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REVIVE
WELLNESS CENTER

www.revivewellnesscenter.com
Your resource for natural health and healing

NEW PATIENT FORM AND PRICE LIST (updated May 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 - 1 ½ 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 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 therapy** 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) $300.00 Return visit (45 min-1 hour) $200.00

Nutritional Counseling
30-60 minutes $225

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, 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 after purchase.

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 $50.00 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.

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 SIGNATURE or parent of minor) (DATE)

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.

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, chi-nese 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)

PATIENT INFORMATION - page 1

Name: _____ Date of Birth: _____ Date: _____

Address (city, state, zip code):

_____

_____

Phone Number: (mobile)_____(home)_____

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)_____

Occupation:_____

Medical insurance company & plan:

_____

ID #:_____ Group #_____

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

_____

_____

Allergies:

_____

_____

Have you been under the care of a Naturopathic doctor or Acupuncturist before?

_____

_____

Referred by:_____

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):

_____
_____
_____

PATIENT INFORMATION – page 3

Do you CURRENTLY have? (CHECK ALL THAT APPLY)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain > 10lbs
- ☐ Weight Loss > 10lbs

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing up blood
- ☐ Sputum Production
- ☐ Wheezing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting or Stopping Urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Pain

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains w/ Walking
- ☐ Leg Swelling
- ☐ Night awakening from trouble breathing
- ☐ Palpitations
- ☐ Shortness of Breath

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

GASTROINTESTIONAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Aches/Pains
- ☐ Muscle Weakness

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

PATIENT INFORMATION – page 4

HEIGHT/WEIGHT

Current Weight:_____
Current Height:_____
Ideal Weight: _____

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

_____
_____

Social history: Married_____ Divorced _____
Sexual orientation & gender preference_____

Do you have any relationship stressors?

_____

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

Do you have any history of infertility or pregnancy losses?

_____

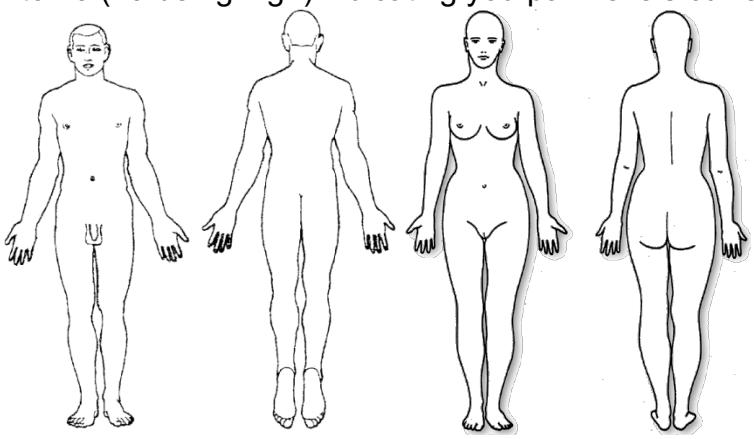
Significant physical traumas (auto accidents, brain injuries, etc.):

_____
_____
_____

Surgeries (include dates):

_____
_____

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



PATIENT INFORMATION – page 5

HABITS:

- ☐ Cigarettes _____(packs per day) / Past Smoker Y N
- ☐ Caffeine (Coffee, Tea, Soda)
- ☐ Alcohol_____(number of glasses or bottles per week)
- ☐ Recreational Drugs (Marijuana)
- ☐ Sweets
- ☐ Salt

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 has one of the following.

- ☐ High blood pressure
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Stroke
- ☐ Seizures
- ☐ Asthma
- ☐ Allergies
- ☐ Alcoholism
- ☐ Mental illness
- ☐ Arthritis
- ☐ Inherited blood disorder
- ☐ Autoimmune disorder
- ☐ Cancer_____(type)
- ☐ Diabetes (Type I or II)

PATIENT INFORMATION – page 6

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?

_____
_____
_____
_____

How committed are you to making the changes necessary to achieve health goals (i.e. compliance to physician treatment protocols)?

_____
_____
_____
_____