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

REVIVE WELLNESS CENTER.

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

Naturopathic Medicine: Holistic primary care. May include nutritional counseling, natural supplement plan, homeopathy, hydrotherapy, and lifestyle counseling.

First office visit (1 hour)	$180.00
Return office visit (45 min)	$110.00

FREE for New Patients- 15 minute consultation

We are providers of **Anthem Blue Cross Blue Shield of CT**, **Connecticare**, **Oxford Health plans, Aetna**, and **Healthnet** for Naturopathic Medicine. Specialty co-pays apply for visits if covered by these insurance plans. **PLEASE BE ADVISED THAT HAVING THESE INSURANCE 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 possible reimbursement of services if you have out-of-network benefits.

SERVICES NOT COVERED BY INSURANCE:

Acupuncture and Chinese Herbal Medicine:

First Office visit (1 hour)	$140.00
Return office visit (45 min)	$90.00

If receiving Acupuncture in addition to a Naturopathic Medical visit that is covered by insurance, we will absorb $70 of the $90 return Acupuncture visit fee and you will be charged only **$20 in addition to your copay**.

Specialty Lab Test Kits: $20.00 or as priced **Blood Draws** $10.00
Craniosacral Therapy: $90.00
Facial Rejuvenation: $135.00 12 weeks recommended for optimal results
Nutritional Supplements and herbal medicines are not covered by insurance.

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. **Missed appointments or cancellations with less than 24 hours notification will be charged $50.00. PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE**. We accept cash and checks, MasterCard and Visa.

Physician____Date_________________

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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.

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 $50 for any appointment I do not cancel within 24 hours notice.** **Medicare** does not cover naturopathic care. 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.

PATIENT PRIVACY AGGREMENT

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. The signature below also gives informed consent for the holistic treatment (Naturopathic medicine, Acupuncture, Craniosacral therapy, herbal medicine, and supplementation) of the individual or the minor for whom they are legally in charge.

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) (DATE)

Physician____Date__________________

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PATIENT INFORMATION - page 1

Name: ___________________________________ Date of Birth: _____________ Date: _______________

Address:____
____
city, state. Zip code ____
Phone Number: (home)______________________ (work)___________________________________
Email address: ____
I would like to receive your free newsletter_________
Social Security #:_________________________
Occupation: ____
Medical insurance company & plan: ____
Card #:___________________________ Group # ___________________________________
Primary care physician (name, location & phone number):
____
____
Permission to contact you regarding reminder calls, laboratory results, and supplement pick up information (please indicate preferred method)___________________________________
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?
____
____
____
____
____
____
____
____
____

Please list current medical conditions with dates of diagnosis:
____
____
____
____
____

Current medications & supplements (Please include dosages):
____
____
____
____
____

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PATIENT INFORMATION - page 2

Name: ___________________________________ Date of Birth: _____________ Date: _______________

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 birth history (prolonged labor, forceps delivery, etc.)
____
____

Social history:
Married______ Divorced _______ Any relationship stressors ___________________________
Do you have children?: ___________ If yes, number of children: ___________

Significant physical traumas (auto accidents, etc.):
____
____
____
____

Surgeries (include dates):
____
____
____
____
____

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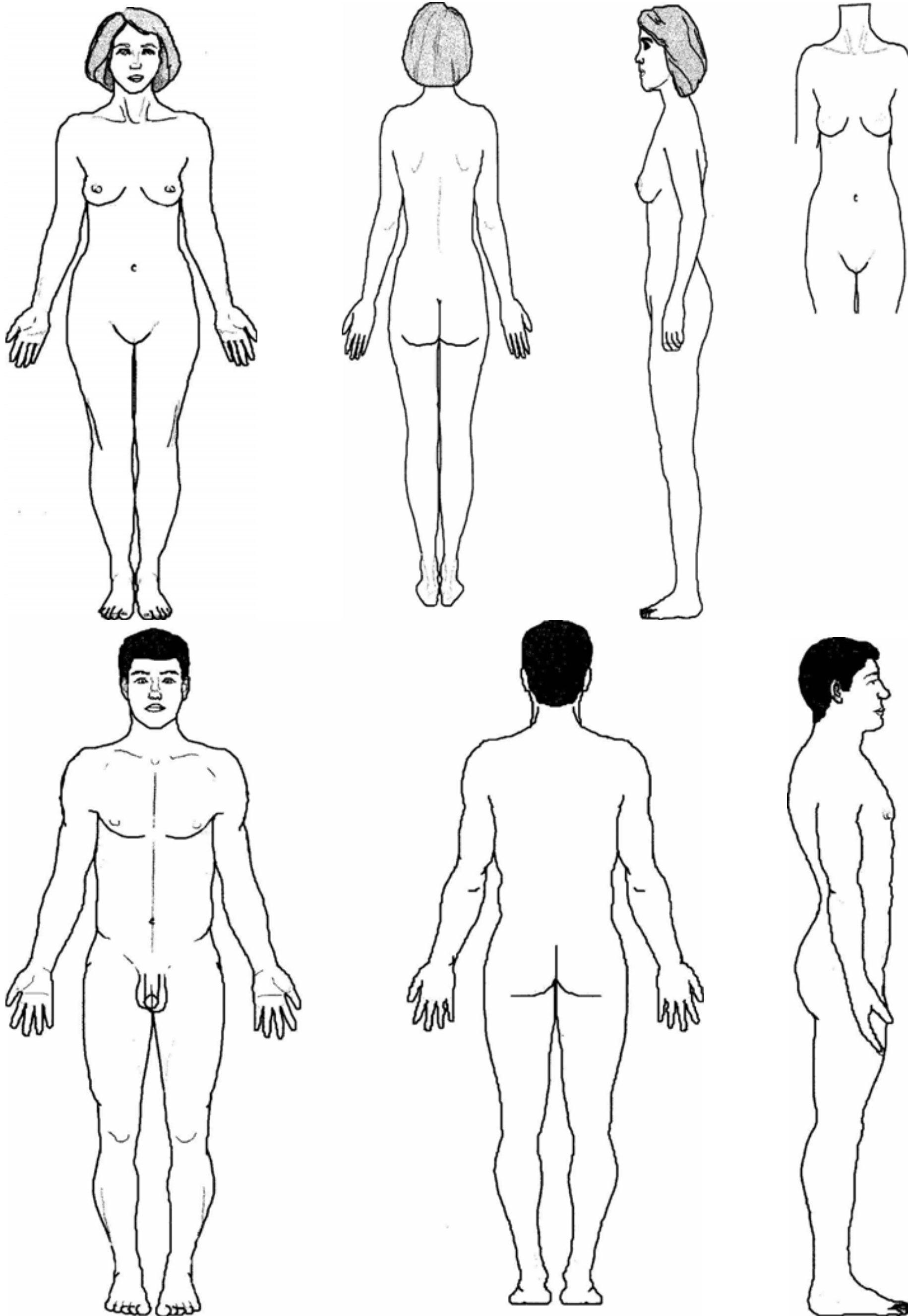
PATIENT INFORMATION- page 3

Patient Name: ____________________________ Date of Birth: _____________ Date: _________

Please circle any current areas of pain on the following diagrams:



Physician____Date_________________

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PATIENT INFORMATION - page 4

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

DENTAL HISTORY: Please list number of cavities, surgeries, significant trauma, 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

____
____
____

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

____
____
____
____

Physician____Date_________________