WOLFSON
Integrative Cardiology

Office of Jack M. Wolfson DO, FACC
10585 N Tatum Blvd, Suite D-135
Paradise Valley, AZ 85253
office: 480-535-6844 fax: 480-535-6845

New Patient Intake Form

Please fill out this questionnaire as thoroughly as possible. Print all information clearly and mark anything you don't understand with a question mark. All information contained in these pages is completely confidential.

Personal Information

Today's date: _____

Name: _____Age: _____Date of birth: ___/___/___

Sex:

- o Male
- o Female

Phone (mobile): _____ (home): _____

Preferred:

- o Mobile
- o Home

Is it OK to leave messages?

- o Yes
- o No

Address: _____City: _____

State: _____ Zip: _____

Email address: _____

How did you hear about Wolfson Integrative Cardiology? _____

_____

What is your most important reason for making this appointment? _____

_____

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Insurance Information

Insurance company: _____ Policy number: _____

Group number: _____ Name of insured: _____

Birthdate: ____/____/____

Current Complaints

_____

_____

_____

Health History

Please check any of the following **cardiac related** medical problems:

- o High blood pressure
- o Rheumatic fever
- o Abnormal cholesterol
- o Congestive heart failure
- o Congestive heart failure
- o Aneurysm
- o Atrial fibrillation
- o Coronary artery disease
- o Pacemaker/defibrillator
- o Valvular disease
- o Erectile dysfunction
- o Rapid heart beat
- o Heart attack
- o Peripheral arterial disease
- o Stroke/TIA
- o Stent
- o Edema
- o Varicose veins

Please check any of the following **gastrointestinal** medical problems:

- o Heartburn/reflux
- o Gall bladder
- o Hemorrhoids
- o Ulcer

(cont. on next page)

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- o Constipation
- o Colitis
- o Diarrhea, How many bowel movements a day:_____
- o Hepatitis
- o Pancreatitis
- o Gas/bloating
- o Other _____

Cancer history?

- o Yes, type: _____ Did you have chemo or radiation (specify)? _____
- o No

Please check any of the following **autoimmune** medical problems:

- o Rheumatoid arthritis
- o Lupus
- o Eczema
- o Psoriasis
- o Other: _____

Please check any of the following **neurologic** medical problems:

- o Tremors
- o Parkinson's
- o Multiple Sclerosis
- o Memory loss
- o Headaches

Please check any of the following **endocrine** medical problems:

- o Hypothyroidism
- o Hyperthyroidism
- o Diabetes
- o Low testosterone
- o Adrenal
- o Menstrual status: _____

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Kidney/bladder/prostate please list any history:

_____

Please check any of the following **pulmonary** medical problems:

- o Asthma
- o Emphysema/COPD
- o Pneumonia
- o Other: _____

Please check any of the following **psychiatric** medical problems:

- o Depression
- o Anxiety
- o Bipolar
- o Other: _____

Please check any of the following **STD's**:

- o Herpes
- o HIV
- o Other: _____

Please list surgery history:

_____

_____

Dental history including number of metal amalgams and root canals:

_____

_____

_____

Please list all current pharmaceuticals including dosage and frequency:

_____

_____

_____

_____

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Please list all current OTC medications:

_____

_____

Please list all current supplements including brand, dosage and frequency:

_____

_____

_____

_____

_____

Please list all allergies to medications/food/environment:

_____

_____

_____

Family History including mother, father, brothers, sisters, grandparents, aunts and uncles:

_____

_____

_____

Diet History:

_____

_____

_____

_____

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Social History

Tobacco:

- o Yes, how often: _____ o No

Illicit drugs:

- o Yes, how often: _____ o No

Alcohol:

- o Yes, how often:_____ o No

Exercise:

- o Yes, how often: _____ o No

Toxic exposures:

- o Yes, how often: _____ o No

Marital status:

- o Married o Other: _____
- o Single

Occupation history:

_____

Do you follow any particular diet? _____

Doctor history: List other doctors currently or in past that have treated you:

_____

_____

_____

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Record Release Authorization

To: _____

- o Doctor
- o Hospital

Office: ( )_____ Fax: ( )_____

Address: _____ City: _____ State: _____

Zip code: _____

I hereby authorize and request you to release to:

Wolfson Integrative Cardiology, LLC
Jack M. Wolfson DO, FACC
10585 N Tatum Blvd, Suite D-135
Paradise Valley, AZ 85253

P: 480-535-6844
F: 480-535-6845

health@thedrswolfson.com

The following information:

Complete Medical Record or other _____

I authorize the release of photocopies of the following medical records and/or x-ray/scan files. Records or files shall include all confidential communicable disease-related information (as defined in ARS 36-661), sensitive information including HIV/AIDS/Genetic testing, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information. Concerning my illness and/or treatment from _____ to _____.

Name: _____ Age: _____ Date of birth: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____

Signature: _____ Date: _____

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Patient's Informed Consent Document

Patient is to read each paragraph and sign at the bottom of each page.

Today's date: _____

Name: _____ Age: _____ Date of birth: ____/____/____

o Male o Female

Phone number (mobile): _____ (home): _____

Name and Address of Physician

Dr. Jack M. Wolfson D.O., F.A.C.C.
Wolfson Integrative Cardiology
10585 N Tatum Blvd., Suite D-135
Paradise Valley, AZ 85253

I have specifically sought out the services and perspective of Dr. Wolfson and his nurse pracitioner for the way in which they practice integrative and alternative medicine. While Dr. Wolfson is a board-certified cardiologist and a Fellow of the American College of Cardiology (FACC), Wolfson Integrative Cardiology focuses on integrative and alternative medicine for cardiology care as well as internal medicine.

I fully understand the following:

(a) **Much of Dr. Wolfson's treatment being recommended is not recognized as traditional but is an integrative or alternative method. Integrative and alternative medicine, like any other treatment or medication, may or may not alleviate or cure the condition(s) for which it is offered.**

(b) **Dr. Wolfson believes that integrative and alternative medicine may be valuable to your health. However, as with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing, as well as other available testing options, including lab work, before deciding whether the work-up and following medical analysis and possible treatment provided by Dr. Wolfson is right for you. It is important that you read and understand the information contained in this form so that you can make an informed choice about being treated at Wolfson Integrative Cardiology, by its agents, and Dr. Wolfson, specifically. If after reading this form, you have any concerns or questions regarding the testing or treatment you should talk to Dr. Wolfson or his staff.**

(c) **The federal government, including Medicare and Medicaid, and most insurance companies do not generally pay or reimburse for most nutritional supplements recommended by Dr. Wolfson.**

(d) **Some of the testing being recommended at Wolfson Integrative Cardiology are not recognized as traditional but are alternative testing methods.**

I have read and understand the content of this page _____.

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(e) Some of the services provided by Dr. Wolfson and his nurse practitioner include low level laser therapy, IV therapy, hormone therapy, supplementation therapy, and health coaching, ECG, echocardiography, holter monitor, and treadmill testing.

Dr. Wolfson or staff will provide a description and explain all services to you prior to treatment.

(f) While Dr. Wolfson cannot guarantee the results of the treatment protocol and therapy, the likelihood of treatment success often increases in patients who follow a healthy lifestyle. Therefore, Dr. Wolfson strongly urges patients to maintain a healthy lifestyle. Many of the factors which contribute to a healthy lifestyle include:
   (1) Limit alcohol, not smoking, and avoiding caffeine;
   (2) Low carbohydrate nutrition;
   (3) Physical activity;
   (4) Reducing stress;
   (5) Taking recommended nutritional supplements; and
   (6) Maintaining any medication or treatment regimen proposed by your doctors.

In addition to contributing to the success of the treatment protocol and therapy, following a healthy lifestyle may increase the safety of some of the treatments, and prolong the benefits of it. If you have any concerns about your ability to maintain a healthy lifestyle, Dr. Wolfson's treatment and therapy may not be appropriate for you. You should discuss with your doctor any questions you may have about healthy life habits before undergoing integrative and alternative treatment.

(g) Dr. Wolfson believes the healthiest diet is a low carbohydrate diet, often referred to by Dr. Wolfson as the "Caveman Diet." You, the undersigned, realize that this diet is not the official recommended diet by either the American College of Cardiology, or the American Heart Association. If you have any questions about any type of nutrition, please ask Dr. Wolfson or his staff.

(h) Dr. Wolfson recognizes guidelines published by the American College of Cardiology but does not always base his recommendations in concordance with such guidelines.

(i) Some of the nutritional supplements prescribed or recommended at Wolfson Integrative Cardiology have never been tested by the FDA for determination of the actual contents or the medical effectiveness of the formulations.

(j) Dr. Wolfson may refer you to other providers, traditional and/or alternative. The care rendered by such providers is the sole and separate responsibility of those providers.

I have ready and understand the content of this page _____.

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(k) While your treating doctor believes that the alternative and integrative treatments may be beneficial to your health and well-being, the traditional medical and scientific communities often dispute the medical/scientific proof of the effectiveness or therapeutic value of the treatments. You are free to contact any medical group, doctor, or association on their view of any testing or treatment before you begin. Dr. Wolfson believes the testing and treatment he oversees are valuable and might improve your health.

(l) I may leave Wolfson Integrative Cardiology at any time. It was my independent choice whether to see Dr. Wolfson and his nurse practitioner and it is always my choice whether to continue with them. I also understand that Dr. Wolfson reserves the right, at any time and without cause, to discontinue any patient due to poor compliance with Dr. Wolfson's recommended program or any other reason.

(m) Wolfson Integrative Cardiology is a direct pay practice. Payment is due at the time of service. Some portion of services performed at Wolfson Integrative Cardiology may be covered and reimbursable my your insurance company.

(n) You, the patient, understands that Wolfson Integrative Cardiology is available from 9am to 5pm, Monday through Friday. The office is closed weekends and holidays. No medical provider will be available during off hours, and we do not always have a provider in office each day of the week. The office may be closed during times of vacation. If you have a medical emergency, please call 911 or go to the closest emergency room. You may leave a voice message or email at health@thedrswolfson.com and we will get back to you during our business hours.

I, THE UNDERSIGNED, HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT, MY RIGHTS AND RESPONSIBILITIES, AND HEREBY GIVE CONSENT TO UNDERGO ALTERNATIVE AND INTEGRATIVE TREATMENT AT WOLFSON INTEGRATIVE CARDIOLOGY. INFORMATION ABOUT ME AND MY RECORDS WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.

Signature: _____ Date: _____

Witness: _____ Date: _____

I have read and understand the content of this page _____.

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Notice of Privacy Practices

To our patients – this notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

The following circumstances may require us to use or disclose your health information:

1. The public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Jack M. Wolfson DO, FACC, 10585 N Tatum Blvd, Suite D-135, Paradise Valley, AZ, 85253. Note: We must respond to this request within 30 days.

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4. You may ask us to amend your health information if you believe it is incorrect or incomplete and if the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Jack M. Wolfson DO, FACC, 10585 N Tatum Blvd. Suite D-135, Paradise Valley, AZ, 85253. You must provide us with a reason that supports your request for amendment. Note: We must respond within 60 days. The privacy officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make changes.
5. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jack M. Wolfson DO, FACC. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Questions regarding this notice or our health information privacy policies, please contact Jack Wolfson DO, FACC.

Signature confirms receipt of Patient Privacy Information.

Signature: _____ Date: _____

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Medicare Acknowledgement Agreement

Please read and sign ONLY if Medicare applies to you.

This agreement is between Dr. Jack M. Wolfson DO, FACC ("Physician"), whose principal place of business is 10585 N Tatum Blvd, Suite D-135, Paradise Valley, AZ, 85253;

and patient _____ ("Patient"), who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on Sept. 1st, 2012, and is not excluded from participation in Medicare Part B under Sections 1126, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

_____

_____

_____

History, physical examination, diagnosis testing and the interpretation of such tests:

_____

_____

In exchange for the Services, the Patient agrees to make payments to Physician. Patient also agrees, understands and expressly acknowledges the following:

- **Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.**
- **Patient is not currently in an emergency or urgent health care situation.**
- **Patient acknowledges that Medi-Gap will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.**
- **Patient acknowledges that he/she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.**

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- **Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.**
- **Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if they were not private contract and a proper Medicare claim were submitted.**
- **Patient acknowledges that a copy of this contract has been made available to him/her.**
- **Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.**

Patient signature: _____

Date: _____