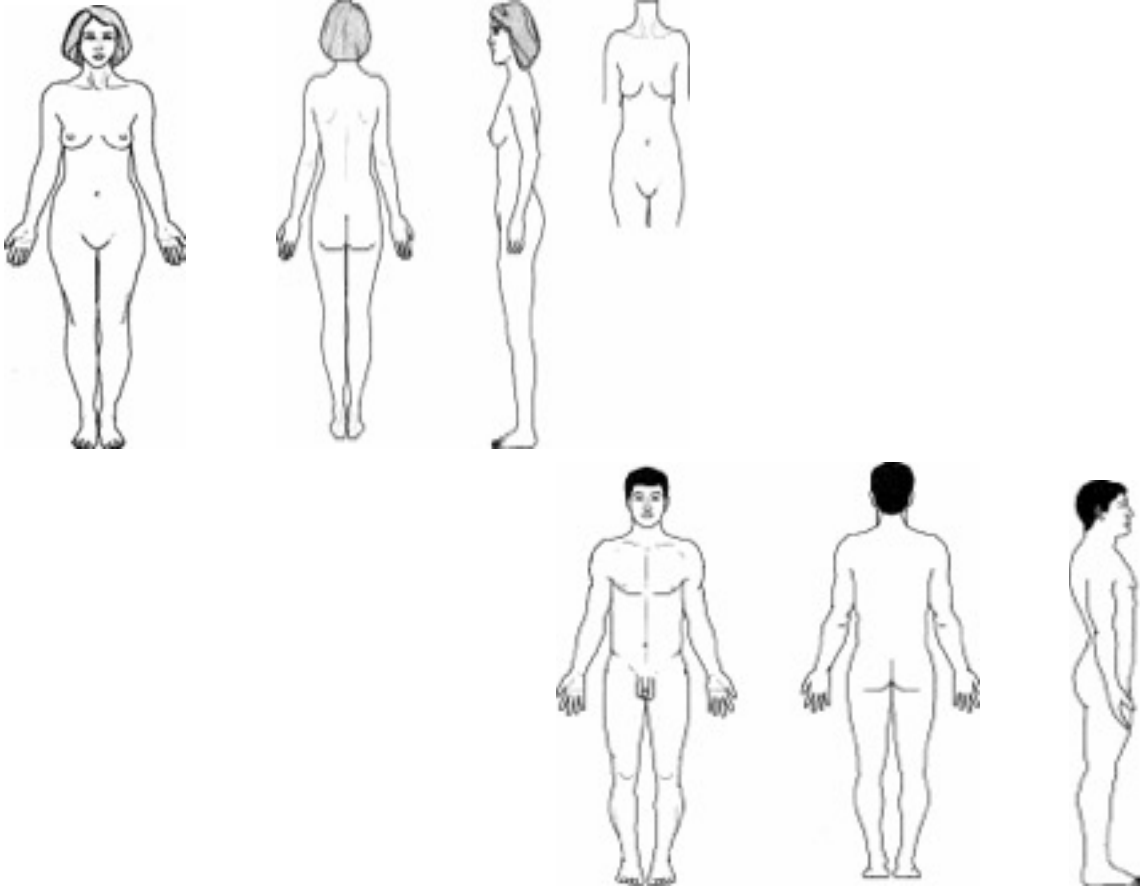
Surgeries (include dates):

Physician _____ Date _____



PATIENT INFORMATION - page 2

Please circle any current areas of pain on the following diagrams with numbers of a scale of 1 to 10 (10 being high) indicating your pain levels currently.



For facial rejuvenation acupuncture:
What areas of your face and skin are you unhappy with?



PATIENT INFORMATION- page 3

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

HABITS:

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

WHAT IS YOUR BLOOD TYPE:

- Type O Type A Type B Type AB
- Rh factor + Rh factor - Serotype Unknown

DENTAL HISTORY: Please list number of cavities, amalgam fillings, surgeries, significant traumas, etc,

FAMILY HISTORY:

[Please check the box if an immediate 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

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

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