Holistic Medicine and Skin Care
1670 Route 34 N., suite 3C
Wall Township, NJ 07727

Welcome to our office.

In order to allow sufficient time with Dr. Rothman, I am including some important information and forms that will need to be completed before coming into our office.

The first section explains what metabolic testing is and how to prepare for the test. **This is not a requirement for CIRS patients looking to only be treated by Dr. Shoemaker's protocol.** However, we can get very valuable information from this quick, non-invasive test that may help guide your treatment. If you are interested in doing metabolic therapy, please follow these instructions carefully.

Metabolically Directed Wellness at the MD Wellness

The test takes about 5-10 minutes and will be repeated at every visit on your treatment to follow your progress.

There are 3 main parts to the test. One part is a urine and saliva test. A fresh urine sample is analyzed for specific gravity (a measure of the concentrating ability of the kidneys, as well as anabolic-catabolic balance) and pH (a measure of acid-base balance). The saliva pH is also measured by having you place a pH strip on your tongue. (This is a measure of acid-base balance and can also be used to determinate how well you are metabolizing fats, proteins and carbohydrates.

The second part of the test is that of your blood pressure and pulse rate. These measurements are done lying on your back and then standing up. The action of standing is a stress to your cardiovascular system and the change in the pulse and blood pressure to this stress can reveal a lot about your fluid, electrolyte and cardiovascular status. The respiratory rate will be counted, and you will be asked to hold your breath for as long as possible. The breath hold and respiratory rate can be used to assess your acid-base balance.

Lastly, pupil size, deep tendon reflexes and derma graphic reflex will be assessed. This information is used to determine your autonomic tone, acid-base balance, thyroid status, and histamine response.

Phone: 732-268-7663 Fax: 732-268-7664 info@mdwellnessmd.com
www.mdwellnessmd.com

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PREPARATION FOR THE TEST

It is important that this test reflects **your** body chemistry without interference or effects from drugs, supplements and chemicals.

1. No Tylenol, Advil, Aspirin, Ibuprofen, Aleve, Nyquil, Benadryl, or any other over the counter (OTC) medications for 3 days.
2. **No coffee, tea, cola or chocolate for 24 hours.**
3. No soda or other carbonated beverages for 12 hours.
4. No gum chewing, candy, cough drops, breath fresheners for ½ hour
5. If you smoke cigarettes, refrain from smoking for 1 hour prior to appointment.

Regarding the use of nutritional supplements:

1. Activator will not have any effect on the results and may be taken.
2. If I recommended a supplement for you to take go ahead and take it, however, you must know exactly which supplements you took. Please don't arrive saying, "I took all the stuff you wanted me to take" I will ask you precisely what you took and when you took it. You must be prepared to give me a precise answer. This will expedite the process.
3. If you are taking alternative bile resin binders such as Charcoal or Bentonite clay, please continue to take this.
4. If you are taking any other supplements on your own (which you should not be doing anyway). Definitely DO NOT TAKE THEM for 3 days before the test.

Regarding the use of prescription drugs:

1. Try to limit your prescription drug use as much as possible.
2. If you take a drug in the morning, delay the morning dose until after your test (if possible).
3. If you take a drug in the evening, skip that dose the night before the test (if possible).
4. If you take thyroid medication, please take it as normal on your visiting day.
5. If you have any questions, call the office.

Please be ready to give a urine sample on your arrival to the clinic. However, Do NOT drink excessive amounts of water in the morning drink normal and healthy amounts. Excessive water intake will affect the results.

YOU DO NOT NEED TO FAST FOR THE METABOLIC TEST

Please remember to follow this preparation prior every office visit

On the following sections you will find a questionnaire and other important forms. Please, print, fill out completely, and bring these forms with you when you come for your appointment. Please do **NOT** mail, fax, or e-mail back these forms as they are not guaranteed to be delivered on time for your appointment or be delivered in legible condition. If you have lab results available, please bring those with you as well.

MD Wellness
Personal Information

Your Name:	Last:	First:
DOB:	Month/Day/Year:	Age:
Address:	Address:	City:
	Apt/Ste:	State/Zip:
Contact:	Home phone:	Mobile:
	Work:	Fax:
	Email :	
How did you hear about us?		
What health issues/symptoms are you looking to resolve or improve?		

Please Note: We are not contracted with any insurance companies, nor do we submit any claim forms.

I authorize and consent to the administration of all diagnostic and therapeutic treatments that may be considered by **Dr. Michael Rothman**, as medically indicated or necessary based upon prior discussion. I am aware that I have the final say so in all aspects of my medical management by Dr. Michael Rothman and/or his associates, representatives and appropriate office staff.

_____and dated this_____, _____ 20____.

Signature

I acknowledge that I have received a copy of **MD Wellness, LLC**'s Notice of Privacy Policies, detailing how my information may be used and disclosure as permitted under federal law.

_____and dated this_____, _____ 20____.

Signature

MD Wellness

HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: *(Last, First, M.I.)* ☐M ☐F	**DOB:**
Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed	

HOME STATUS

Do you live with others in your home? ☐Yes ☐No

If Yes, How many people live in your home? _____

PERSONAL HEALTH HISTORY

List Any Medical Problems That Other Doctors Have Diagnosed

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

List Your Prescribed Drugs , Over-the-Counter Drugs, Vitamins or Nutritional Supplements and Inhalers: (*Please attach additional page, if necessary)*

Name of Drug	Dosage	Frequency Taken

Allergies to Medications:

Name of Drug:	Reaction You Had:

FAMILY HISTORY		

OTHER PROBLEMS		
Sleep:	How many hours of sleep do you get each night?	
	Do you feel rested/ refreshed in the morning?	□Yes □No
	Do you have trouble falling asleep?	□Yes □No
	Do you have trouble staying asleep?	□Yes □No
	Do you have trouble waking up too early?	□Yes □No
Headaches:	Do you suffer from headaches?	□Yes □No
	If Yes, please answer the following questions:	
	Does your headache affect both sides of your head or only one side?	
	Do you see "auras" (visible lights) prior to your headaches?	□Yes □No
	Do you get nauseas with you headaches?	□Yes □No
	Have ever been diagnosed as having "migraines"?	□Yes □No
Fatigue:	Do you suffer from fatigue?	□Yes □No
	If Yes, please answer the following questions:	
	Is your fatigue characterized by excessive sleepiness in the day?	□Yes □No
	Do you feel "burnout"?	□Yes □No
	Do you suffer from "brain fog"?	□Yes □No
	Do you feel unmotivated?	□Yes □No
Pain:	Do you suffer from pain?	□Yes □No
	If Yes, please answer the following questions:	
	Do you have pain in your muscles?	□Yes □No
	Do you have pain in your joints?	□Yes □No
	Is your pain worse at any particular time of the day? Morning, afternoon or evening?	□Yes □No
	Does activity make the pain worse or better?	□Yes □No
	Is the pain alleviated with the application hot or cold compressions?	□Yes □No
Low Blood Sugar:	Are you constantly hungry and need to eat several times each day?	□Yes □No
	Do you, at times, feel hungry, anxious, weak, or unfocused and feel much better immediately after you eat?	□Yes □No

REVIEW OF SYSTEMS

(please check appropriate boxes)

Constitutional:	□Fever □Weight loss □Night sweats	
Ears, Nose, Mouth and Throat:	□Hearing Loss □Ear pain □Ear infections □Ringing in ears □Balance problems □Oral Thrust	□Post Nasal Drip □Sinus Infections □Sinus headaches □Sore throat □Mouth Sores
	Did you have any recent dental work? □Yes □No If yes, when was the last visit? _____ Did you have any silver filling or amalgam? □Yes □No If yes, when was the last removal? _____	
Cardiovascular:	□Chest pain □High blood press □Irregular pulse □Heart murmur	□History of high LDL (bad cholesterol) □History of low HDL (good cholesterol) □ Elevated Triglycerides

Circulation:	Do you suffer from?		
	☐Cold Feet	☐Hands and Feet fall asleep	
	☐Cold Hands	☐Fingernail turn blue	
Respiratory:	☐Asthma ☐Chronic cough ☐Emphysema ☐Shortness of breath	☐Bronchitis ☐Pneumonia ☐Sputum	
Gastro-Intestinal:	**Bowel Regularity:**	Do you move your bowels every day? If not how many time each week?	☐Yes ☐No
		Do you take or eat things to help you to move your bowel (prunes, fibers…)?	☐Yes ☐No
		Do you suffer from loose stools or diarrhea more than once each month?	☐Yes ☐No
	Other gastro-intestinal Symptoms:	Do you suffer from heartburn or indigestion?	☐Yes ☐No
		Do you suffer from gas or bloating?	☐Yes ☐No
		Do you have problems with eating or your appetite?	☐Yes ☐No
		Do you feel "sick" after you eat?	☐Yes ☐No
		Do you have "food allergies"?	☐Yes ☐No
		If Yes, Please Specify: Food / Reaction You Had	
Genitourinary:	☐Urinary tract infect ☐Painful urination ☐Blood in urine ☐Difficulty urinating	☐Incontinence ☐Urgent Urination ☐History of Kidney stones	
	Do you usually get up to urinate during the night? If Yes, How many times?		☐Yes ☐No _____
Musculoskeletal:	☐Arm/leg weakness ☐Back pain ☐Neck pain Do you feel joint pain? ☐Yes ☐No In which joints? _____		
Skin:	☐Dry skin ☐Oily skin ☐Eczema ☐ Itchiness	☐Fungal infection *(Athletes foot, jock itch)*	
Endocrine:	☐Diabetes	☐Thyroid disease	☐Hormone Problems
MENTAL HEALTH			
Neurological:	☐History of Seizures ☐Memory problems ☐ Vertigo	☐ Inability to concentrate	
	Do you get dizzy if you stand up quickly?		☐Yes ☐No
	Do you find yourself in the middle of a task and then forget what you were doing?		☐Yes ☐No
Psychiatric:	Do you find yourself anxious at times?		☐Yes ☐No
	Do you feel depressed?		☐Yes ☐No
HEALTH HABITS AND PERSONAL SAFETY			
Exercise:	☐Sedentary (No exercise) ☐Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) ☐Occasional Vigorous Exercise (i.e. work or recreation less than 4x week for 30 min) ☐Regular Vigorous Exercise (i.e. work or recreation 4x week for 30min or more)		
Diet:	Are you dieting? ☐Yes ☐No If yes, are you on a physician prescribed medical diet? ☐Yes ☐No Number of meals you eat in an average day? _____		

	DO YOU CONSUME THE FOLLOWING FOODS? (check appropriate box and circle appropriate items) *(Its important we understand because some foods you consume may be detrimental to your health)* ☐Fried Foods (French Fries/ Fried Chicken/Mozzarella sticks/Onion rings/ Bacon) How often do you eat Fried Foods? _____ ☐Sweets (Cake/ Cupcakes/ Ice Cream/ Pies/ Candy bars) How often do you eat Sweets? _____ ☐Sugar ☐Artificial Sweeteners How often in a day do you use these sweeteners? _____ ☐Sweet Drinks (Sodas/ Fruit Juices/ Ice Coffees/ Energy Drinks/ Smoothies) How often do you have sweet drinks?_____ ☐Pre-packed food(Microwavable dinners / Lean Cuisine / HungryMan/ HealthyChoice) How often do you eat Pre-packed foods? _____ ☐Oils - Vegetable/ Canola/ Corn/ Peanut/ Pam How often do you consume oils? _____ ☐Spreads - Smart Balance/Pam/ I Can't Believe It's Butter/ Margarine/ Butter How often do you consume Spreads? _____ How often do you consume Soy Products? _____
	What is your Typical: Breakfast Lunch Dinner _____ Do You Snack During the day? ☐Yes ☐No What do you snack on? _____ Do You Drink Water? ☐Yes ☐No What Kind? _____ How Much Water Do you Intake Daily? ☐Less then 8oz ☐1-3 Glasses ☐4-6 Glasses ☐7-8 Glasses ☐More Then 8 glasses Do You Eat Meat? ☐Yes ☐No If Yes, How Do You Like It Prepared? ☐Rare ☐Medium Rare ☐Medium ☐Medium Well ☐Well Done
Caffeine:	☐None ☐Coffee ☐Tea ☐Cola Number of Cups/Cans per Day?
Alcohol:	Do you drink alcohol? ☐Yes ☐No If Yes, what kind? _____ How many drinks per week? _____
Tobacco:	Do you use tobacco? ☐Yes ☐No ☐Cigarettes - Pks/day _____ ☐Chew -#/day _____ ☐Pipe - #/day _____ ☐Cigars - #/day _____ # of Years _____ or Year Quit _____
Sex:	Are you sexually active? ☐Yes ☐No If yes, are you trying for a pregnancy? ☐Yes ☐No If not trying for a pregnancy, list contraceptive or barrier method used _____ Any discomfort with intercourse? ☐Yes ☐No Are you satisfied with your sexual functioning? ☐Yes ☐No

WOMEN ONLY	
Do you still get your cycle?	□Yes □No
Age at onset of menstruation	
Date of last menstruation	
Are your cycles regular?	□Yes □No
What is the length of your cycle? (Normal cycle is 28 days)	Days
How many days do you bleed during your cycle?	Days
Do you bleed light, normal, or heavy?	
Are your cycles painful?	□Yes □No
Number of pregnancies?	
Number of live births?	
Are you pregnant or breastfeeding?	□Yes □No
Any hot flashes or sweating at night?	□Yes □No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	□Yes □No
Experienced any recent breast tenderness, lumps, or nipple discharge?	□Yes □No
Have you been diagnosed with Endometriosis?	□Yes □No
Have you ever had vaginal yeast infections? If Yes, how many times? When was the last one?	□Yes □No _____
Have you ever had Fibrocystic Breast Disease?	□Yes □No
Have you ever had Polycystic ovaries?	□Yes □No
MEN ONLY	
Do you feel burning discharge from penis?	□Yes □No
Has the force of your urination decreased?	□Yes □No
Do you have any problems emptying your bladder completely?	□Yes □No
Any difficulty with erection or ejaculation?	□Yes □No
Any testicle pain or swelling?	□Yes □No

MD Wellness

Mold Illness questionnaire

Diagnosis of CIRS-WDB	
Have you had the genetic testing?	□Yes □No
Do you know your HLA-DR?	□Yes □No If Yes, specify:_____
Have you been told that you have the "dreaded gene"?	□Yes □No
Have you ever been treated for a mold/biotoxin/CIRS ?	□Yes □No
Prior/Current Treatment of CIRS-WDB	
Binders	
Have you taken binders like CSM and Welchol or alternative binders like bentonite clay, zeolite clay, activated charcoal?	□Yes □No If Yes, specify:_____ _____
Are you still taking them?	□Yes □No
What is the dosage?	
MARCoNS	
Have ever been diagnosed or treated for MARCoNS?	□Yes □No
Were you ever on BEG spray (or some other alternative)?	□Yes □No
Were you re-tested?	□Yes □No
Was the MARCoNS eradicated?	□Yes □No
Did you develop more anti-biotic resistance ?	□Yes □No
VIP	
Have you ever taken VIP?	□Yes □No
Are you currently taking VIP?	□Yes □No
What is the dose?	
Lyme's Disease	
Have you ever been diagnosed with Lyme's disease?	□Yes □No
Was this by a lab test?	□Yes □No
Or a "clinical diagnosis" based on symptoms?	□Yes □No
Were you treated with antibiotics?	□Yes □No
Which ones? for how long?	
Co-infections	
Have you ever been diagnosed with a co-infection?	□Yes □No

Babesia, Bartonella, Erlichia, Anaplasma,?	□Yes □No
Were you treated for co-infections?	□Yes □No
Anti-Fungals	
Have you been treated with anti-fungal drugs?	□Yes □No
Or anti-fungal supplements?	□Yes □No
Which ones?	_____ _____
Are you currently taking anti-fungals?	□Yes □No
Home Environment	
How long have you been in your current home?	
Do you own or rent your home?	
Have you had any water intrusions (floods, leaks) in your home?	□Yes □No If Yes, specify:_____ _____
Visible Mold?	□Yes □No
Musty Smell?	□Yes □No
Environmental Testing	
Have you ever done an ERMI, HERTSMI-2, Mold inspection, or other methods?	□Yes □No When?_____ If Yes, specify type of test and results: _____ _____ _____ _____
Remediation	
Was it remediated?	□Yes □No
Use of negative pressure and blocked off space?	□Yes □No
Moldy items safely discarded?	□Yes □No
HEPA vacuumed?	□Yes □No
Air Scrubbers used?	□Yes □No
Environmental Re-Testing	
Was you home retested after remediation?	□Yes □No
Which methods?	
Air Filters/Air Purifiers	
Are you using air filters, air purifiers or personal devices?	□Yes □No
Brand, type?	

Work Environment	
How long have you been in your current workplace?	
What is your occupation?	
Have you had any water intrusions (floods, leaks) in your workplace?	☐Yes ☐No
Visible Mold?	☐Yes ☐No
Musty Smell ?	☐Yes ☐No
Other Environments	
Do you frequently visit other indoor environments such as antique stores, libraries, schools, hospitals, day care centers, gyms, fitness centers?	☐Yes ☐No If Yes, specify:_____ How Often:_____

MD Wellness

I _____, hereby authorize the office of Dr. Michael Rothman, his employees, representative or designated representative, or lawyer to act in my behalf in regards to the Institutes, when I am unable to provide a personalized release of information. The MD Wellness will keep records of said releases of information in my records and will make these releases available to me upon request

Patient's Signature **Today's date**

Information released tracking

Date	Requestor	Authorized	Charges	Sent date

Date: When request received?
Requestor: Who has asked for the information?
Authorized: How the patient authorized the release. Must be done in person if they did not sign a limited power of attorney.

Charges

Insurance companies; Life and Medical	$25.00 + Postage we will copy
Personal copy for patient	$10.00 we copy. (First Time Coping is Complimentary)

Personal copies for patients will only be given in person.

Sent date: When the document left our office.

Note to patient: Please maintain a copy of this release form in your files.

Phone: 732-268-7663 Fax: 732-268-7664 info@mdwellnessmd.com
www.mdwellnessmd.com

MD Wellness

Patient Treatment Agreement

By signing this form:

- ☐ I confirm that specific verbal and/or written instructions regarding my diet , air quality, and the use of nutritional supplements have been provided to me by Dr. Rothman and/or the staff at MD Wellness, and that I agree to comply with these instructions.
- ☐ I agree to follow any future instructions and accept responsibility to request clarification on any such instructions that may be unclear, or it will be assumed as understood and agreed.
- ☐ I am aware that it is necessary to follow the preparation steps for the metabolic typing test prior every visit, otherwise the test results may be compromised.
- ☐ I acknowledge that it is crucial to adhere to scheduled follow-up appointments, and that failure to do so may result in treatment complications and/or adverse effects.
- ☐ I recognize that if it is absolutely impossible to keep my scheduled appointment, I am strongly encouraged to give as much advance notice as possible to ensure a new appointment is secured within an acceptable time frame**.**
- ☐ I understand that MD Wellness is a “no wait” practice, therefore it is highly recommended to arrive at least 15 minutes prior to my scheduled appointment time. Further, I am aware that arriving late for my appointment will decrease my consultation time with Dr. Rothman, however I will be charged in full for the original time allocated to my appointment.

_____ _____

Print full name **Date**

_____

Signature

Note to patient: Please maintain a copy of this release form in your files.

MD Wellness

Medical Services Agreement

_____(PATIENT) and MD Wellness (Dr. Michael E Rothman.) hereby enter into this agreement for provision of medical services specified herein ("Services"). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge, the, PATIENT and PHYSICIAN agree as follows:

1. The PATIENT agrees not to submit a health insurance claim (or request the PHYSICIAN to submit a claim on PATIENT'S behalf) under the Social Security Act (MEDICARE) for the services, even if you may think that such services are or maybe otherwise covered under health insurance or MEDICARE.

2. **The PATIENT agrees to be responsible for the SERVICES.** Although metabolic balancing therapy is medically beneficial, insurance companies have not yet accepted this position. At this point in time, neither insurance companies nor MEDICARE will reimburse for preventive care or metabolic balancing therapy. As a result of this, medical records will not be provided to any insurance company or MEDICARE. The United States Department of Health and Human Services, Office of Inspector General takes the position that a PHYSICIAN who orders "medically unnecessary" tests may be subject to civil penalties. Because of this, it is the policy of this office not to fill out any insurance benefit claim forms or provide a letter of medical necessity. The Health Insurance and Reform Act of 1997 allows the Federal Government to investigate what they may determine is "health insurance fraud" or any medical treatment not deemed "medically necessary" by the Federal Government.

3. The PATIENT acknowledges that health insurance companies or "Medigap plans" (42 U.S.C., section 1882) will not provided reimbursement, for the SERVICES and that no fee limits (including those specified in 42 U.S.C., Section 1395a",'- 1848g) **will** apply to the amounts PHYSICIANS charge for their SERVICES.

4. The PATIENT acknowledges that PATIENT has the right to have services provided by other PHYSICIANS for whom payment may be made under health insurance plans or MEDICARE.

5. Our **INVOICE** contains pertinent information regarding your office services and purchases. This form was generated for your personal records only although; patients have submitted it to their insurance company with a claim form for reimbursement. **This frequently causes subsequent inquiries by the insurance company to which we do not respond**.

Patient's Signature	Date:
_____	_____
Physician Signature	Date:
_____	_____
Witness Signature	Date:
_____	_____

MD Wellness

Notice of new HIPAA Guidelines for MD Wellness Patients

In general, the HIPPA privacy rule is intended to give further protection for the patient's privacy of medical records and information. This federal rule is now a law as of April 14, 2003. It restricts the dissemination of your personal information to any entity other than those that you specifically indicate by an **in-person information release form**. Additionally, we are restricted in the means by which your own information is provided to YOU. Therefore, please indicate by checking all the applicable, those means by which we can continue to provide you with your medical reports, appointment confirmations and/or receivables of lab results:

I wish to be contacted in the following manner(s):

☐ **Home Phone**
Leave message with detailed information
Leave message with call back number

(___) _____
Home number

☐ **Mobile Phone**
Leave message with detailed information
Leave message with call back number

(___) _____
Mobile number

☐ **E-mail Report**

_____
e-mail address

☐ **Written Communications**
Please continue to send to my home

_____
_____
_____
Mailing Address

Print full name **DOB**

Patient's signature **Today's date**

Note to patient: Please maintain a copy of this release form in your files.

MD Wellness

Insurance Disclaimer

Dear Patient,

Treatment of environmental illness is a unique and rapidly growing form of medicine, which is not recognized by the insurance industry. It is viewed as a form of General Health and/or Alternative Medicine making it a non-reimbursable service.

More so, due to both state and federal issues relating to billing for office visits, we have been advised by legal counsel to disassociate from all forms of third party insurance programs. We therefore, are not contracted or participate with any insurance companies and no longer supply the following:

____ 1. Insurance billing forms.
____ 2. Standardized Service codes.
____ 3. Standardized Diagnostic codes for office visits
____ 4. Transmit any information to any insurance company or their representatives.

_____

_____

Print name and date

Patient's signature

Note to patient: Please maintain a copy of this release form in your files.

MD Wellness ***Physician-patient e-mail communication consent form***

Risks of using e-mail

The physician offers patients the opportunity to communicate by e-mail. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via e-mail without understanding and accepting these risks. The risks include, but are not limited to, the following:

• The privacy and security of e-mail communication cannot be guaranteed.
• Employers and online services may have a legal right to inspect and keep emails that pass through their system.
• E-mail is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the e-mail once it has been sent.
• E-mails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
• E-mail can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. E-mail senders can easily misaddress an e-mail, resulting in it being sent to many unintended and unknown recipients.
• E-mail is indelible. Even after the sender and recipient have deleted their copies of the e-mail, back-up copies may exist on a computer or in cyberspace.
• Use of e-mail to discuss sensitive information can increase the risk of such information being disclosed to third parties.
• E-mail can be used as evidence in court.
• The physician uses encryption software as a security mechanism for e-mail communications.

Conditions of using e-mail

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of e-mail communication.
• The patient is responsible for informing the physician of any types of information the patient does not want to be sent by e-mail. Such information that the patient does not want communicated over e-mail includes:

_____

_____

The patient can add to or modify this list at any time by notifying the physician in writing.

The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by e-mail. I acknowledge the physician's right to, upon the provision of written notice; withdraw the option of communicating through e-mail. Any questions I may have had were answered.

Patient's signature:_____
Date:_____/_____/_____

MD WELLNESS APPOINTMENT CANCELLATION, CHANGE AND "NO-SHOW" POLICY

At MD Wellness, we strive to provide excellent patient care and customer service. To that end, appointments are all scheduled in advance, and are lengthy enough (thirty minutes to two and half hours) to provide sufficient time to get to the root cause of your problems. Also we do NOT overbook our schedule (unlike most other doctor's offices) at MD Wellness and therefore waiting times are usually nonexistent or very short (rarely more than 15 minutes)
Dr. Rothman's services are in very high demand, and his schedule is filling up weeks in advance. Many people are seeking his care to help them solve their chronic health related issues. Unfortunately, we are experiencing a large amount of "no-shows", "last minute" cancellations and changes to our schedule. Apparently a substantial percentage of patients are making appointments only to change their plans at the last moment.
The Doctor's time is scarce and valuable and when you make an appointment with him, this time is reserved just for you. These last minute changes are very problematic, creating large "holes" in our schedule while simultaneously depriving other patients the chance to see Dr. Rothman.
We are therefore announcing a new policy at MD Wellness to help mitigate against these scheduling problems;

New patients will pay a 25% deposit for their visit at the time they make their initial appointment. Any changes for a new patient must be made at least three MD Wellness regular business days prior to your scheduled appointment. MD Wellness regular business hours are Monday / Wednesday 9:00 AM – 2:00 PM, Friday 9:00 AM – 5:00 PM, Thursday 9:00 AM – 6:00 PM and Tuesday from 9:00 AM – 7:00 PM. Cancellations or changes made less than 3 regular business days prior to your appointment will result in a forfeiting of your security deposit. Follow up patients will be also be subject to a 25% cancellation fee unless notice is given 3 regular MD Wellness business days prior to your appointment.

Patients that are chronic offenders of our cancellation policy will be required to pay the full cost of their visits in advance.

At MD Wellness, we understand that true emergencies arise that require last minute changes to your schedule. In case of a true emergency, we request that you provide some sort of evidence to substantiate your emergency. True emergencies will not be subject to the aforementioned fees.

Our services are very scarce and valuable. We strive to treat every person with great care, compassion and respect. We expect our patients to reciprocate by treating us the same way.

I_____ fully understand and agree with the MD Wellness cancellation and rescheduling policy

Print Name _____ Date ____/____/____

Credit/Debit Card Authorization Form

I _____ hereby authorize **MD Wellness** and **MD Skin** to charge $ to my Credit Card(s) listed below for consultations, "late cancellation" and "no show" fees. This authorization will remain on file until I cancel this authorization in writing.

Name: _____
(Please Print)

Address: _____
(Please Print) Street City State Zip

Home phone: _____ Cell: _____

Credit card Information

Name: _____
(Please Print – As shown in the Card)

Billing Address: _____
(Please Print) Street City State Zip

Credit Card Type: Visa Master Amex Discover Other: _____

Credit Card Number: _____

Expiration Date: _____/_____ Security Code (CID): ___ ___ ___

MD Wellness Return and Exchange Policy

Products and supplements must be in an unopened package.
Returns must be done within 30 days of the purchase date.
Liquid supplements are non-refundable.
Shipping and Handling fees are non-refundable.
There is a 10% restocking fee taken from the price of the return. Air purifying products require 15% restocking fee.
All returns are subject to exemptions and evaluation by management

_____ _____
Signature Date