Welcome to The Kaplan Center for Integrative Medicine!

Thank you for selecting us to provide you with comprehensive and compassionate medical care. We look forward to partnering with you to improve your health and wellbeing.

At your appointment, your provider will ask about your medical history, and, if time allows, begin your treatment program. The first discussion between you and your doctor is critically important to the process of accurately identifying your medical issues, and formulating your individualized health care plan. Therefore, we ask you to complete the attached questionnaires and forms and bring them with you to your appointment. If you plan to complete your paperwork at The Kaplan Center, please arrive 30-40 minutes before your scheduled appointment.

If you have any questions, please call us at 703-532-4892, option – 2, and we will assist you in any way that we can.

We look forward to meeting you!

Attached, please find:

- Patient Registration Form
- Kaplan Medical Center Financial Policies Form (sign and date only)
- Confidential Communication Request Form
- Patient Consent Form (sign and date only)
- 8 – page Health-History Questionnaire including 1 – page Pain Level Questionnaire
- 3 – page Standardized Health Questionnaire (SF-36)
- Patient Authorization Form (to allow others access to your chart/patient information)
- Notice of Privacy Practices

Immediately below is important insurance information we urge you to review prior to your appointment:

Although we do not participate with any insurance programs, we want you to receive the maximum possible reimbursement for our services. We recommend that you contact your insurance company *prior* to your first visit to obtain the following information:

- Find out if you have 'out-of-network' benefits and what percent of your insurance company's 'allowable charges' will be covered. The initial office visit will be billed using insurance code '99205'. Your insurance company can estimate the reimbursement you can expect to receive. Your insurance company should provide you with claim forms and the mailing address to which claims should be sent.

- Find out if any medical services require prior authorization. Many companies require prior authorization for acupuncture, osteopathic manipulation, physical therapy, and radiological studies. Have a clear understanding of your insurance company's procedure for obtaining prior authorization.

- Ask if your insurance company requires that office-visit notes be attached to your reimbursement-claim form. If so, we will be happy to provide you with this information.

- Your doctor may order laboratory testing or other procedures as part of your evaluation. The cost of any such tests are **not** included in the fee for your initial appointment. For routine laboratory testing, many patients prefer the convenience of having their blood drawn at The Kaplan Center. Other patients prefer to obtain an order for labs to be drawn at an 'in-network' facility. Please note that specialty laboratory testing may only be available through The Kaplan Medical Center.

We will make every effort to provide you with the most complete and accurate fee slip to submit to your insurance company. After your appointment, but before leaving the Kaplan office, please review your fee slip to ensure that it includes the date of service, your doctor's signature, and a checkmark in the box next to the doctor's name. This will help ensure that your insurance company processes your request for reimbursement expeditiously.

KAPLAN CENTER FOR INTEGRATIVE MEDICINE / KAPLAN CLINIC
Patient Registration Form

PLEASE PRINT

Patient Name: _____ Name you prefer to be called: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: _____ Email Address: _____

SS#: _____ **Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Committed Relationship

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Whom should we thank for referring you? ☐ Friend/ Family ☐ Physician: _____

☐ Media: _____ ☐ Internet: _____

☐ Other, please specify: _____

Financially Responsible Person: ☐ Self ☐ Spouse ☐ Parent ☐ Other (Relationship): _____

Name: _____ Phone: ☐ Home ☐ Work ☐ Cell _____

Address: _____ **Responsible Party's Signature**: _____

Responsible Party's Employment Status: ☐ Employed ☐ Retired ☐ Student Employer: _____

Emergency Contact: ☐ Same as Financially Responsible Person **Relationship**: _____

Name: _____ Phone: ☐ Home ☐ Work ☐ Cell _____

Address: _____

Please initial: I certify that I DO NOT have Medicare: _____ Medicaid: _____ Tricare/Champus: _____ Insurance Coverage.
Initial: I certify that if I have Medicare, I only have original Medicare: _____ an advantage plan: _____ Part A *only*: _____ Part B: _____

I certify that I AM NOT seeking treatment for a work-related accident of occupational disease that might be covered under a worker's compensation plan provided by my employer. Please initial: _____

I**nsurance Information:**

Primary Medical Insurance Company: _____

Address: _____ Phone: _____

Insured / Card Holders Name: _____ Relationship: _____ Insured's Date of Birth: _____

Policy #: _____ Group #: _____ Group Name: _____

Secondary Medical Insurance Company: _____

Address: _____ Phone: _____

Insured / Card Holders Name: _____ Relationship: _____ Insured's Date of Birth: _____

Policy #: _____ Group #: _____ Group Name: _____

I voluntarily present myself for treatment at the Kaplan Clinic, and I herby authorize my physicians and such associates, assistants and designees as they may select and the staff, agents and employees to perform, and I herby consent to, such medical care, including diagnostic procedures, medical treatments and examinations, as may be necessary in the opinion of my physicians.

I hereby authorize Kaplan Clinic to apply for benefits on my behalf for services rendered. I request payment be made directly to Kaplan Clinic, PC. I certify that the information I have provided is true and accurate. I further authorize the release of any medical information or other information for this or any related claim to any insurance company.

I permit a copy of this authorization and assignment to be used in place of the original. This will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if my balance remains unpaid for 45 days or more, it will be subject to an 18% annual interest rate, and if it becomes necessary to refer my account to a collection agency, I agree to pay the collection costs.

Patient Signature: _____ Date: _____

Signature of Parent or Legal Guardian (if applicable): _____

Kaplan Center for Integrative Medicine Policies / Kaplan Clinic

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. The following is a statement of several important Kaplan Center for Integrative Medicine policies, which we require that you read and sign *prior* to treatment.

Worker's Compensation, Medicaid, Active Duty: We cannot accept new Medicaid patients, Workers Compensation cases, or Active Duty Military patients at this time.

Fee for Service: FULL PAYMENT IS DUE AT THE TIME OF SERVICE—THE CLINIC ACCEPTS CASH, CHECKS, VISA, MASTER CARD, AMERICAN EXPRESS, or DISCOVER CARDS. A request for special arrangements, in which you pay 20% at the time of service and the balance within 30 days, (allowing time for your insurance company to reimburse you before the balance is due) may be made after six visits to the Clinic. All requests must be made in writing and sent to the Kaplan Center's Billing and Insurance Department. In any event, all outstanding balances older than 30 days are due in full. The Center processes statements on the 15th of each month and will include a $5.00-$10.00 statement charge for any 30-day or older outstanding balances. If a bill is not paid within 60 days or the balance exceeds $1,000.00, payment in full will be required on each date of service.

Returned Checks: There is a $25 fee for each returned check.

Insurance Reimbursement/Covered Services: Your health insurance policy is a contract between you and your insurance company. The Kaplan Center is not a party to that contract and does not accept assignment of benefits. We will give you two copies of your fee slip at each visit. One copy is for you to submit to your insurance company: the other is for your own records. The fee slip includes standard information that insurance companies routinely require to process their reimbursement to you. Please be aware that some, and perhaps all, services provided at the Kaplan Center for Integrative Medicine may be "non-covered" services, and therefore, may be deemed "unreasonable" or "unnecessary" by Medicare or another insurance program. We urge you to contact your insurance company prior to treatment to learn what services your insurer will and will not cover. The Kaplan Center offers insurance filing services for a fee; for details, please speak to a Kaplan representative.

Usual and Customary Rates (UCR): The Clinic is committed to providing the best treatment possible for our patients and we charge what we believe is a reasonable fee for the time and services provided. You are responsible for payment in full, regardless of any insurance company's determination of usual and customary rates. Please contact your insurance company regarding any reimbursement concerns.

Copies of Fee Slips: We provide you with two copies of your fee slip at the time of your visit. If you request additional copies of fee slips for past dates of service, there will be an initial $10.00 search and handling charge, plus a $0.50 per page copying charge, and a charge for the applicable postage. Furthermore, if your insurance company requests information beyond that provided on your fee slip, such as copies of your medical records, we will bill your insurance company for the cost of providing such information and send the requested information upon receipt of payment. If your insurance company does not pay the cost of such requested information, you may be billed for the copies.

Termination of Service: If, at any time, there is an outstanding balance, services may be terminated. In this event, written notice will be given to the patient informing him or her that the Clinic will provide urgent medical care only for the following two weeks, during which time the patient will be responsible for identifying another medical care provider.

Charge for Missed Appointments: Unless canceled at least 2 business days in advance, the patient will be charged $50.00-$150.00 for a missed appointment. Please help us serve you better by keeping your scheduled appointments.

Minor Patients: Minors must have permission from a legal guardian to be treated, except for exemptions provided by law. For unaccompanied minors, non-emergency treatment will be denied unless the minor has written permission for treatment from a legal guardian and charges have been pre-authorized to an approved credit card, or payment will be made by cash or check at the time of service. The adult accompanying a minor patient (and/or parent/guardian) is responsible for full payment at the time of service. Until the minor reaches eighteen years of age, his/her parents or legal guardian will have full access to the child's health information.

Deemed Consent: I understand that the laws of Virginia provide that if my physician or any person employed by or under the direction and control of my physician is directly exposed to my body fluids in any manner which may, according to the current guidelines of the Centers for Disease Control, transmit the human immunodeficiency virus (HIV) or the Hepatitis B or Hepatitis C virus, I am deemed by law to have consented to testing for infection with the HIV, Hepatitis B, or Hepatitis C virus. I further understand that by law I will be deemed to have consented to release of these test results to the person exposed to my body fluids.

Please let us know if you have any questions or concerns about the Kaplan Medical Center's billing policies or procedures.

I have read these policies, and I understand and agree to them.

Signature of Patient/Responsible Party: _____ Date: _____

KAPLAN CENTER FOR INTEGRATIVE MEDICINE
CONFIDENTIAL COMMUNICATION REQUEST FORM

You have a right under the HIPAA guidelines to request the type of confidential communications you would like to have with the Kaplan Center. To help us get your healthcare information to you in an efficient manner, please complete this form identifying your wishes. We will accommodate reasonable requests. As always, the Kaplan Center is dedicated to maintaining the privacy of your healthcare information.

Phone communication:

Do you authorize the Kaplan Center to leave a message on your answering machine containing the caller's name, the Kaplan Medical Center office phone number, and a brief description of why we are calling (which may include the name of your physician or healthcare provider)?

I authorize the Kaplan Center to leave this type of message:

At my home number: **Initial**:_____ On my cell phone number: **Initial**:_____
At my work number: **Initial:**_____ Do not leave a message: **Initial:** _____

In the event that the Kaplan Center would need to leave a more involved message including detailed Protected Health Information (**PHI**), do you authorize leaving a message with PHI on your answering machine? For example: "Your throat culture was positive, please continue your antibiotics." or "We received your x-ray results and your chest x-ray is normal."

I authorize the Kaplan Center to leave this type of message:

At my home number: **Initial**:_____ On my cell phone number: **Initial**:_____
At my work number: **Initial:**_____ Do not leave a message: **Initial:** _____

Paper Communication:

In the course of meeting my healthcare needs:

I authorize the Kaplan Center to send PHI via regular mail. **Initial:** _____
I understand that if I do not initial the above box I will be charged for certified, return-receipt-requested postage when PHI is mailed to me. **Initial:**_____

At your request, the Kaplan Center may fax your PHI to your **personal** fax.
Upon my verbal request, I hereby authorize the Kaplan Center to fax my PHI to the following:

Fax number:_____ **Initial**:_____

Pharmacy Communication:

The Kaplan Center communicates with pharmacies electronically, via phone, and via fax. By initialing below, you authorize the Kaplan Medical Center to communicate your pharmacy.

I authorize the Kaplan Center to communicate with my pharmacy:

Via phone: **Initial:**_____ Via fax: **Initial:**_____ Electronically: **Initial:**_____

Electronic Communication:

Do you authorize the Kaplan Center to send you non-protected information via e-mail, including the Kaplan newsletter, and other general notices such as the availability of flu shots?

I authorize the Kaplan Center to send information to my e-mail address below:
_____ **Initial**: _____

Appointment Reminders:

The Kaplan Center offers patients multiple types of automated appointment reminders. Patients are automatically enrolled in automated telephone calls and emails, and may enroll in text messaging as well.

Via phone: **Initial:**_____ Via text: **Initial:**_____ Via email: **Initial:**_____

Print Patient Legal Name:_____
Home Phone:_____ Work Phone:_____ Cell Phone: _____
Patient/ Legal Guardian **Signature:** _____ Date:_____

THE KAPLAN CENTER
for Integrative Medicine
THE CHRONIC PAIN AND ILLNESS EXPERTS

Patient Authorization Form

I, _____, hereby authorize the disclosure of the following Protected Health Information (PHI):
(Patient's Name)

- ☐ Appointment and Account Information
- ☐ Medical Records
- ☐ Laboratory and Radiology Findings
- ☐ Attend appointments with no restrictions
- ☐ Insurance/Billing/Account Information
- ☐ Visit Notes
- ☐ Prescription Information
- ☐ Insurance/Billing/Account Information

I authorize the Kaplan Center to release this information to the following persons/offices/agencies:

Name: Address: Fax / Phone:

_____

_____

_____

_____

I am requesting this information be released for the following purposes(s):

Coordination of Care

Other: _____

This authorization shall remain in effect from the date signed below until: _____
(Date)

This date cannot exceed one year from the date signed and must be renewed annually. A photocopy of this authorization will be as valid as the original.

I understand that:

1. I may request a copy of the PHI that will be used or disclosed.
2. I may revoke this authorization in writing by contacting Kaplan Center.
3. Once the Kaplan Center completes my request to release my Personal Health Information (PHI), the Clinic is not responsible for any subsequent disclosure of my PHI.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____ _____
(Printed Patient Name) (Printed Name of Legal Guardian – if Applicable)

Kaplan Center for Integrative Medicine
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and 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:

1. Conduct, plan, and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payors (this includes providing information for the patient to be reimbursed).
3. Conduct normal healthcare operations. For example, to evaluate the quality of care you receive from us.

I have received a copy of the Kaplan Medical Center's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the Kaplan Medical Center Notice of Privacy Practices prior to signing this consent. I understand that the Kaplan Medical Center has a right to change its Notice of Privacy Practices (such as; if the Privacy Officer changes or there is a change in the law). I may contact the Kaplan Medical Center at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that the Kaplan Medical Center restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the Kaplan Medical Center is not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the Kaplan Medical Center has taken action relying on this consent.

A copy of this consent will be as valid as the original.

Print Patient Name: _____

Print Guardian Name: _____

Signature: _____

Date: _____

THE KAPLAN CENTER FOR INTEGRATIVE MEDICINE
Patient History Questionnaire

Name:_____ Date: _____
What is the major complaint that brings you to our office? Please describe briefly:

How long has this been a problem?

What treatment have you had so far?

What provides some relief?

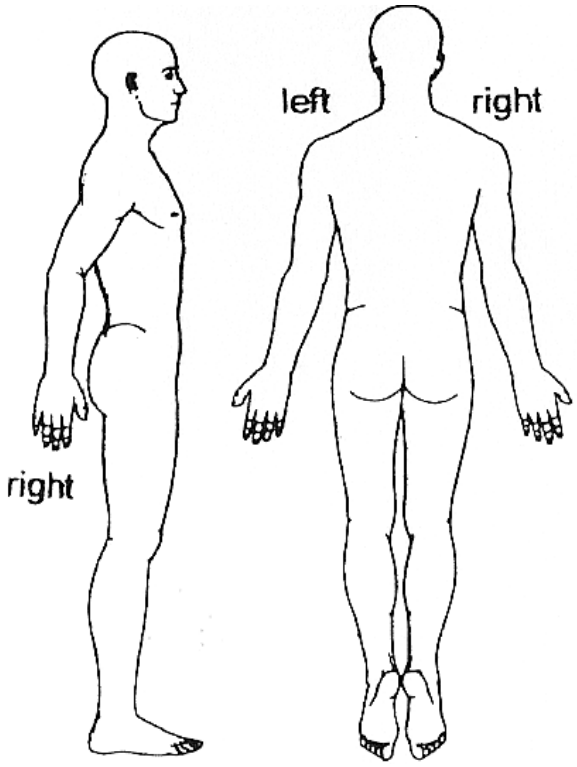
What makes it worse?

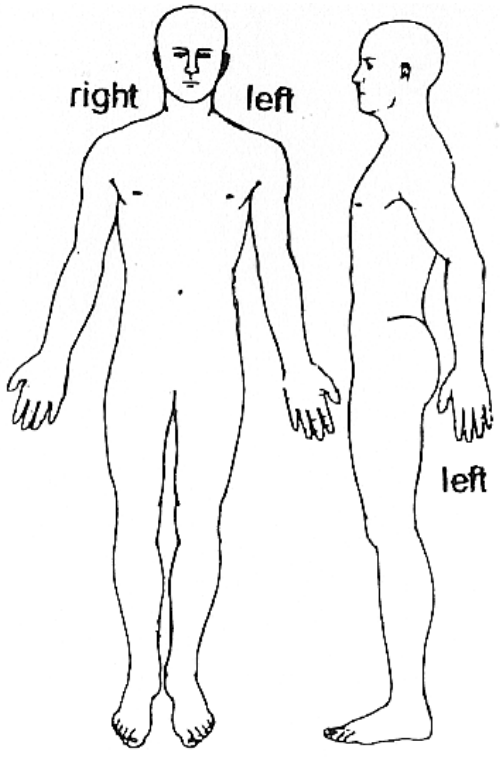
YOUR CURRENT PAIN COMPLAINT

On the diagrams below, please mark the areas of the body where you are experiencing abnormal sensations, and describe these sensations using the key below:

////// = ACHE ***** = PINS & NEEDLES → = STABBING
XXX = CRAMPING ⦸⦸⦸ = NUMBNESS ↯↯↯ = BURNING

You may also add your own sensation symbols if necessary (indicate what your symbols represent).





Office Use Only:
Doctor's Initials: _____ Patient Name: _____ Date: _____

PAIN-LEVEL QUESTIONNAIRE

On a scale of 0 to 10 (0 = no pain, 10 = worst possible pain), please indicate how you would rate your average pain over the last week:

Area of pain: _____

0 1 2 3 4 5 6 7 8 9 10

Area of pain: _____

0 1 2 3 4 5 6 7 8 9 10

Area of pain: _____

0 1 2 3 4 5 6 7 8 9 10

Area of pain: _____

0 1 2 3 4 5 6 7 8 9 10

Area of pain: _____

0 1 2 3 4 5 6 7 8 9 10

Is your current problem the result of a car accident? ☐ Yes ☐ No

If YES, be sure to provide additional information below. If NO, please go to the Family history section starting on the next page.

CAR ACCIDENT PATIENTS *ONLY*

Please give the location of the accident: _____
Were you wearing a seatbelt? ☐ Yes ☐ No
Please describe the car accident and the injury you sustained:

Prior to this accident, have you had the same or similar symptoms? ☐ Yes ☐ No
If yes, please describe:

Have you been unable to work due to the accident? ☐ Yes ☐ No
Dates you have missed work:
Dates on light duty at work:

Have you been involved in other car accidents prior to this? ☐ Yes ☐ No

List dates of all prior car accidents and your related symptoms:
Date: _____ Symptoms: _____
Date: _____ Symptoms: _____
Date: _____ Symptoms: _____

Attorney Name and Address: _____
Attorney Phone: _____ Attorney Fax: _____

Insurance Company Name and Address:

Claim File Number: _____

What radiology tests have been done, and what were the results?
X-Ray: ☐ Yes ☐ No Dates: _____ Results: _____
MRI: ☐ Yes ☐ No Dates: _____ Results: _____
CAT Scan: ☐ Yes ☐ No Dates: _____ Results: _____
EMG/Nerve Conduction Studies: ☐ Yes ☐ No Date: _____ Results: _____

Office Use Only:
Doctor's Initials: _____ Patient Name: _____ Date: _____

YOUR FAMILY HISTORY

Other than yourself, how many people live in your household?___Adults: _____ Children: _____

Siblings: Brother(s): _____ Sister(s): _____ Age range: _____
Living: _____ Living: _____
Deceased: _____ Deceased: _____
If deceased, date and cause of death:

Parents: Mother is: ☐ Living ☐ Deceased
If deceased, date and cause of death:
Father is: ☐ Living ☐ Deceased
If deceased, date and cause of death:

Race/Ethnicity: ☐ Black/African American ☐ White/Caucasian
☐ Asian/Pacific Islander ☐ Hispanic/Latino
☐ American Indian ☐ Other: _____

Please check below if you, or any blood relative previously had, or currently has, the following:

Condition	Yourself	Mother	Father	Sibling	Other
Allergies					
Anemia					
Angina					
Arthritis					
Asthma					
Cancer (other than skin cancer)					
Depression, OCD, Schizophrenia					
Diabetes (whether taking insulin or not)					
Epilepsy					
Glaucoma					
Gout					
Heart Attack / MI					
Heart Disease					
Hypertension / High Blood Pressure					
Kidney Disease					
Migraines					
Skin Cancer					
Skin Disease (other than cancer)					
Stroke					
Thyroid Disease					
Tuberculosis					

WOMEN ONLY

Age of menses onset: _____
Flow: ☐ Heavy ☐ Moderate ☐ Light ☐ Irregular
Days between periods: _____ Days of flow: _____ Last period began on: _____
Problems? ☐Pain ☐Cramps ☐Pain with intercourse ☐Bleeding with intercourse ☐Menopause symptoms

Pregnancies: _____ Live Births: _____ Miscarriages: _____

Office Use Only:
Doctor's Initials: _____ Patient Name: _____ Date: _____

Please check below if you have any of these problems, or have had them in the past:

NOSE / THROAT	Current	Past	Details
Nose Bleeds			
Sinus Problems			
Hayfever/Seasonal Allergy			
Chronic Sore Throat			
Hoarseness			

EYES / EARS	Current	Past	Details
Blurred Vision			
Double Vision			
Other Vision Problems			
Eye Infections			
Blindness or Poor Vision			
Deafness or Poor Hearing			
Ringing in Ears			
Ear Infections			

STOMACH / GI	Current	Past	Details
Indigestion/Heartburn			
Nausea/Vomiting			
Ulcer/Upper GI Bleeding			
Chronic Abdominal Pain			
Change in Bowel Habits			
Diarrhea			
Constipation			
Bloody Stool			
Hemorrhoids			
Gall Bladder Trouble			
Hernia			
Diverticulosis			
Jaundice/Hepatitis			

LUNGS	Current	Past	Details
Lung Infection			
Bronchitis			
Wheezing			
Shortness of Breath on Exertion			
Shortness of Breath Lying Flat			
Pneumonia			
Pleurisy			
Chronic Lung Disease/Emphysema			

HEART	Current	Past	Details
Chest Pain			
High Blood Pressure			
Heart Murmur			
Irregular Heart Beat			
Palpitations			
Congestive Heart Failure			

Office Use Only:

Doctor's Initials:_____ Patient Name:_____ Date:_____

URINARY / KIDNEYS	Current	Past	Details
Urinary Tract Infections			
Painful Urination			
Blood in Urine			
Night Urination			
Trouble Controlling Urine			
Decreased Force of Urine			
Urethral Discharge			
Kidney Stones			

MUSCLE / JOINTS	Current	Past	Details
Arthritis/Rheumatism			
Chronic Back Problems/Sciatica			
Bone Fracture			
Joint Injury			
Leg Pain with Walking			

SKIN	Current	Past	Details
Rashes			
Psoriasis			
Eczema			
Hives			

GENERAL	Current	Past	Details
Dizzy Spells			
Fainting Spells			
Swollen Ankles			
Loss of Appetite			
Change in Weight			
Nervousness			
Sleeping Problems			
Memory Loss			
Moodiness			
Phobias			
Chronic Fatigue			
Venereal Disease			
Bruise Easily			
Tremors			
Varicose Veins			
Muscle Weakness			
Numbness/Tingling			
Headaches			
Cold or Numb Feet			

PAIN	Current	Past	Details
Neck			
Upper Back			
Lower Back			
Legs			
Arms			
Other			

Office Use Only:

Doctor's Initials: _____ Patient Name: _____ Date: _____

Please indicate below if you have had any of the following:

Operation(s):	Date:	Reason:
Hospitalization(s):	Date:	Reason:
Drug Allergies:	Drug Name:	Reaction:
Environmental & Food Allergies:	Allergic to:	Reaction:

YOUR CURRENT MEDICATIONS

PRESCRIPTION MEDICATIONS (these require a physician's prescription

Medication name:	Dose:	How often you take this:	Prescribed by:

OVER-THE-COUNTER MEDICATIONS, HERBS, AND DIETARY SUPPLEMENTS

(these **do not** require a prescription; such as sleep aids, pain relievers, vitamins, herbal remedies, etc.)

Medications name:	Dose:	How often you take this:	Reason for taking:

Office Use Only:

Doctor's Initials: _____ Patient Name: _____ Date: _____

YOUR HEALTH HABITS

Do you exercise regularly? ☐ Yes ☐ No

If yes, how often? _____ What type of exercise? _____

Do you smoke? ☐ Yes ☐ No If yes, number of cigarettes per day: _____

Caffeine? ☐ Yes ☐ No

If yes: ☐ Cola(s) per day: _____ ☐ Coffee(s) per day: _____ ☐ Tea: _____

Alcohol? ☐ Yes ☐ No

If yes: ☐ Beer ☐ Wine ☐ Liquor How often? _____

Dietary Restrictions: _____

_____

_____

Do you have trouble sleeping? ☐ Yes ☐ No

If yes, check all that apply: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Awaken in early morning

☐ Awaken during sleep (how often?): _____

YOUR OCCUPATONAL HISTORY:

Highest level of education completed:

☐ Some high school ☐ High school graduate ☐ Some college ☐ College Graduate ☐ Post Graduate work

Are you currently employed?

☐ Full-time ☐ Part-time ☐ Student ☐ Homemaker ☐ Retired ☐ Not working due to injury/pain

Your occupation: _____

How many hours do you spend during your workday doing the following activities?

Standing: _____ Working on a computer: _____ Frequent lifting: _____ Heavy lifting: _____

Talking on phone: _____ Repetitive motions: _____ Reaching overhead: _____

Have you traveled outside of the United States? ☐ Yes ☐ No

If yes, please provide location and approximate date of foreign travel:

Date:	Location:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Office Use Only:

Doctor's Initials: _____ Patient Name: _____ Date: _____

YOUR IMMUNIZATIONS

IMMUNIZATION	Date Received	IMMUNIZATION	Date Received
Tetanus		Flu Vaccine	
Hepatitis A		Pneumonia Vaccine	
Hepatitis B		PPD (or BCG)	

Please check below if you have any of these problems (or have in the past):

	Current	Past	Immunized? YES	NO	DATE	Details
Chicken Pox						
Polio						
Measles						
German Measles						
Scarlet Fever						
Mumps						

If there is any other information you would like to share with your physician, please do so here:

Office Use Only:

Doctor's Initials: _____ Patient Name: _____ Date: _____

Patient Name: _____ **Date:** _____

Your Health and Well-Being
SF-36

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Thank you for completing this survey!

For each of the following questions, please mark an X in the one box that best describes your answer.

1. **In general, would you say your health is:**

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. **Compared to one year ago, how would you rate your health in general now?**

   ☐ Much better now than one year ago | ☐ Somewhat better now than one year ago | ☐ About the same as one year ago | ☐ Somewhat worse now than one year ago | ☐ Much worse now than one year ago

3. **The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports, etc	☐ ……..	☐ ……..	☐
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ ……..	☐ ……..	☐
c. Lifting or carrying groceries	☐ ……..	☐ ……..	☐
d. Climbing several flights of stairs	☐ ……..	☐ ……..	☐
e. Climbing one flight of stairs	☐ ……..	☐ ……..	☐
f. Bending, kneeling, or stooping	☐ ……..	☐ ……..	☐
g. Walking more than a mile	☐ ……..	☐ ……..	☐
h. Walking several hundred yards	☐ ……..	☐ ……..	☐
i. Walking one hundred yards	☐ ……..	☐ ……..	☐
j. Bathing or dressing yourself	☐ ……..	☐ ……..	☐

4. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the amount of time you spent on work or other activities	☐ ……..….	☐ …….……	☐ …….....	☐ ……..	☐
b. Accomplished less than you would like	☐ ……..….	☐ …….……	☐ …….....	☐ ……..	☐
c. Were limited in the kind of work or other activities	☐ ……..….	☐ …….……	☐ …….....	☐ ……..	☐
d. Had difficulty performing the work or other activities (for example, it took extra effort)	☐ ……..….	☐ …….……	☐ …….....	☐ ……..	☐

Patient Name: _____ **Date:** _____

5. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
b. Accomplished less than you would like	☐	☐	☐	☐	☐
c. Did work or other activities less carefully than usual	☐	☐	☐	☐	☐

6. **During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

7. **How much bodily pain have you had during the past 4 weeks?**

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

8. **During the past 4 weeks, how much did pain interfere with your normal work including both work outside the home, and housework)?**

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

9. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks…**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of life?	☐	☐	☐	☐	☐
b. Have you been nervous?	☐	☐	☐	☐	☐
c. Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐
f. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐
g. Did you feel worn out?	☐	☐	☐	☐	☐
h. Have you been happy?	☐	☐	☐	☐	☐
i. Did you feel tired?	☐	☐	☐	☐	☐

10. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

(SF-36v2® Health Survey Standard, United States (English))

Patient Name: _____ **Date:** _____

11. How TRUE or FALSE are <u>each</u> of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b. I am as healthy as anybody I know	☐	☐	☐	☐	☐
c. I expect my health to get worse	☐	☐	☐	☐	☐
d. My health is excellent	☐	☐	☐	☐	☐

Thank you for completing these questions!

Horowitz Lyme-MSIDS Questionnaire

The Horowitz Lyme-MSIDS Questionnaire is not intended to replace the advice of your own physician or other medical professional. You should consult a medical professional in matters relating to health, and individuals are solely responsible for their own health care decisions regarding the use of this questionnaire. It is intended for informational purposes only and not for self-treatment or diagnosis.

SECTION 1: SYMPTOM FREQUENCY SCORE

0=None 1=Mild 2=Moderate 3=Severe

1. Unexplained fevers, sweats, chills, or flushing	
2. Unexplained weight change; loss or gain	
3. Fatigue, tiredness	
4. Unexplained hair loss	
5. Swollen glands	
6. Sore throat	
7. Testicular or pelvic pain	
8. Unexplained menstrual irregularity	
9. Unexplained breast milk production; breast pain	
10. Irritable bladder or bladder dysfunction	
11. Sexual dysfunction or loss of libido	
12. Upset stomach	
13. Change in bowel function (constipation or diarrhea)	
14. Chest pain or rib soreness	
15. Shortness of breath or cough	
16. Heart palpitations, pulse skips, heart block	
17. History of a heart murmur or valve prolapse	
18. Joint pain or swelling	
19. Stiffness of the neck or back	
20. Muscle pain or cramps	
21. Twitching of the face or other muscles	
22. Headaches	
23. Neck cracks or neck stiffness	
24. Tingling, numbness, burning, or stabbing sensations	
25. Facial paralysis (Bell's palsy)	
26. Eyes/vision: double, blurry	
27. Ears/hearing: buzzing, ringing, ear pain	
28. Increased motion sickness, vertigo	
29. Light-headedness, poor balance, difficulty walking	
30. Tremors	
31. Confusion, difficulty thinking	
32. Difficulty with concentration or reading	
33. Forgetfulness, poor short-term memory	

34. Disorientation: getting lost; going to wrong places	
35. Difficulty with speech or writing	
36. Mood swings, irritability, depression	
37. Disturbed sleep: too much, too little, early awakening	
38. Exaggerated symptoms or worse hangover from alcohol	
TOTAL Section 1	

SECTION 2: MOST COMMON LYME SYMPTOMS SCORE

If you rated a 3 for each of the following in section 1, give yourself 5 additional points:	
39. Fatigue	
40. Forgetfulness, poor short-term memory	
41. Joint pain or swelling	
42. Tingling, numbness, burning, or stabbing sensations	
43. Disturbed sleep: too much, too little, early awakening	
TOTAL Section 2	

SECTION 3: LYME INCIDENCE SCORE

If true transpose points here:

Please circle the points for each of the following statements you can agree with:	
44. You have had a tick bite with no rash or flulike symptoms. **3 points**	
45. You have had a tick bite, an erythema migrans, or an undefined rash, followed by flulike symptoms. **5 points**	
46. You live in what is considered a Lyme-endemic area. **2 points**	
47. You have a family member who has been diagnosed with Lyme and/or other tick-borne infections. **1 point**	
48. You experience migratory muscle pain. **4 points**	
49. You experience migratory joint pain. **4 points**	
50. You experience tingling/burning/numbness that migrates and/or comes and goes. **4 points**	
51. You have received a prior diagnosis of chronic fatigue syndrome or fibromyalgia. **3 points**	
52. You have received a prior diagnosis of a specific autoimmune disorder (lupus, MS, or rheumatoid arthritis), or of a nonspecific autoimmune disorder. **3 points**	
53. You have had a positive Lyme test (IFA, ELISA, Western blot, PCR, and/or borrelia culture). **5 points**	
TOTAL Section 3	

SECTION 4: OVERALL HEALTH SCORE

54. Thinking about your overall physical health, for how many of the past thirty days was your physical health not good?____days Award yourself the following points based on the total number of days: 0–5 days = 1 point 6–12 days = 2 points 13–20 days = 3 points 21–30 days = 4 points	
55. Thinking about your overall mental health, for how many days during the past thirty days was your mental health not good?_____days Award yourself the following points based on the total number of days: 0–5 days = 1 point 6–12 days = 2 points 13–20 days = 3 points 21–30 days = 4 points	
TOTAL Section 4	

SCORING:

Record your total scores for each section below and add them together to achieve your final score:

Section 1 Total:	
Section 2 Total:	
Section 3 Total:	
Section 4 Total:	
FINAL SCORE	

If you scored 46 or more, you have a high probability of a tick-borne disorder and should see a healthcare provider for further evaluation.
If you scored between 21 and 45, you possibly have a tick-borne disorder and should see a health-care provider for further evaluation.
If you scored under 21, you are not likely to have a tick-borne disorder.

Interpreting the Results:

We see a high frequency of Section 1 symptoms in our patients, including fatigue, joint and muscle pain that often migrates, sleep disorders, as well as memory and concentration problems, and a high frequency of Section 3 symptoms, especially neuropathic pain that comes and goes and migrates (tingling, numbness, burning, etc.). These form a cluster of presenting symptoms that are characteristic of those with a high probability of having Lyme-MSIDS.

In one recent study conducted in our office of 100 consecutive patients, we found that more than 25 percent reported that the following symptoms were present most or all of the time in the month preceding their office visit. Many of these patients reported that these symptoms affected their quality of life: 71 percent reported that their physical health was not good and 47 percent reported that their mental health was not good on at least fifteen days in the previous month.

KAPLAN CENTER FOR INTEGRATIVE MEDICINE
PRIVACY POLICIES

Dear Patient:

The touchstone of excellent medical care is the confidentiality of communications between you and your healthcare providers. This is a value of utmost importance at the Kaplan Center for Integrative Medicine.

As you may know, federal legislation entitled the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires healthcare professionals and other healthcare related entities, such as insurance companies and pharmacies, to notify clients about their rights to privacy concerning their personal healthcare records. In compliance with HIPAA, the Kaplan Medical Center has prepared a statement outlining our rights to privacy under the new legislation. Our "Notice of Privacy Practices" is attached for your review.

At Kaplan Medical Center, we have always and will continue to uphold policies and practices that protect the confidentiality of your private health information. Thank you for selecting us as your physicians and healthcare providers.

Sincerely,

Gary Kaplan, D.O., Medical Director, and Staff

KAPLAN CENTER FOR INTEGRATIVE MEDICINE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

During your first appointment at the Kaplan Medical Center, a medical record was created that contains critical information such as your name, address, age, insurance coverage and medical condition. As you are aware, this record is updated each time you visit or contact the Kaplan Medical Center. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this information is referred to as your Individual Identifiable Health Information (IIHI) or Protected Health Information (PHI).

The terms of this Notice of Privacy Practices (Notice) apply to all records containing your PHI that are created or retained by the Kaplan Medical Center. We reserve the right to revise or amend this Notice of Privacy Practices (such as, if the Privacy Officer changes or there is a change in the law). Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past and for any of your records that we may create in the future. The Kaplan Medical Center will post a copy of the current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

THE KAPLAN MEDICAL CENTER'S OBLIGATIONS:

We are required by law to:

- Maintain the privacy of Protected Health Information (PHI)
- Give you this notice of our legal duties and privacy practices regarding your health information about you
- Follow the terms of our notice that is currently in effect

HOW THE KAPLAN MEDICAL CENTER MAY USE AND DISCLOSE HEALTH INFORMATION

We may use and disclose your Protected Health Information (PHI) under the following circumstances:

1. **Treatment:** The Kaplan Medical Center may use your PHI to treat you. For example, we might use your PHI to contact a pharmacy when we order a prescription for you. We may disclose your PHI to others who assist in your care such as a consulting physician.
2. **Payment:** The Kaplan Medical Center may use and disclose your PHI to bill and collect payment for the services and items you receive from us. For example, we may contact your health insurance company to preauthorize treatment or to obtain payment. We may use your PHI to bill you directly for services rendered, and in the event of non-payment, we may forward selective information (such as your name, address, phone number, and amount due) to other entities to assist us with billing and collections.
3. **Healthcare Operations:** The Kaplan Medical Center may use and disclose your PHI to operate our business. For example, we may use your IIHI to evaluate the quality of care you receive from us.
4. **In Response to a Public Health Risk:** The Kaplan Medical Center may disclose your PHI to public health agencies that are authorized by law to collect it. For example, personal health information may be disclosed for the purpose of maintaining vital records (such as a birth or death); reporting child abuse or neglect; preventing or controlling disease, injury, or disability; notifying a person regarding a potential exposure to a communicable disease; notifying a person regarding a potential risk for spreading or contracting a disease or condition; reporting reactions to drugs or problems with products or devices; notifying individuals if a product or device they may be using has been recalled; and notifying appropriate government agencies and authorities regarding potential abuse or neglect of an adult (including domestic violence). Please note that we will report potential domestic violence or the neglect of an adult only when the patient agrees or when we are legally mandated to disclose the information.
5. **Health Oversight Activities:** The Kaplan Medical Center may disclose your PHI to a health oversight agency for activities required or authorized by law (such as activities necessary to monitor government programs, for example: a Medicare audit).
6. **Lawsuits and Similar Proceedings:** The Kaplan Medical Center may disclose your PHI in response to a Court or Administrative Order. For example, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a subpoena, or other lawful process initiated by a party involved in the dispute, but only when the request is accompanied by a signed release from you.
7. **Workers' Compensation:** The Kaplan Medical Center may disclose your PHI for workers' compensation and similar programs.
8. **Law Enforcement:** The Kaplan Medical Center may release PHI if asked to do so by a law enforcement official.
9. **Military:** The Kaplan Medical Center may disclose your PHI if you are a member of the United States military forces and, the request is made by the proper authorities.
10. **National Security:** The Kaplan Medical Center may disclose your PHI to federal officials to cooperate with intelligence and national security activities authorized by law.
11. **Data Breach Notification Purposes:** The Kaplan Medical Center may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

1. **Individuals involved in Your care or Payment for Your Care:** Unless you object, the Kaplan Medical Center may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that if is in your best interest based on our professional judgment.
2. **Disaster relief:** The Kaplan Medical Center may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes.
2. Disclosures that constitute sale of your PHI; and
3. Uses and disclosures of psychotherapy notes about you.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding your PHI maintained by the Kaplan Medical Center:

1. **Confidential Communications:** You have the right to request that the Kaplan Medical Center communicate with you about your health and health-related issues in a particular way to protect your privacy. To do so, you must send your request in writing to: Office Manager/ Privacy Officer at the Kaplan Medical Center. Your letter must specify the method of confidential communication/contact you want the Kaplan Medical Center to employ. We will accommodate reasonable requests.
2. **Requesting Restrictions:** You have a right to request a restriction in the Kaplan Medical Center's use or disclosure of your PHI; however, the Kaplan Medical Center is not required to accommodate your request. (For example, there may be circumstances where the Kaplan Medical Center is legally required to disclose medical records, such as when responding to a Court Order or during a public health emergency). To request that the Kaplan Medical Center restrict its use of your PHI, you must write to: Office Manager/ Privacy Officer at the Kaplan Medical Center. Your request must include both the information you want restricted and a list of the persons/entities to whom the restrictions should apply.
3. **Inspection and Copies:** You have the right to inspect and obtain a copy of your PHI (excluding psychotherapy notes). To do so, you must submit a request in writing to Office Manager/ Privacy Officer at the Kaplan Medical Center. The Kaplan Medical Center has up to 30 days to make your PHI available to you and may charge a fee to cover the costs associated with your request, such as supplies, copying, postage, and labor. The Kaplan medical Center may not charge a fee if you need the information for a claim benefits under the Social Security Act or any other state or federal needs-based benefit program. The Kaplan Medical Center may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
4. **Right to an Electronic Copy of Electronic Medical Records:** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or, if you do not want this form or format, a readable hard copy form. The Kaplan Medical Center may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
5. **Right to Get Notice of a Breach:** You have the right to be notified upon a breach of any of your unsecured PHI.
6. **Amendment:** You may ask us to amend your PHI if you believe it is incorrect or incomplete. You can obtain a "Request for Correction/Amendment of Protected Health Information" form at the Kaplan Medical Center or by calling or writing to us. The form requires you to provide reasons supporting your request for amendment/correction. The completed form should be sent to the attention of Office Manager/ Privacy Officer, at the Kaplan Medical Center. It is the responsibility of the Kaplan Medical Center to review, and then, either approve or deny your request to amend your PHI. When a request for amendment is denied, the Kaplan Medical Center will provide an explanation in writing.
7. **Accounting for Disclosure:** All of our patients have the right to request an accounting of disclosures. An "accounting of disclosures" is a list of certain non-routine disclosures the Kaplan Medical Center has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. In order to obtain an accounting of non-routine disclosures, you must submit your request in writing to Office Manager/ Privacy Officer at the Kaplan Medical Center.
8. **Paper Copy of this Notice:** You are entitled to receive a paper copy of the Kaplan Medical Center's Notice of Privacy Practices. You may ask for a copy of this notice at any time. To obtain a paper copy of this notice, contact HIPAA Coordinator.
9. **Out-of-Pocket-Payments:** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and the Kaplan Medical Center will honor that request.

COMPLAINTS

Filing a Complaint: If you believe your privacy rights have been violated, you may file a complaint with the Kaplan Medical Center or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Office Manager/ HIPAA Coordinator at the Kaplan Medical Center. To file a complaint with the United States Secretary of Health and Human Services, you may write to: Barbara Holland, Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 150 S Independence Mall West, Suite 372, Public Ledger Building, Philadelphia, PA 19106-9111. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

If you have questions about this notice, please contact: Privacy Officer/HIPAA Coordinator:

Title: Office Manger/Privacy Officer
Address: 6829 Elm Street
Suite 300
McLean, VA 22101
Telephone No: 703-532-4892