OSTEOPATHIC WELLNESS CENTER,LLC
PATIENT REGISTRATION FORM

PATIENT NAME____ DATE_________________________

STREET ADDRESS____

CITY____________________________ STATE_______ ZIPCODE________________ EMAIL ____________________

TELEPHONE NO. (H)_____________ (W)______________ (C)_____________ (F)_______________

SEX______ DATE OF BIRTH_____________________ SSN__________________

PRIMARY CARE PHYSICIAN_________________________ REFERRED BY__________________________________

EMERGENCY CONTACT NAME AND PHONE NO.____

INSURANCE INFORMATION

Is this a personal injury or automobile accident claim? Yes no I don't know
If yes, do you have an attorney? Yes no Please complete the auto/liability claim form, which is available from the receptionist.

1) PRIMARY HEALTH INSURANCE PLAN NAME____

INSURANCE ID#________________________________ GROUP ID#____________________________

SUBSCRIBER'S NAME (if different than patient) ____

SUBSCRIBER'S SSN____________________________ DOB____________________________________

2) SECONDARY INSURANCE PLAN NAME____

INSURANCE ID#________________________________ GROUP ID#______________________________

SUBSCRIBER'S NAME (if different than patient) ____

SUBSCRIBER'S SSN____________________________ DOB_____________________________________

This section only needs to be filled out if patient is under the age of 18

MOTHER'S NAME__________________________________ FATHER'S NAME__________________________________

STREET ADDRESS________________________________ STREET ADDRESS______________________________

City, State, ZIP_____________________________________ City, State, ZIP_____________________________________

SSN_______________________ DOB_________________ SSN___________________________ DOB______________

OSTEPATHIC WELLNESS CENTER, LLC FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

____ Patient with Insurance: You are responsible for deductibles, copays, non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

____ Patient without Insurance (Private Pay): Please make payment for your care at each patient visit. If payment cannot be made at each visit, notify the front desk prior to visit to meet without billing specialist.

____Personal injury (accident): If you are a personal injury/automobile accident patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for services rendered will be your responsibility. Please give all information needed for billing. If statements are to be sent to your attorney instead of to an insurance company, a lien must be signed by your attorney guaranteeing payment for services rendered.

____Medicare: Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any non-covered services.

____ Patient without proof of Insurance: If you do not have evidence of health insurance, or complete information regarding your worker's compensation claim or personal injury claim at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

____Non-participating provider: We do not participate with _______________________________. If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

OSTEOPATHIC WELLNESS CENTER, LLC
GUARANTEE OF PAYMENT
Please initial each section on the line provided.

____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

____ I have been advised that if my health insurance carrier/HMO/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in adavance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

____ I authorize payment of benefits from my insurance carriers directly to Osteopathic Wellness Center. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying Osteopathic Wellness Center].

____ **Cancelation Policy:**
I understand that there is a $75 reinstatement fee charged if I miss or cancel my appointment (with less than 24 hours notice) three or more times in a 12 month period. This fee must be paid prior to scheduling another appointment.

____**Minor Patients only:**
The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

PAYMENT IS REQUIRED AT TIME OF SERVICE
THERE WILL BE A $25.00 FEE FOR RETURNED CHECKS
For your convenience, we also accept VISA and MasterCard.

I have read and understand my financial responsibilities as outlined in both pages of this Osteopathic Wellness Center Financial Policy document.

X____ ______________________________
Patient's Signature Date

____
Patient's Printed Name

____ ______________________________
Printed name of person signing on behalf of patient Relationship to patient

OSTEOPATHIC WELLNESS CENTER, LLC CONSENT FORM / PRIVACY NOTICE
Please initial each section on the line provided.

____ **Consent for Treatment:**
I consent to diagnostic procedures and medical care as necessary in the judgment of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

____ **Medical Release Authorization:**
With my consent, Osteopathic Wellness Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

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

To review the more comprehensive version of this notice or if you have any questions, please contact our office administrator at 203-438-9915

Osteopathic Wellness Center is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy
At Osteopathic Wellness Center your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure
Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

____**Consent for Contact:**
With my consent, Osteopathic Wellness Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

OSTEOPATHIC WELLNESS CENTER, LLC

Practice Duties – Regarding your health care information

Osteopathic Wellness Center is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

Osteopathic Wellness Center is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights – Regarding their health care information

The patient has the right to request the practice to restrict use and disclosure of protected health information. Osteopathic Wellness Center is not required to agree to the requested restriction.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to Osteopathic Wellness Center's use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Osteopathic Wellness Center may decline to provide treatment to me.

X____ ________________________

Patient's Signature — Date

____

Patient's Printed Name

____ ________________________

Printed name of person signing on behalf of patient — Relationship to patient

OSTEOPATHIC WELLNESS CENTER, LLC
Initial Visit Patient Questionnaire

Name____ **Date**__________________
DOB________________ **Primary Care Provider**_________________________________

What brings you here for your visit today?____

Please tell us more about your pain.

Location of Pain	Describe (sharp, dull, shooting, throbbing, aching…)
i.e. Right side of low back	**Intermittent; sharp and shooting**

When did the pain begin?_______________
Was the onset of pain: (check one) sudden or gradual?

Trauma history: Please list your age and type of trauma you have experienced from birth to present including falls, motor vehicle accidents and emotional trauma (Example: birth: vacuum extraction; 8 y/o: fell down stairs, lost consciousness, broke left leg)____
____
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____
Is the pain the result of a work-related injury? yes no unknown
Is the pain the result of an automobile or personal injury claim? yes no unknown

If you have **headaches**, how many days per month have you had them during the past 3 months?
0-5 6-10 11-15 16-20 21-25 26-30 more than one a day
Do you have any other symptoms before or during a headache?________________________________
What brings on, or triggers your headaches?____

Please circle the number on the line below that describes the overall amount of pain you are experiencing today:
No pain---worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the worst your pain has been in the last month:
No pain---worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes the least your pain has been in the last month:
No pain---worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Is your pain worse (check the box that best applies):

	At night		In the morning		End of shift/day		Hot, humid days
	No difference day or night		Wet/cloudy days		Cold days		Certain time of year

Please circle the number on the line below that describes your ability to sleep at night:

Didn't sleep a wink---fell asleep immediately and

0 1 2 3 4 5 6 7 8 9 10 slept all night

Check the box that best describes your emotional health (check ONE):

	Happy/cheerful		Optimistic		Anxious		Worried
	Angry		Depressed		Suicidal		Compulsive
	Indifferent		Hopeless		Frustrated		Panicked
	Other (please explain):						

Which of the following activities increase or decrease your pain? (Place an ⇧ or ⇩ in the small boxes)

	Getting out of bed		**Standing up**		**Prolonged standing**		**Sitting**
	Bending backward		**Lying on back or side**		**Looking up or sideways**		**Washing/combing hair**
	Lifting		**Twisting**		**Straining**		**Reaching over**
	Coughing/sneezing		**Leaning forward**		**Going downstairs**		**Long car rides**
	Exercising		**Computer work**		**Reading**		**Walking**
	Running		**Other:**				

What tests/treatments have you had for your current problem(s)? **Where?**

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Past Medical History: Please check any conditions you have or have had in the past:

	AIDS/HIV positive		Alcoholism		Anemia		Anorexia
	Appendicitis		Arthritis		Asthma		Bleeding disorders
	Blood clots		Cancer		Diabetes		Drug dependency
	Emphysema		Epilepsy/seizures		Glaucoma		Goiter
	Osteoporosis		Gout		Heart disease		High cholesterol
	High blood pressure		Kidney disease		Liver disease/hepatitis		Migraines
	Prostate problems		Psychiatric care		Acid reflux (GERD)		Stomach ulcers
	Stroke		Thyroid problems		Irritable bowel		depression

Comments:____
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Past Surgical History: Please list all surgeries you have had and the approximate year:
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Medications: Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.
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Allergies: Are you allergic to any medications/substances? ___No ___Yes:
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Social History: Do you smoke or chew tobacco? ___No ___Yes _____packs per day for _____years
Did you ever smoke or chew tobacco? ___No ___Yes When did you quit?______________________
Alcohol intake: ___Never ___Rare ___Occasional; Average number of drinks per day:_______
Do you currently, or have you ever used recreational drugs? ___No ___ Yes
Occupation (current or previous):____
Are you working: ___ Full-time ___Part-time ___Retired ___Disabled
Are you married / single / divorced / widowed? __________happily?
Do you have any children? If yes, what are their ages?____
____
_____

Family History: Have your relatives had any of the following medical problems?

Blood Relative	Arthritis	Migraines	Cancer	Joint problems	Osteoporosis
Mother					
Father					
Brother/Sister					
Children					
Grandparents					

Review of Systems: Please check any problems you are now having or have had repeatedly in the last month

	Fatigue		Fever		Weight change		Weakness
	Headaches		Dizziness		Head injury		Confusion
	Vision changes		Hearing loss		Ear aches		Sinus trouble
	Trouble swallowing		Jaw pain		Chest pain/pressure		Shortness of breath
	Rapid heart beat		Irregular heart beat		Calf pain with walking		Swelling of ankles
	Blood clots		Chronic cough		Coughing up blood		Wheezing
	Poor appetite		Heartburn/indigestion		Belly pain		Diarrhea
	Constipation		Rectal bleeding		Nausea/vomiting		Poor bowel control
	Painful urination		Poor bladder control		Difficulty urinating		Rash/hives
	Painful/swollen joints		Back pain		Arm or leg pain		Difficulty walking
	Convulsion/seizures		Numbness/tingling		Weakness arms/legs		Difficulty sleeping
	Depression		Anxiety		Excess thirst/urination		Easy bruising/bleeding
	Other (please describe)						

Comments____

For women: Date of last menstrual period:____________
History of irregular or painful periods? ___No ___Yes

What is your goal for today's visit?____

You authorize the release of office notes to your primary care physician and referring physician by signing here:____
Patient Signature

Reviewed by:__________________________________
Date:____________________________________

What to Expect After Treatment:

While osteopathic treatment is unique to every individual, there are several things that will help you to better understand the treatment process.

1. After the initial one or two treatments, occasionally you may feel worse before you notice any relief. This is because as your self-healing mechanism is activated, your body continues to readjust as it integrates the treatment. This usually passes after several hours or may last up to a full day or so.

   For increased pain after a treatment, we usually recommend Topricin cream (topical homeopathic) applied to all painful areas 2 to 3 times daily. Please continue using this as prescribed, as it will speed up the healing of tissues, as well as provide pain relief. Bach Rescue Remedy is sometimes prescribed to help the treatments to integrate better for the first month. It is also good for very stressful events (physical or emotional). Take 1 dropperful under the tongue, every 1 to 2 hours. Saloxicin (a natural anti-inflammatory can also be taken, 2-3 tabs 3 times daily).

   A 20-minute bath with Epson salt or sea salt will help to draw toxins out of the body and provide muscle relaxation.

   Tylenol or Motrin may be used if pain is more severe.

   Often nutritional support will also be recommended to further speed up the body's healing process. We will often recommend Metagenics or Xymogen or other high quality nutritional supplements. It is best to take them as prescribed with meals to improve absorption. It is important to continue using the multivitamin/mineral supplement, Multigenics, (Active Nutrients), EPA/DHA (fish oil), and Calcium Magnesium (Ossipan MD) indefinitely, as most of us are deficient in these nutrients. Wait 102 days before starting each new product to allow time to adjust. Other supplements can be decreased after a few months depending on your blood work and overall level of health. If you run out of your supplements, you may order more by calling Xymogen at 800-647-6100, Acct# JOHNSTD. If you wish, Metagenics supplements, please consult with the Office Manager.

2. You may notice significant improvement, some improvement, or none at all after the first treatment. On average, it takes about 4 to 5 treatments to begin to experience relief from the original complaints. This varies tremendously with each person based on their overall level of health, which depends on various factors (multiple medical problems, number of prescription medications, amount of exercise, quality of diet, lifestyle stressors and old injuries and surgeries.)

   Usually, you will return for follow-up in a few days or a week later. The initial treatments will usually be spaced apart by a few days or up to a week or two. As Dr. Johnston assesses your system at each visit, he will determine when it is best to return. Treatment can last from 20-35 minutes depending on what your body will accommodate for that day. As your systems begin to improve and your nervous system and cranial mechanism improves, we will begin to space out treatments by an extra week or so. After you have recovered, it is still recommended that you return in 4 to 6 weeks for a maintenance (tune up) treatment. Osteopathic treatment can prevent many problems before they surface and keep you in overall good balance, alignment and health.

3. It is helpful to refrain from chiropractic and other manual treatments during osteopathic treatment to better evaluate your response. Gentle massage, acupuncture, shiatsu, and occasionally other treatments may be done one to two days before or after osteopathic treatment. Please check with Dr. Johnston to be sure. After your treatment, it is helpful, if you can relax for 30-60 minutes to get the optimum benefit. You may feel very tired after a treatment if it is your first one or if it has been several months since your last visit. If you are exhausted, please listen to your body and go to bed early that evening.

4. Often times, after patients start to feel better, they go back to their normal activity too soon and end up overdoing it. This can cause the strain pattern to return and feel like your pain and other symptoms have returned. This is actually only a minor setback and one or two treatments will correct this.

   Please limit your normal activity (vigorous workouts, golf, yoga, weight training, gardening, lifting, bending over, etc.) as much as possible during the first few treatments. Please ask Dr. Johnston questions about specific activities you may do and how to modify them. Usually, you are the best judge, so please listen to your body and allow it time to rest and heal.

5. Dr. Johnston often will recommend gentle stretching and deep breathing and relaxation exercises initially and then more extensive core strengthening programs and exercises from Dr. Fulford's book, "The Touch of Life". It is very important to do these exercises as prescribed, as they are part of the treatment and healing process. The core muscles, when strengthened correctly, will enable you to gain a greater awareness of your body and your everyday movements, as well as to maintain better alignment and postural stability. This will lead to longer lasting effects from

each osteopathic treatment and quicken recovery. **The Core Program,** by Peggy Brill, PT is a terrific book to start with, Core I, every other day for the first 4-6 weeks.

6. Remember; please ask questions if you have any. The Osteopathic Resource Sheet lists several places to find more specific details about osteopathy. **The Touch of Life,** by Robert Fulford, DO is highly recommended quick reading to explain Osteopathy. As one of my patients told me, if they had not read Dr. Fulford's book, they would not have understood the treatment I was doing! You can leave a message anytime on the machine and Dr. Johnston will return your call as soon as possible. Osteopathic treatment is unique for each individual and everyone responds to the treatment at different rates. This is because the body's healing mechanism is unique for each person.

Thank you for your commitment to osteopathy and allowing me to assist you in your healing process.

***David L. Johnston*, DO**

OSTEOPATHIC RESOURCES

WEBSITES

- www.osteopathicwellness.net
- www.cranialacademy.org
- www.osteohome.com – Dr. Dolgin
- www.academyofosteopathy.com
- www.setf.com
- www.osteopathic.org – AOA Site for parents
- www.osteopathiccenter.org – Dr. Frymann / children

BOOKS

- **The Touch of Life** – Robert Fulford, D.O.
- **The Difference a DO Makes** – Bob Jones
- **The DOs – Osteopathic Medicine in America** - Norman Gevitz

ARTICLES

"Healing and the Natural World"
James Jealous, D.O. - Alternative Therapies, January, 1997, Vol. 3

"Osteopathy in the Cranial Field: The Approach of W.G. Sutherland, D.O."
Rachel Brooks, M.D.- Physical Medicine and Rehabilitation: State of the Art Reviews, Vol. 14, No. 1, February, 2000. Philadelphia, Hanley and Belfus, Inc.

"The Osteopathy Alternative",
Susan Rubenstein December 1990 East/West