Gary A. Klingsberg, D.O.
Medical Director • Center for Nutrition and Preventive Medicine • 177 N Dean St., Suite 308, Englewood, NJ 07631 • Telephone 201-503-0007
Fax 201-503-0008

TO OUR PATIENTS

Thank you for choosing the Center for Nutrition and Preventive Medicine to address your health care needs. Please complete the following forms so that we can update our systems and confirm your understanding of our services and payment policies. Please bring your completed forms with you when you visit our office.

"NON-COVERED SERVICES"

I hereby acknowledge by this statement that I have been fully informed that some, and perhaps all of the medical services provided by Dr. Klingsberg throughout the course of my treatment may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance programs for the reasons set forth in the plans. I realize that my insurance carrier and/or Medicare will not pay for such "non-covered" services and that I will be personally responsible for payment for all such "non-covered" services at the time that they are rendered**. I will not submit claims for reimbursement of these services to the Medicare Program and/or any other medical insurance programs**.

_____ _____
Patient's signature Witness

_____
Date

ASSIGNMENT OF BENEFITS

I authorize payment of medical insurance benefits to Dr. Gary Klingsberg for medical services rendered.

Although I have assigned benefits to Dr. Gary Klingsberg, I fully understand that the ultimate responsibility for payment of fees for services (including any applicable deductible or co-payment) is mine. I further understand and agree that if an assigned insurance payment is sent by the insurance company as a matter of policy or error to me, I will endorse the insurance company's check to and deliver it to Dr. Gary Klingsberg, along with a copy of the explanation of benefits that the insurance company has provided to me.

_____ _____
Patient's signature Print name

_____
Date

_____ _____
Insurance Company Policy number

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment & follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address on the Notice to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE: INITIALS: REASON:

CENTER FOR NUTRITION AND PREVENTIVE MEDICINE

Today's date:			Referred by:	
Patient's Last name:	First:	Middle:	Date of birth: / /	Sex: ❑ M ❑ F
Street address:			SSN: - -	
City:		State:	Zip:	
Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner				
Home phone no.: ( )	Cell phone no.: ( )		Office phone no.: ( )	
E-mail address:			Occupation:	
Preferred method of communication: ❑ E-mail ❑ Phone ❑ Mail			Employer:	
Name of insured (if different from patient): Relationship to insured: ❑ Spouse ❑ Child ❑ Other			Date of birth of insured: / /	
Primary insurance: Plan name: ID no.: Group no.:			Type: ❑ PPO ❑ POS ❑ HMO Copay: $ Deductible: $	
Secondary insurance: Plan name: ID no.: Group no.:			Type: ❑ PPO ❑ POS ❑ HMO Copay: $ Deductible: $	
Demographic information: ❑ Non-Hispanic ❑ Hispanic Preferred language:			Race (list more than one if applicable):	

Describe the problem or condition which prompted this visit:
List any medications you are taking with their dosage and frequency:
List any dietary supplements you are taking with their dosage and frequency:
Do you have any allergies to medication or other substances? If so please list:
List any operations and their dates:
List any major or serious illnesses you have had (heart attack, diabetes, cancer, measles, etc.) and their dates:
List any accidents or injuries and their dates:

List number of pregnancies:	Births:	Last menstrual period:	Irregular? ❑ Yes ❑ No	
Date of last: Pap smear:	Mammogram:	Chest X-ray:	Colonoscopy:	Bone density test:

If any family members have had the following disorders please list them below:				
Cancer	Type	Heart Disease (heart attack, stroke, etc.)	Diabetes	Obesity

Have you had: Flu vaccine? ❑ Yes ❑ No Date ___/___Pneumonia vaccine? ❑ Yes ❑ No Date__/___
Tetanus vaccine? ❑ Yes ❑ No Date ___/____ Hepatitis B vaccine? ❑ Yes ❑ No Date(s)__/___, __/___, __/___
Do you smoke? ❑ Yes ❑ No How many packs / day? ____ For how many years? ____ Quit ____years ago.
Do you drink alcoholic beverages? ❑ Yes ❑ No What type? _____How much daily?_____
Do you drink coffee? ❑ Yes ❑ No Type? _____# cups / day? _____
Do you drink tea? ❑ Yes ❑ No Type? _____ # cups / day? _____
Do you drink colas? ❑ Yes ❑ No Type? _____ # cups / day? _____
Are you presently following any type of special diet? ❑ Yes ❑ No
Please describe it: _____
Are there any foods you cannot or will not eat? ❑ Yes ❑ No Please list them:
_____
Do you exercise regularly? ❑ Yes ❑ No How many minutes daily? _____
What activities do you engage in?
_____
Classify your weight control: ❑ No problem, can eat anything
❑ Minor problem, amenable to self-control
❑ Major problem, numerous diets, ups and downs
What diets have you tried, if any?

Minimum weight as an adult: _____lbs. at age: _____ Maximum weight as an adult: _____lbs. at age: _____

Have you had any of the following conditions or problems? (If yes, please check and circle as appropriate. Add any additional pertinent comments.)

	Nearsighted, farsighted, presbyopia, cataracts		Abdominal pain
	Glaucoma, trouble seeing at night		Constipation
	Double vision		Diarrhea
	Difficulty with hearing		Unusual bowel movements (bleeding, dark black,
	Ringing in ears		Floating, greasy, etc., other)
	Dizziness		Liver disease (hepatitis: type A, B, C, jaundice)
	Stuffed nose, allergies (What time of year?_____)		Gallbladder disease
	Headaches, type_____ frequency_____		Ulcer, type: _____
	Seizures		Other gastrointestinal disease
	Numbness, tingling, pins and needles sensation		Kidney disease (infections, stones, bleeding, other)
	Weakness, fatigue (how long? _____)		Bladder or prostate problems (trouble urinating, slow,
	Cardiovascular disease (heart attack, stroke,		urination at night, (# times____/night, burning)
	hypertension, angina, atherosclerosis, palpitations,		Blood disorders (anemia, prolonged bleeding, etc.)
	arrhythmia, heart murmur, other)		Diabetes, type:_____Year of onset _____
	Difficulty breathing, coughing, wheezing		Thyroid disease Type _____
	Asthma		Arthritis or gout (describe where) _____
	Bronchitis, emphysema		Lipid disorder (high cholesterol, high triglycerides)
	Trouble swallowing, painful swallowing		Sexually transmitted diseases: herpes, Chlamydia, gonorrhea, syphilis, HPV, HIV
	Nausea		Low sex drive, erection difficulty
			PMS, menopausal symptoms, describe_____

Do you have any other disease or condition not listed above that we should know about? Please list and explain: