



OFFICE POLICY

We invite you to get acquainted with OWC and ask that you review our policies and fee schedules, as well as acknowledge on the signature lines below.

Office Hours: Monday – Friday; 9:30 AM – 5:30 PM / Every other Saturday; 9:00 AM – 12:45 PM
Every effort is made to examine newborn infants as soon after birth as possible.

Scheduling / Cancellations: A message may be left at any time to cancel an appointment. The earlier you can inform us of your change in plans, the more efficient use we can make of our time. You will be charged a \$45 cancellation fee if you cancel less than 24 hours prior to your scheduled appointment.

Apparel: Loose-fitting, comfortable clothing is suggested. Sweat pants or leggings and t-shirts are best. Please, no jeans; no jewelry. Please refrain from wearing perfumes or scented oils in consideration of those with allergies.

Fees and Payment: OWC is committed to providing the best treatment possible at a reasonable fee.

- Payment is required at the time of service. We accept cash, check, Visa or Mastercard.
- In the event of payment default, the patient agrees to pay a finance charge of 1½ % per month on the unpaid balance in addition to collection costs and reasonable attorney fees.
- In the case of minors, the parent or guardian who accompanies the minor is responsible for the bill. In the event the parents are divorced or separated with one being responsible for medical bills, we require payment from the minor or person accompanying the minor, who can then be reimbursed by the responsible party.
- The patient will be charged a fee of \$25 for any returned check for non-sufficient funds.

Children: Every attempt is made to provide a relaxing and serene atmosphere for our clients and staff. We request that children remain in the waiting room or specified treatment room and that they not be allowed to run freely in the office area.

Cell Phones: We ask that all cell phones be turned off when entering the office for an appointment. If you must use your cell phone, kindly place the call in the building lobby.

We understand that you have come here to seek specialized treatment and we will endeavor to assist you in a speedy recovery; but of course, we cannot guarantee any specific result.

Thank you for taking your time to read our policy.

I agree and acknowledge:

Print Name

Signature

Date

DAVID L. JOHNSTON, DO

158 DANBURY ROAD, RIDGEFIELD CT 06877



WWW.OSTEOPATHICWELLNESS.NET

P. 203.438.9915 F. 203.431.4410

INSURANCE BENEFITS AUTHORIZATION

Statement to Permit Payment of Insurance Benefits to Provider, Physician and Patient

I request that payment of authorized insurance benefits be made either to me or on my behalf to David L. Johnston, D.O. for services furnished to me by the provider. I authorize my holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits payable for related services.

Insured's Name: _____

Insured's Insurance Company: _____

Patient's Signature: _____

Date: _____

I understand that my insurance company may not fully reimburse me for services provided by Dr. Johnston and agree to accept financial responsibility for all services rendered.

Signature: _____

Date: _____



PATIENT HIPPA ACKNOWLEDGEMENT

David L. Johnston, D.O.

I have been offered the Privacy Notice established by the practice of David L. Johnston, D.O. before signing this document. This notice has been made available to me and describes the types of uses and disclosures of my PHI that may occur in my treatment, payment of my bills or in the performance of health care operations of the practice. It describes my rights and the practice's duties with respect to my protected health information.

A copy of the Privacy Notice is available in the waiting room.

The practice reserves the right to change the privacy practices that are described in the privacy Notice. I may obtain a revised Privacy Notice by calling the office and contacting the Office Manager.

Patient Name

Signature Patient, Guardian or Personal Representative

Date

To be completed if the staff is unable to obtain a signature:

On _____ I attempted to obtain a written acknowledgement of receipt of the Privacy Notice from the above named person, but was unable to because:

- Patient declined to sign this consent form
- Patient did not understand this consent form
- Other (specify) _____

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Office Manager _____

PLEASE READ ~ MANDATORY OFFICE POLICY

Your perfume is another patient's poison! Please do not wear it in our office.

Because we treat people with Asthma, Allergies, Environmental Sensitivities, Cancer and Migraines, who become sicker from perfume and fragrance products, your perfume may literally poison others who come to our office. They suffer a serious chronic illness or invisible disability and their health will be harmed with even the smallest exposure to fragrance.

Unfortunately, there is no way to wear personal fragrance privately. Your use of fragrance WILL have negative health consequences for others if you wear it. It lingers even after you have gone. As much as we want you to be comfortable, we need to ban all forms of personal fragrance from the office for the sake of everyone.

Thank you for avoiding it on the days you visit. Your cooperation is greatly appreciated.



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

DIRECTIONS

From Points North and East

From I-84, get off at Exit 3, by the Danbury Fair Mall, and take Route 7 South. Proceed approximately 4 miles to Route 35 (Danbury Road), (VALERO Gas Station on right), make a right and go 2 miles towards Ridgefield. Make a left turn into parking lot before Ridgefield Bank.

From Points South

From I-95 or the Merritt Parkway, take the exit for Route 7 North. Proceed approximately 17 miles to Route 35 (Danbury Road), (Patio.com on the left). Turn left and drive 2 miles west towards Ridgefield. Turn left into parking lot before Ridgefield Bank.

OR

From Route 7, turn left onto route 102 (Branchville Road). Proceed 5 miles to Route 35 Main Street and make a right. Go through town of Ridgefield. After passing Copps Hill Shopping Center on left, go through traffic light at Farmingville Road. Office is on the right next to Ridgefield Bank.

From Long Island/Westchester

Take I-95 or GCP to the Clearview Expressway to the Throggs Neck Bridge and take I-95 North (Bruckner Expressway/New England). Drive approximately 4 miles to Exit 9 – the Hutchinson River parkway North. Proceed approximately 13 miles where the parkway will split; stay left and take I-684 North. Drive approximately 17 miles and take the exit for Route 35 (Cross River/Katonah). At the end of the ramp, make a right onto Route 35 East. Proceed approximately 12 miles, to the Fountain in Ridgefield. Turn left and proceed through town on Main Street; bear right onto Danbury Road (Route 35). After passing Copps Hill Shopping Center on the left, proceed through the light on Farmingville Road. The office is the second building on the right next to Ridgefield Bank.

From NYC / Westchester

Take 87 North (Major Deegan) to 287 East to the Saw Mill River Parkway North. Do NOT go onto 684, but stay to the right for the Cross River/Katonah exit for Route 35. At the end of the ramp, make a right onto Route 35 East. Proceed approximately 12 miles to the fountain in Ridgefield. Make a left and proceed through town on Main Street, which will bear right and turn into Danbury Road (Route 35). After passing Copps Hill Shopping Center on the left, proceed through the light at Farmingville Road. The office is the second building on the right next to Ridgefield Bank.

By Train

Take MetroNorth out of Grand Central Station to either Katonah or Brewster, NY station. Then take a taxi via Route 35 to Ridgefield from Katonah (see from NYC above) or via Route 84 East from Brewster (see from points north and East above).

OR

Take MetroNorth to the Norwalk, CT stop. Transfer to the Danbury train and get off at the Branchville Station. Then by taxi, take Route 7 North to Route 35. Turn left and the office is 2 miles on the left, next to Ridgefield Bank.

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CHILD MEDICAL AND HEALTH HISTORY

A. Identification

Child's Name: Age: Birthdate: Sex: M / F
Address: City: State: Zip:
Phone: (H) (W) (C) (F) Parent's email:
Social Security # How did you hear of us?
Mother's Name: Father's Name:
Parent's Family Status: Married / Divorced / Separated / Never Married (circle one)
Emergency Contact: Phone:

B. Insurance Information

Primary Insurance: Policy #: Group ID:
Patient's relationship to insured: Child / Other
Insured's Name (holder of policy): Insured's SS#:
Secondary Insurance: Policy #: Group ID:
Patient's relationship to insured: Child / Other
I AM THE PARENT OR LEGAL GUARDIAN AND AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS AND RELATED CLAIMS. I REQUEST PAYMENT TO MYSELF OR TO THE PARTY WHO PROVIDED THE CARE.
Signature Date

c. Chief Complaint

Please list your child's major problems and/or symptoms and the approximate dates they began (if none, please write your reason for seeking this consultation). Please rank in order of severity.

Table with 2 columns: PROBLEM AND/OR SYMPTOM, DATE PROBLEM BEGAN

If you have seen other practitioners for these problems, indicate the results of these evaluations:

Two horizontal lines for writing evaluation results.

D. Family Medical History

Please indicate if you, the parents have had any of the following problems in the past. Please note years affected and if mother or father has particular problem.

Alcoholism	Depression	Herpes	Lyme Disease	Smoker
Allergies	Diabetes	HIV	Mental Illness	Thyroid Disease
Anemia	Digestive Disease	Hypoglycemia	Migraine Headache	
Arthritis	Drug Problems	Hepatitis	Multiple Sclerosis	
Asthma	Eating Disorder	High Blood Pressure	Prostate Disease	
Cancer	Eczema	Irritable Bowel	Rheumatic Fever	
Celiac Disease	Emphysema	Kidney Disease	Seizures	
Crohn's Disease	Heart Disease	Lupus/AutoImmune	Stomach/Intestinal Ulcers	

How many siblings does the child have? _____

Please list names, ages and any medical problems.

Name	Age	Medical Problems?

E. Prenatal History (For mother to complete)

Did you smoke during pregnancy? Yes / No Did you drink during pregnancy? Yes / No

Did you receive immunizations for flu or tetanus? Yes / No Did you receive rhogam? Yes / No

Did you have gestational diabetes? Yes / No Did you have pre-eclampsia (high blood pressure)? Yes / No

Did you have any serious illnesses? Yes / No

If so, please explain: _____

F. Perinatal Period (For mother to complete)

Was your child born prematurely? Yes / No if so, how many weeks? _____

Did you experience any complications during delivery? Yes / No If so, please detail and note any medications you may have been given: _____

Did your child need any special care after delivery? Yes / No If so, please explain: _____

G. Early Childhood

Has your child been diagnosed with any chronic medical conditions to date? Yes / No If so, please list and note who diagnosed condition:

DIAGNOSIS	DOCTOR

Was your child breastfed? Yes / No If so, for how long? _____

Has your child frequently been treated with antibiotics for respiratory or ear/throat infections? Yes / No If so, approximately how many times? _____ Were there any delays in developmental milestones? Yes / No If so, please explain: _____

H. Immunizations: Specify when received if known (or attach copy of immunization schedule):

IMMUNIZATION	DATES RECEIVED	IMMUNIZATION	DATE RECEIVED
Polio (oral / shot)		Hemophilus Influenza (HIB)	
Measles / Mumps / Rubella		Pnemococcus (PCV)	
Diphtheria/Pertussis/Tetanus			
Hepatitis B			
Chicken Pox			

I. Hospitalization / Surgical History: Dates and reasons:

DATE	REASON

J. Current Medications / Supplements

Please write name, dosage and how often taken.

PRESCRIPTION/OVER THE COUNTER MEDICATIONS	SUPPLEMENTS

Please list any medications your child may have an allergy to and the type of reaction: _____

Environment

Are there any pets in the house? Yes / No If yes, please list type(s) _____

Is the child's room carpeted? Yes / No Does any family member smoke in the house? Yes / No

Please complete primary care provider or pediatrician information:

Name: _____ Address: _____ Phone: _____

If you have a specialist, please complete:

Name: _____ Address: _____ Phone: _____

Specialty _____

K. Review of Systems

Please check next to the symptoms that you have experienced over the past 6 months.

General	Skin	Eyes	Ears	Nose
Fevers	Dryness	Eye Pain	Excessive Wax	Runny Nose
Night Sweats	Rashes	Redness	Discharge	Nasal Discharge
Insomnia	Itching	Discharge	Itching	Sneezing
Frequent Colds/Flu	Nail Fungus	Itching	Ringing / Tinnitus	Frequent Bleeding
Fatigue	Brittle Nails	Excessive Tearing	Decreased Hearing	Frequent Snoring
		Dryness		
		Blurred Vision		
		Poor Night Vision		
Mouth	Throat	Endocrine	Cardio/Pulmonary	Gastrointestinal
Oral Sores	Frequent Soreness	Intolerance to Heat	Shortness of Breath	Heartburn
Funny Taste	Difficulty Swallowing	Intolerance to Cold	Palpitations	Bloating/Gas
Bad Breath	Painful Swallowing	Shakiness	Cough	Nausea
Coating on Tongue	Change in Voice	Fatigue	Chest Pain	Vomiting
	Frequent Clearing Throat	Increased Appetite	Leg Cramps when Walking	Hemorrhoids
	Hoarseness	Decreased Appetite	Leg Cramps at Night	Black or Dark Stools
		Weight Gain/Loss	Varicose Veins	Blood in Stools
		Sweat Easily	Lightheadedness	Constipation
		Cold Hands/Feet	Passed Out	Diarrhea
		Hair Loss/Thinning	Leg Swelling	Thin Stools
		Excess Facial Hair		
		Eyebrows Thinning		
Neurological	Mental/Emotional	Musculoskeletal	Genitourinary	Men Only
Numbness of a Limb	Anxiety	Joint Pain	Difficulty Urinating	Testicular Lumps
Weakness of a Limb	Depression	Muscle Aches	Cloudy Urine	Penile Discharge
Tension Headaches	Suicidal Thoughts	Back Pain	Involuntary Loss of Urine	Penile Lesions
Migraine Headaches	Panic Attacks	Morning Stiffness	Frequent Urination	Impotence
Room Spinning	Nervousness		Nighttime Urination	Breast Enlargement
Head Trauma				
Memory Loss				

L. Diet Survey

Please check all the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

Frequent = at least once per day Often = several times/week Occasional = once/week or less Seldom = once or twice/month or less
Never = almost total avoidance

	Frequently	Often	Occasional	Seldom	Never
Alcoholic Beverages					
Eat at Restaurants					
Eat at Fast Food Restaurants					
Pastries, Cookies, Candies, Ice Cream, Other Sweets					
Add Sugar to Coffee, Tea, Cereals, Other Foods					
Colas or Other Soft Drinks					
Instant Breakfasts, Pop Tarts, Doughnuts, Muffins					
Cold Breakfast Cereals					
Caffeine Drinks (Coffee, Tea, Cola, Chocolate)					
Deep Fried Food					
Margarine of any Type					
Whole Grain Hot Cereals (Oatmeal, Wheatena, etc.)					
Meat (Beef or Veal, Pork or Ham, Lamb, Liver)					
Chicken or Turkey – Regular or Free Range?					
Fresh Fish					
Processed Meat (Bologna, Turkey Roll, Sausage, etc.)					
Fresh Raw Fruit					
Fresh Vegetables, Raw or Cooked					
Salads					
Whole Grains or Whole Grain Breads					
White Bread or White Flour Products					
Beans and Legumes (Lentil, Kidney, Chickpea, etc.)					
Yogurt – Whole or Lowfat, Plain or Flavored (circle)					
Milk – Whole, Lowfat, or Skimmed (circle)					
Cheese					
Eggs – Regular or Free Range (circle)					
Salt					
Herbs, Fresh and Dried, or Spices					
Drink Adequate Water – Tap, Filtered, Bottled (circle)					
Eat Excessively if Bored or Depressed					
Swallow Food Before Chewing Well					
Hurried or Rushed Meals					
Stuff Yourself					
Read and Understand Food Labels					
Sneak or Hide Foods					
Adequate Fiber or Roughage in Diet					
Artificial Sweeteners (Saccharin, Nutrasweet, etc.)					
Shop at Health Food Stores					