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

www.revivewellnesscenter.com

NEW PATIENT FORM AND PRICE LIST updated January 1st 2018

Naturopathic Medicine & Functional Medicine: Holistic primary care & general check-ups. Therapies may include individualized natural supplement plan, nutritional counseling, homeopathy, herbal medicine, and lifestyle counseling.
First visit (1 hour to 1 1/2 hours) $360.00
Return visit (15-45 mins) $185.00
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 15-30 minutes of **Acupuncture** to your naturopathic visit for an additional fee of only $30 ($75 of the cost of Acupuncture is absorbed by Revive).
- Add 20-30 minutes of **Craniosacral therap**y to your naturopathic visit for an additional fee of only $55 ($80 of the cost of craniosacral is absorbed by Revive).

Acupuncture and East Asian Medicine: Modalities cupping, moxa, electroacupuncture, tui na, gua sha and herbal medicine.
Acupuncture (45 min-1 hour) $105.00
($55 for first 15 minutes plus an additional $50 thereafter)
Add ons: cupping +$25, Tui na/massage +$25, Moxabustion +$25
Acupuncture plus each add ons: $130

Craniosacral Therapy: A physical therapy & energetic technique that uses light touch to balance the muscular and nervous system. Very relaxing.
1 hour session $135
Add on: Acupuncture +$25= $160

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) $185
12 sessions recommended for maximal benefit. Not covered by insurance.

Homeopathic Constitutional Consultation: Insurance coverage may apply.
First visit (2 hours) $360.00 Return visit (45 min-1 hour) $185.00

Nutritional Counseling
30-60 minutes $225

Physician_____Date_____

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Phone consults Naturopathic Medicine/Functional Medicine/Nutrition:

First office visit 60 minutes	$360.00
Follow up calls between 16-30 minutes	$185.00
15 minute or less	$50

Established patient phone consults 5 minutes or less- free of charge.

FREE for New Patients: 15 minute consultation.

INSURANCE.Providers of Anthem BC/BS, Aetna, Connecticare, 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

LAB TESTS:There is no way to know if lab testing is covered until it is billed. If you would like to use your insurance for lab testing, you are responsible for any fees not covered or deemed medically necessary by your insurance company.

Nutritional Supplements and herbal medicines are not covered by insurance. HSA may be used if medically necessary.

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. 3

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/mail-

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ing/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.

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 including payment policy.

_____

(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:_____

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PATIENT INFORMATION - page 2

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):

_____
_____
_____
_____
_____
_____

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):

_____
_____

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

_____

_____

_____

_____

Social history: Married_____ Divorced _____

Sexual orientation & gender preference_____

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.):

_____

_____

_____

_____

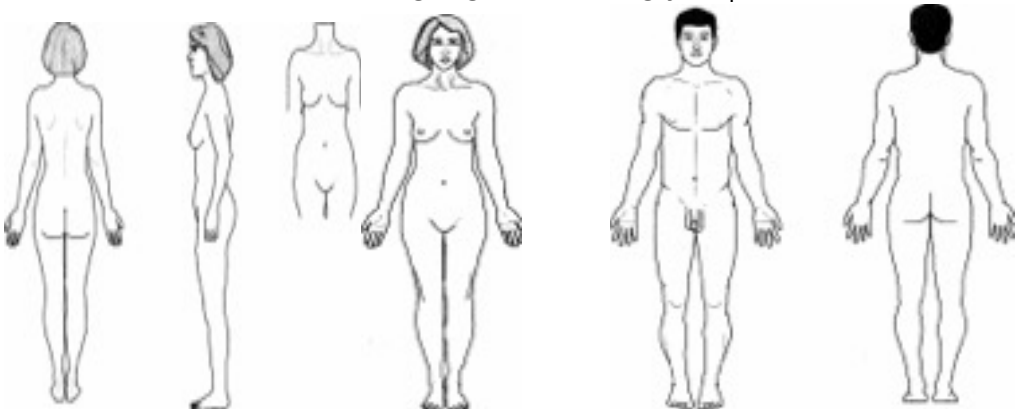
Surgeries (include dates):

_____

_____

_____

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



For facial rejuvenation acupuncture:

What areas of your face and skin are you unhappy with?

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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 or eating disorders

_____

_____

_____

_____

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?:

_____

_____

_____

_____

Physician_____Date_____