

LifeWorks Wellness Center

301 Turner Street, Clearwater, Florida 33756
Phone Number: 727-466 6789 Fax Number: 727-451 1010

NEW PATIENT PAPERWORK

AND

WHAT TO EXPECT AT YOUR INITIAL CONSULTATION

When you call to make your first appointment you will be asked to either arrive a half hour early to complete the New Patient paperwork, or you can complete the forms in advance and bring them with you. (The email you have received will give you the exact time to arrive.) The New Patient paperwork is 18 pages and it is important that you fill in every single page, filling in your correct legal name (not nicknames) and signing all the applicable pages where a signature is asked for.

The New Patient paperwork consists of a very comprehensive list of questions about every aspect of your health, from current issues, to the state of your oral health, to your diet and exercise routine, through to previous health problems and surgeries.

On your arrival at our clinic, please hand your paperwork to the receptionist, and sign your name in the sign-in log. Once your New Patient Paperwork has been processed, you will be triaged, which means your blood pressure, weight, temperature etc. will be taken and noted down by a technician. You will then be returned to the lobby to wait for your consultation.

During your consultation with your practitioner, this in-depth history will be reviewed, and will provide them with a good overall picture of your state of health. It may also help to pinpoint the underlying causes of illnesses you may have. The time spent with the practitioner at your initial consultation takes approximately one hour, which allows them to conduct a really thorough evaluation.

Your practitioner will discuss the reasons for your visit and will then set about identifying the root cause of your problems. A standard physical exam will be done and a special type of neurological testing is done to help determine the major environmental toxin stressors that are effecting your body. This method also helps to make sure that the supplement program you get is optimized for your body.

When the evaluation is complete, your practitioner will explain their findings and describe how they can be handled. Sometimes this can be done with natural supplementation and other times it may involve lab tests, IV therapy or other modalities conducted at the clinic.

When your practitioner visit is complete, the Service Consultant will type up what your treatment plan is from your practitioner's notes, along with all the applicable costs of each step. (You may have a wait while she is typing this up and seeing the patient before you.) You will then meet with her, and get your own copy of your treatment plan (the list of lab testing, treatment steps and supplements that your practitioner has laid out for you) so that you can see clearly what the cost of each step is should you decide to move forward.

If you have lab work to do – such as blood, stool, urine or saliva tests – you can be scheduled to either do them that same day, or the following day (depending on your availability or if the tests require fasting).

You will also have the opportunity to see the Scheduler, to schedule the following steps of your treatment plan. You can also contact her by phone or email. This information will all be provided to you.

(Please note: all lab work needs to be done and submitted to the laboratory for processing before you can start on any treatment steps.)

We will do all we can to assist you in moving smoothly through your treatment plan so you can achieve optimum health.

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Name: _____

Date: _____

LifeWorks' founder, Dr. David Minkoff writes a bi-weekly newsletter called *The Optimum Health Report*. Devoted to natural solutions, this newsletter is delivered free via email. If you would like to receive it, plus weekly emails about promotions and events, please write your email address below.

Email address: _____

PLEASE PRINT CLEARLY

Please tell us how you initially heard about LifeWorks Wellness Center? (Please check which one applies)

Referral

Friend/family (name) _____

Practitioner (name) _____

Magazine/Newspaper –

Natural Awakenings _____

Tampa Bay Wellness _____

Internet (please list what you searched for) _____

Talk/lecture (which one & where) _____

Email _____

Around Town

Billboard _____

Nature's Food Patch _____

Hotel (name) _____

Drive by _____

Other

Facebook _____

Other (please state) _____

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NEW PATIENT REGISTRATION

PATIENT NAME _____ SS# _____

PERMANENT ADDRESS (STREET, CITY, STATE & ZIP) _____

HOME PHONE _____ CELL# _____ WORK PHONE _____

DRIVER'S LICENSE NUMBER AND ISSUING STATE _____ **MEDICARE-YES OR NO (PLEASE STATE)** _____

LOCAL ADDRESS & PHONE (IF DIFFERENT FROM ABOVE) _____

DATE OF BIRTH _____ MARITAL STATUS _____ SEX _____ RACE/ETHNICITY _____

OCCUPATION _____ E-MAIL ADDRESS _____

SPOUSE / PARENT'S NAME _____ DATE OF BIRTH _____

SPOUSE / PARENT'S EMPLOYER _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

All professional services rendered are charged to the patient. Necessary information will be provided to the patient in order to expedite insurance reimbursement, if applicable. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper.

AUTHORIZATION TO PROVIDE MEDICAL CARE

I authorize LifeWorks Wellness Center, Inc., to render medical care and treatment. I agree to be responsible for payment. By my signature I authorize the release of any medical records needed by my insurance carrier (if applicable) for processing any claims incurred.

SIGNATURE _____ DATE _____

SIGN BELOW IF THE PATIENT IS A MINOR AND COMPLETE THE MINOR CONSENT FORM

I hereby represent the above listed patient as a minor and give authorization for full medical treatment.

SIGNATURE _____ RELATIONSHIP _____ DATE _____

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AUTHORIZATION FOR PATIENT EMAILS AND PHONE MESSAGES

By my initials, I authorize LifeWorks Wellness Center staff to leave private or confidential health information messages on my voice mail, or with whomever answers at the following telephone number(s):

Home: _____ Cell: _____

Further, I authorize protected health information to be sent to this e-mail:

“E-mail communications are not encrypted, and while efforts are made to ensure privacy, confidentiality cannot be guaranteed and patients are responsible for securing their part of the communication. The originating e-mail address is not monitored and should not be used to send medical information or questions.”

Patient Printed Name: _____

Patient Signature: _____

Date: _____

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HEALTH QUESTIONNAIRE

Name: _____ Date: _____ Age: _____

1. What is the purpose of your visit? _____

2. Please describe the symptoms you have _____

3. When did it start? _____
4. Have the symptoms been getting worse or staying the same or coming and going? _____
5. Is there anything that makes them worse or better? _____
6. If you have discomfort or pain where is it? _____
7. Does it stay there or radiate to another place in your body? _____
8. What is the quality of the pain or discomfort? _____
9. Is there anything that makes it better? _____
Worse? _____

SYMPTOMS Check () symptoms you currently have.

GENERAL

- __ Chills
- __ Depression
- __ Dizziness
- __ Fainting
- __ Fever
- __ Forgetfulness
- __ Headache
- __ Loss of Sleep
- __ Loss of Weight
- __ Nervousness
- __ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- __ Arms __ Hips
- __ Back __ Legs
- __ Feet __ Neck
- __ Hands __ Shoulders

GASTROINTESTINAL

- __ Appetite Poor
- __ Bloating
- __ Bowel Changes
- __ Constipation
- __ Diarrhea
- __ Excessive Hunger
- __ Excessive Thirst
- __ Gas
- __ Hemorrhoids
- __ Indigestion
- __ Nausea
- __ Rectal Bleeding
- __ Stomach Pain
- __ Vomiting
- __ Vomiting Blood

EYE, EAR, NOSE, THROAT

- __ Bleeding Gums
- __ Blurred Vision
- __ Crossed Eyes
- __ Difficulty Swallowing
- __ Double Vision
- __ Earache
- __ Ear Discharge
- __ Hay Fever
- __ Hoarseness
- __ Loss of Hearing
- __ Nosebleeds
- __ Persistent Cough
- __ Ringing in Ears
- __ Sinus Problems
- __ Vision – Flashes
- __ Vision – Halos

GENITO – URINARY

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

SKIN

- Bruise Easily
- Hives
- Itching
- Change in Moles
- Rash
- Scars
- Sore That Won't Heal

CARDIOVASCULAR

- Chest Pain
- High Blood Pressure
- Irregular Heart Beat
- Low Blood Pressure
- Poor Circulation
- Rapid Heart Rate
- Swelling of Ankles
- Varicose Veins

MEN ONLY

- Breast Lump
- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Other

WOMEN ONLY

- Abnormal Pap Smear
- Bleeding Between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other

Date of Last Menstrual Period _____

Date of Last Pap Smear _____

Have You Had a Mammogram? _____

Are You Pregnant? _____

Number of Children _____

10. What is your usual Breakfast _____

Lunch _____

Dinner _____

11. What is your usual bowel movement habit _____

How Often? _____

12. How is your sleep? _____

How many hours? _____ Restful or not? _____

13. Do you do any exercise? _____

14. How is your energy? _____

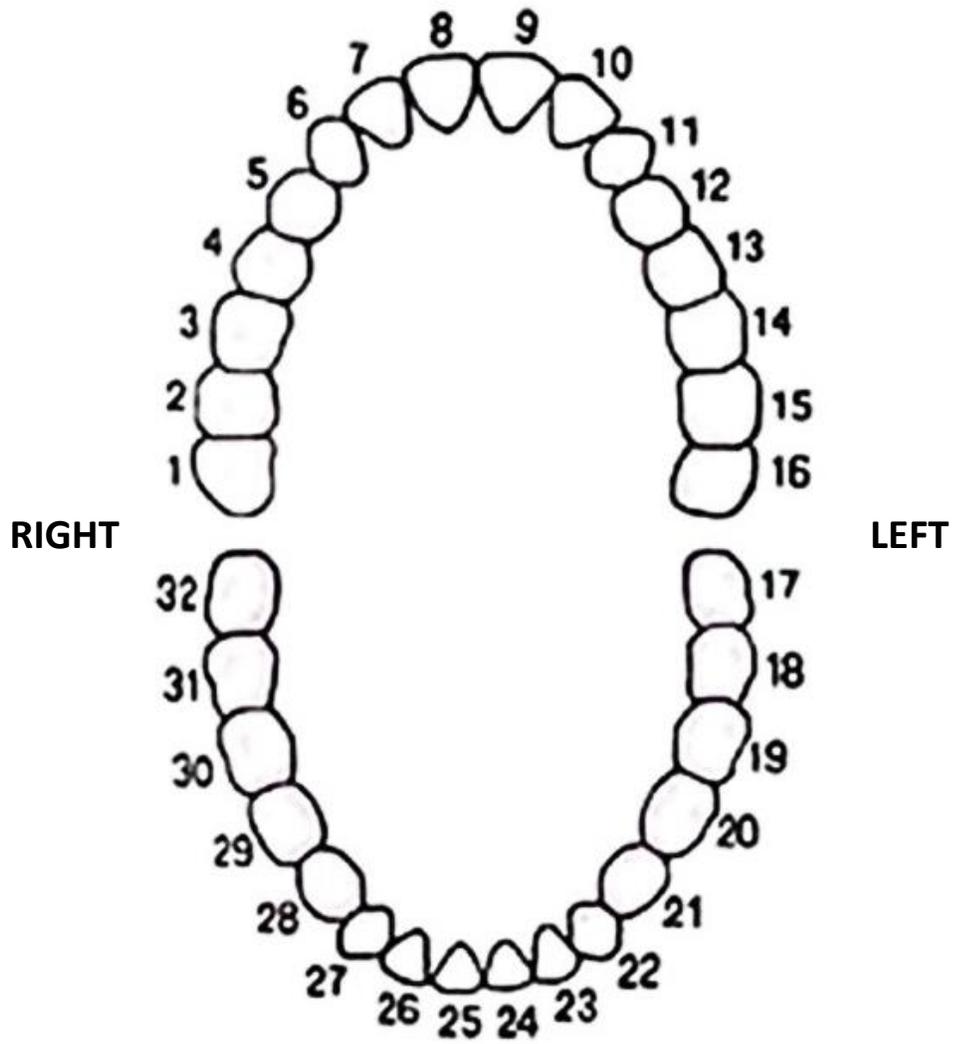
15. When is the last time you saw a dentist for a full checkup? _____

16. Do you have any root canals? _____

Mercury/Silver fillings? _____

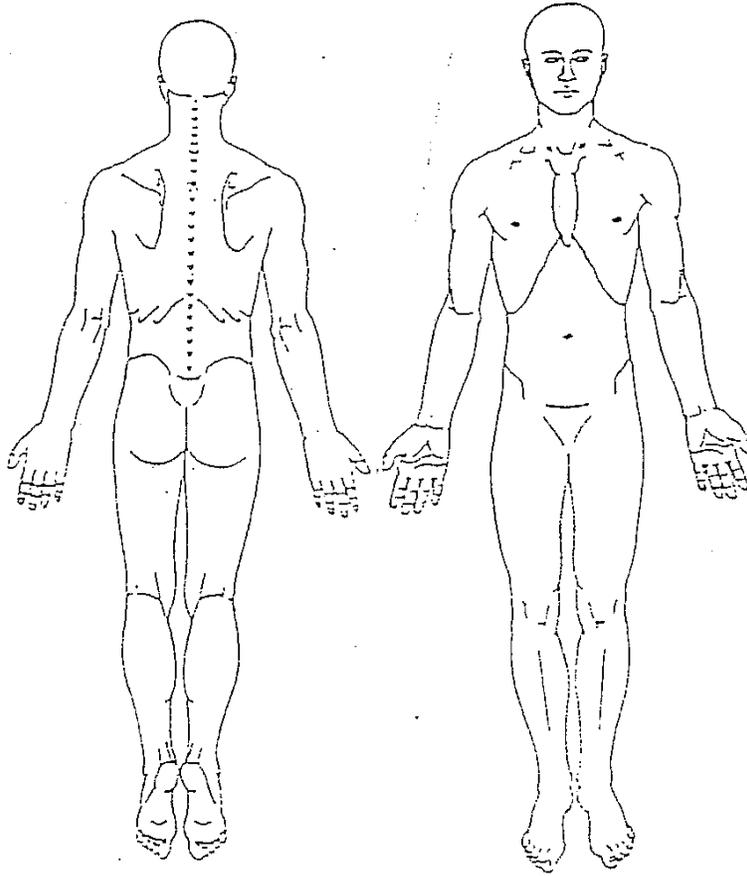
Pulled teeth? _____

Please mark the diagram:



17. Do you have any scars or places where you have had stitches or surgery?

Please mark them on the diagram:



18. What prescriptions are you currently taking?

NAME	DOSAGE	FREQUENCY

MEDICATION/DRUG ALLERGIES _____

HOSPITALIZATIONS/ SURGERIES			PREGNANCY HISTORY		
YEAR	HOSPITAL	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates _____

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

PAST MEDICAL HISTORY	DATE	OUTCOME	Caffeine
			Tobacco
			Drugs
			Alcohol
			Other

OCCUPATION CONCERNS check (✓) if your work exposes you to the following:

			Stress
			Hazardous Substances
			Heavy Lifting
			Other
			Your Occupation:

FAMILY HISTORY Fill in the health information about your family.

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature _____ Date

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NOTICE THAT SERVICES ARE NOT PRIMARY CARE

I understand that neither Dr. David Minkoff nor any other physician or practitioner I see at LifeWorks is acting as my primary care physician. I understand that even though LifeWorks physicians and practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to also have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have.

This is also important because LifeWorks practice is exclusively office-based and is not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility to inform LifeWorks who my primary care physician and specialists are, to let LifeWorks know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep LifeWorks physicians and practitioners informed on an ongoing basis.

I also understand that it is very important to let my primary care physician know about any treatments performed at LifeWorks, in order to ensure that my care is safe and properly coordinated.

My primary care physician is:

Name _____

Address _____

City, State, Zip _____

Phone _____

I am also being treated for _____ by _____

Address _____

City, State, Zip _____

Phone _____

Date: _____

Patient/Guardian Signature

Patient Name

Patient/Guardian Name Printed

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PATIENT FINANCE POLICY

Lifeworks Wellness Center's agreement for service is with YOU and NOT your insurance company. Although we will assist you with invoices that you may be able to submit to your insurance company, you are ultimately responsible for the full cost of the services you receive. Our service fees are neither contingent nor dependent upon your insurance carrier's approval.

The clinic practitioners have opted out of Medicare. Medicare Part B patients are required to sign a private contract with their practitioner prior to commencing services and are responsible for full payment of services based on Lifeworks Wellness Center's normal fee schedule. Please ask the Front Desk for the private contract documents for your medical practitioner.

We accept check, cash, MasterCard, Visa, Discover, and American Express payment for services. Accounts with returned checks will be charged a \$25.00 overdraft fee. If your account is delinquent, it will be placed with a collection agency. In this event, you will be responsible for all costs of collection. Timely payment will prevent consequences to your credit rating.

The adult accompanying any minor patient and the parents of the minor are responsible for full payment.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss this with our clinic Manager.

I have read and understood my financial responsibilities under this policy. I authorize the release of any medical information to private insurers so that they may process my insurance claims.

PATIENT/RESPONSIBLE PARTY

Date_____

WITNESS

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NEW PATIENT AUTHORIZATIONS & ACKNOWLEDGEMENTS

Treatment Authorization: I authorize medical treatment of ____ myself ____ my minor child by the physicians at LifeWorks Wellness Center, LLC (“ LifeWorks”) and by any professional staff provided under physician supervision, or by other practitioners as I shall elect to see such as nursing staff.

Medical Records Release Authorization: I authorize LifeWorks to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company, managed care program, or federal or state agencies upon their specific request. I also authorize any physician or health care provider I have seen to release my medical records to LifeWorks. Such authorization extends to records regarding my minor child, if applicable.

Financial/Insurance Responsibility: I understand and agree to the following policies regarding financial and insurance responsibilities: Payment is required at each visit. I am responsible for charges incurred for all treatment rendered. LifeWorks does not participate in any insurance, thus I am fully responsible for the payment of my services. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treating practitioner(s). I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for LifeWorks to take action to secure payment of an outstanding balance owed.

I understand that LifeWorks does not participate in any insurance so that it is my responsibility to contact my insurance company for any questions regarding possible reimbursement for services that I have paid for at LifeWorks. I agree that LifeWorks will not be required to submit claims for me but will provide me copies of invoices of my services received.

Notice to Medicare Part B Patients: LifeWorks practitioners have opted out of Medicare. Medicare Part B patients are required to sign a private contract with their practitioner prior to commencing services and are responsible for full payment of services according to LifeWork’s fee schedule at the time of services. As part of this contract, I understand I will not be able to submit any claims for reimbursement to Medicare Part B.

Other Insurance Plans: I understand that, if my insurance plan provides reimbursement for services provided by non-participating providers, I may submit a claim myself to request reimbursement. I understand that it is my responsibility to know my plan benefits and that LifeWorks is not responsible for determining or assisting mw with collecting insurance benefits.

Claim Management: My treating practitioner(s) will respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information.

Patient Acknowledgement: I certify that the information I have reported about my insurance coverage is correct. I certify that I am here to receive medical care and for no other purpose.

Notice as to Nature of Services: I understand that care I receive at LifeWorks may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative medical medicine, holistic, or innovative services. Because many of these are efforts to resolve underlying difficulties in the body's capacity to function, they are also known as functional medicine. Many of these services may not be recognized as standard medical practice, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that prescribed for me.

No Guarantees. I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive at LifeWorks.

Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Date: _____

Patient/Guardian
Printed

Patient/Guardian Name
Signature

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PRIVACY NOTICE AND AUTHORIZATION

As you are no doubt aware, major changes in Federal privacy requirements – the HIPAA privacy regulations - obligate most physician practices to provide notice about privacy rights and detailed policies designed to protect your privacy. These requirements were put in place because so much patient information is now being shared in digital format over computer networks. Because LifeWorks Wellness Center does not bill electronically or otherwise share patient information in digital format, and may decline to do so because it is a “small provider” under Medicare’s requirements, this office is not subject to the detailed provisions of the HIPAA privacy regulations.

In addition to assisting us in keeping the cost of our services reasonable, this will also allow us to collect less personal information than required under HIPAA. LifeWorks remains committed to protecting patient confidentiality. You should understand the following with regard to how we treat your personal health information, which includes medical and dental information:

- 1) When you register as a new patient, you will be asked to sign an authorization, also provided below, that includes a release of information allowing us to provide personal health information to your insurance company for the purpose of assisting you in obtaining payment and to any health care practitioner to which a LifeWorks’ practitioner refers you for care. The authorization also allows us to request and obtain records from practitioners that you have seen for the purpose of assisting us in your treatment. If you wish records sent to a health provider you have not yet seen, a family member, an attorney, or other party outside of this list, you must first sign a release of information before we can forward your information.
- 2) We cannot release information to family members, other than parents or legal guardians, even if they are involved in your care, without your written permission.
- 3) In order to ensure quality of care, LifeWorks records are occasionally reviewed both internally and by outside consultants in legal, clinical, record keeping and other concerns that affect the quality of the services we provide. Only necessary information is accessed, and any such review is performed by professional staff working under the condition of confidentiality.
- 4) If you wish to limit the nature of information that is released, or the parties noted above to whom information may be provided, please ask to meet with LifeWorks privacy coordinator to discuss these limitations. In some instances, LifeWorks may not be in a legal position to honor requested limitations, or there may be consequences that you need to be aware of, such as limitations upon receipt of insurance payment or upon the quality of care delivered. It is best to discuss any such concerns in advance.
- 5) You may revoke authorization for the future release of information in writing. We may in that event, however, decline to provide further treatment.
- 6) We may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

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NOTICE AND AGREEMENT: **PATIENT HEALTH CLAIM SUBMISSION**

LifeWorks Wellness Center's agreement for service is with YOU and NOT your insurance company thus you are responsible for the full cost of the services you receive. The adult accompanying any minor patient and the parents of the minor are responsible for full payment.

To assist patients to successfully manage claim submission for insurance reimbursement, LifeWorks Wellness Center suggests that you retain one of the outside insurance billing companies listed below. These companies charge a nominal fee to prepare, submit and follow your claim through to payment or an explanation of benefits. LifeWorks does not have a financial relationship with these companies, but will provide them with information needed to properly file your claim. The use of a third-party biller provides you with an insurance resource while allowing LifeWorks to focus its efforts on providing quality healthcare. In addition to the policies in Lifeworks' Authorizations, Office Policies, and General Consent, please note the following:

- The superbill we provide at time of service provides a list of charges for payment. It is not sufficient to nor intended to serve as support for a claim and should not be submitted to your insurance company. If you wish to submit for reimbursement, please use a third-party billing company.
- Given the increasingly complex nature of medical billing, LifeWorks cannot respond to patient requests to prepare or assist in presenting claims and is providing these billing companies to fill that role. LifeWorks does not do any pre-authorization for insurance.
- Neither LifeWorks nor any third-party billers can predict or guarantee that any item or service will be covered. Some of LifeWorks' services are considered non-covered by most insurance companies. Patients are responsible for payment to LifeWorks even if a service is non-covered or considered "not medically necessary" or "experimental."
- LifeWorks will convey accurate information to the third-party billing company but is not responsible for errors or misrepresentations made by the billing company. LifeWorks does not respond to insurance company requests for additional information but we will work with the third-party billers listed below. If you have a question about a pending claim or denial, please refer back to the billing company that has been assisting you with your claim.
- If you have an HMO, Medicare Advantage, TriCare or other medical insurance plan that limits your reimbursement to only in-network providers or providers for whom you have received a referral from your primary care physician, no reimbursement will be available for LifeWorks' services as we do not participate in any insurance plans.
- LifeWorks' physicians and practitioners are opted-out of Medicare. Medicare cannot be billed for and will not cover any service. Medicare Part B patients are required to sign a private contract with their LifeWorks practitioner prior to commencing services and are responsible for full payment of services based on LifeWorks Wellness Center's normal fee schedule. Please ask the Front Desk for the private contract documents for your medical practitioner. A third-party biller may be able to obtain limited reimbursement from a Medicare supplementary (Medigap) program, though this is discretionary and this would likely only be the 20% or other portion for which they would be responsible if Medicare had paid.

- In order to receive LifeWorks' prices on laboratory testing, patients must use the laboratory designated by LifeWorks. Patients are free to use the laboratory of their choice where an equivalent test or panel of tests are offered, and may in some cases be able to obtain insurance reimbursement, but if insurance reimbursement is denied, you as the patient would owe the balance due to that laboratory. The fees owed would be set by that laboratory and may be much higher than if your diagnostic testing was done at a laboratory as ordered by your practitioner. Insurance coverage for the use of any laboratory, including LifeWorks' designated laboratory, depends on a patient's policy and cannot be guaranteed.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss this with our clinic Manager.

Agreement. I have read, understand, and agree to the policies outlined above. I agree not to directly submit any LifeWorks superbill that I receive directly to my insurance. I may choose to use an outside third-party biller who will have the insurance coding information from LifeWorks that would be needed to submit claims to my insurance. Coverage is not guaranteed.

Release of Information. I authorize LifeWorks Wellness Center, its physicians, health care practitioners and staff to release my medical information to my insurance company. I also authorize release of information to the third-party biller I choose to manage my claims, which becomes effective once I have entered into an agreement with a third-party biller and that billing company contacts LifeWorks on my behalf. I can revoke this authorization by giving five (5) days advance notice in writing to LifeWorks at any time.

Date: _____

Patient or Guardian Signature

Patient or Guardian Name Printed

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NOTICE TO ALL PATIENTS

For confidentiality purposes, LifeWorks Wellness Center has a policy which forbids patients from taking photographs or videos within the clinic. This includes photographs and videos of all staff, other patients, treatments and modalities. Any patient who violates this policy may no longer be accepted at LifeWorks as a patient.

For this reason, we ask that all patients sign below to say they acknowledge and understand our policy.

I the undersigned have read and agree to adhere to the policy above.

Signature

Date

Print name