



## **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. They are as follows:

The first section explains what metabolic testing is and how to prepare for the test. Please follow these instructions carefully.

### **Metabolically Directed Wellness at the MD Wellness**

You will be undergoing a metabolically directed functional test. This is a non-invasive, inexpensive test. The results are instantaneous. The information that the test yields can be extremely valuable in diagnosis and in making therapeutic decisions.

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 determine 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.

## *MD Wellness*

## 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 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 (please write legible).

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

*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.

<b>Name:</b> <i>(Last, First, M.I.)</i>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>HOME STATUS</b>			
Do you live with others in your home?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, How many people live in your home?		_____	
<b>PERSONAL HEALTH HISTORY</b>			
<b>List Any Medical Problems That Other Doctors Have Diagnosed</b>			
<b>Surgeries:</b>			
Year	Reason	Hospital	
<b>Other Hospitalizations:</b>			
Year	Reason	Hospital	
<b>List Your Prescribed Drugs , Over-the-Counter Drugs, Vitamins or Nutritional Supplements and Inhalers:</b> <i>(Please attach additional page, if necessary)</i>			
Name of Drug	Dosage	Frequency Taken	
<b>Allergies to Medications:</b>			
Name of Drug	Reaction You Had		

<b>FAMILY HISTORY</b>							
<b>OTHER PROBLEMS</b>							
<b>Sleep:</b>	<p>How many hours of sleep do you get each night? _____</p> <p>Do you feel rested/ refreshed in the morning? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you have trouble falling asleep? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you have trouble staying asleep? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you have trouble waking up too early? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>						
<b>Headaches:</b>	<p>Do you suffer from headaches? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="text-align: center;">If Yes, please answer the following questions:</p> <p>Does your headache affect both sides of your head or only one side?</p> <p>Do you see "auras" (visible lights) prior to your headaches? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you get nauseas with you headaches? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Have ever been diagnosed as having "migraines"? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>						
<b>Fatigue:</b>	<p>Do you suffer from fatigue? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="text-align: center;">If Yes, please answer the following questions:</p> <p>Is your fatigue characterized by excessive sleepiness in the day? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you feel "burnout"? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you suffer from "brain fog"? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you feel unmotivated? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>						
<b>Pain:</b>	<p>Do you suffer from pain? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="text-align: center;">If Yes, please answer the following questions:</p> <p>Do you have pain in your muscles? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you have pain in your joints? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Is your pain worse at any particular time of the day? Morning, afternoon or evening? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Does activity make the pain worse or better? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Is the pain alleviated with the application hot or cold compressions? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>						
<b>Low Blood Sugar:</b>	<p>Are you constantly hungry and need to eat several times each day? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you, at times, feel hungry, anxious, weak, or unfocused and feel much better immediately after you eat? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>						
<b>REVIEW OF SYSTEMS</b> <i>(please check appropriate boxes)</i>							
<b>Constitutional:</b>	<input type="checkbox"/> Fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Night sweats						
<b>Ears, Nose, Mouth and Throat:</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="checkbox"/>Hearing Loss  <input type="checkbox"/>Ear pain  <input type="checkbox"/>Ear infections  <input type="checkbox"/>Ringing in ears  <input type="checkbox"/>Balance problems  <input type="checkbox"/>Oral Thrust </td> <td style="width: 50%; border: none;"> <input type="checkbox"/>Post Nasal Drip  <input type="checkbox"/>Sinus Infections  <input type="checkbox"/>Sinus headaches  <input type="checkbox"/>Sore throat  <input type="checkbox"/>Mouth Sores </td> </tr> <tr> <td style="border: none;">           Did you have any recent dental work? <input type="checkbox"/>Yes <input type="checkbox"/>No            If yes, when was the last visit? _____ </td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">           Did you have any silver filling or amalgam? <input type="checkbox"/>Yes <input type="checkbox"/>No            If yes, when was the last removal? _____ </td> <td style="border: none;"></td> </tr> </table>	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear infections <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Balance problems <input type="checkbox"/> Oral Thrust	<input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Sinus headaches <input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth Sores	Did you have any recent dental work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last visit? _____		Did you have any silver filling or amalgam? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last removal? _____	
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Did you have any silver filling or amalgam? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the last removal? _____							
<b>Cardiovascular:</b>	<input type="checkbox"/> Chest pain <input type="checkbox"/> High blood press						
	<input type="checkbox"/> History of high LDL (bad cholesterol)						

	<input type="checkbox"/> Irregular pulse <input type="checkbox"/> Heart murmur	<input type="checkbox"/> History of low HDL (good cholesterol) <input type="checkbox"/> Elevated Triglycerides	
<b>Circulation:</b>	Do you suffer from?		
	<input type="checkbox"/> Cold Feet <input type="checkbox"/> Cold Hands	<input type="checkbox"/> Hands and Feet fall asleep <input type="checkbox"/> Fingernail turn blue	
<b>Respiratory:</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic cough <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sputum	
<b>Gastro-Intestinal:</b>	<b>Bowel Regularity:</b>	Do you move your bowels every day? If not how many time each week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you take or eat things to help you to move your bowel (prunes, fibers...)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you suffer from loose stools or diarrhea more than once each month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Other gastro-intestinal Symptoms:</b>	Do you suffer from heartburn or indigestion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you suffer from gas or bloating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you feel "sick" after you eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you have "food allergies"?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		If Yes, Please Specify:	
	Food	Reaction You Had	
<b>Genitourinary:</b>	<input type="checkbox"/> Urinary tract infect <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating Do you usually get up to urinate during the night? If Yes, How many times? _____	<input type="checkbox"/> Incontinence <input type="checkbox"/> Urgent Urination <input type="checkbox"/> History of Kidney stones <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Musculoskeletal:</b>	<input type="checkbox"/> Arm/leg weakness <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain Do you feel joint pain? In which joints? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Skin:</b>	<input type="checkbox"/> Dry skin <input type="checkbox"/> Oily skin <input type="checkbox"/> Eczema <input type="checkbox"/> Itchiness	<input type="checkbox"/> Fungal infection <i>(Athletes foot, jock itch)</i>	
<b>Endocrine:</b>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Hormone Problems	
<b>MENTAL HEALTH</b>			
<b>Neurological:</b>	<input type="checkbox"/> History of Seizures <input type="checkbox"/> Memory problems <input type="checkbox"/> Vertigo Do you get dizzy if you stand up quickly? Do you find yourself in the middle of a task and then forget what you were doing?	<input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Psychiatric:</b>	Do you find yourself anxious at times? Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>ENVIRONMENTAL</b>			
Do you have any rooms in your home or work that present the following?			
History of leak or water damage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Visible mold?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Musty or moldy smell?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have a basement in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, has it ever flooded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have pets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, what kind? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>HEALTH HABITS AND PERSONAL SAFETY</b>																												
<b>Exercise:</b>	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional Vigorous Exercise (i.e. work or recreation less than 4x week for 30 min) <input type="checkbox"/> Regular Vigorous Exercise (i.e. work or recreation 4x week for 30min or more)																											
<b>Diet:</b>	<p>Are you dieting? <input type="checkbox"/> Yes    <input type="checkbox"/> No  If yes, are you on a physician prescribed medical diet? <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Number of meals you eat in an average day? _____</p> <p><b><u>DO YOU CONSUME THE FOLLOWING FOODS?</u></b>  (check appropriate box and circle appropriate items)  <i>(Its important we understand because some foods you consume may be detrimental to your health)</i></p> <p><input type="checkbox"/> Fried Foods ( French Fries/ Fried Chicken/Mozzarella sticks/Onion rings/ Bacon)  How often do you eat Fried Foods? _____</p> <p><input type="checkbox"/> Sweets (Cake/ Cupcakes/ Ice Cream/ Pies/ Candy bars)  How often do you eat Sweets? _____</p> <p><input type="checkbox"/> Sugar    <input type="checkbox"/> Artificial Sweeteners  How often in a day do you use these sweeteners?  _____</p> <p><input type="checkbox"/> Sweet Drinks (Sodas/ Fruit Juices/ Ice Coffees/ Energy Drinks/ Smoothies)  How often do you have sweet drinks? _____</p> <p><input type="checkbox"/> Pre-packed food(Microwavable dinners / Lean Cuisine / Hungry Man/ Healthy Choice)  How often do you eat Pre-packed foods? _____</p> <p><input type="checkbox"/> Oils - Vegetable/ Canola/ Corn/ Peanut/ Pam  How often do you consume oils? _____</p> <p><input type="checkbox"/> Spreads - Smart Balance/Pam/ I Can't Believe It's Butter/ Margarine/ Butter  How often do you consume Spreads? _____</p> <p>How often do you consume Soy Products? _____</p> <p>What is your Typical:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Breakfast</th> <th style="width: 33%;">Lunch</th> <th style="width: 33%;">Dinner</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Do You Snack During the day? <input type="checkbox"/> Yes    <input type="checkbox"/> No  What do you snack on? _____</p> <p>Do You Drink Water? <input type="checkbox"/> Yes    <input type="checkbox"/> No  What Kind? _____</p> <p>How Much Water Do you Intake Daily?  <input type="checkbox"/> Less then 8oz    <input type="checkbox"/> 1-3 Glasses    <input type="checkbox"/> 4-6 Glasses    <input type="checkbox"/> 7-8 Glasses    <input type="checkbox"/> More Then 8 glasses</p> <p>Do You Eat Meat? <input type="checkbox"/> Yes    <input type="checkbox"/> No  If Yes, How Do You Like It Prepared?  <input type="checkbox"/> Rare    <input type="checkbox"/> Medium Rare    <input type="checkbox"/> Medium    <input type="checkbox"/> Medium Well    <input type="checkbox"/> Well Done</p>	Breakfast	Lunch	Dinner																								
Breakfast	Lunch	Dinner																										
<b>Caffeine:</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola    Number of Cups/Cans per Day?																											

<b>All questions contained in this questionnaire will be kept strictly confidential.</b>	
<b>Alcohol:</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what kind? _____ How many drinks per week? _____
<b>Tobacco:</b>	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cigarettes - Pks/day _____ <input type="checkbox"/> Chew -#/day _____ <input type="checkbox"/> Pipe - #/day _____ <input type="checkbox"/> Cigars - #/day _____ # of Years _____ or Year Quit _____
<b>Sex:</b>	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If not trying for a pregnancy, list contraceptive or barrier method used _____ Any discomfort with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you satisfied with your sexual functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>WOMEN ONLY</b>	
Do you still get your cycle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age at onset of menstruation	_____
Date of last menstruation	_____
Are your cycles regular?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies?	_____
Number of live births?	_____
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with Endometriosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had vaginal yeast infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, how many times?	_____
When was the last one?	_____
Have you ever had Fibrocystic Breast Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had Polycystic ovaries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>MEN ONLY</b>	
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No



# 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

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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.**

## MD Wellness

# Patient Treatment Agreement

**By signing this form:**

- I fully understand that Metabolic Balancing / Hormonal Balancing Therapy will cause changes to my body chemistry. As such, I confirm that specific verbal and/or written instructions regarding my diet 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.

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**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

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## 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,

Metabolic Balancing is a unique and rapidly growing form of alternative medicine, which is not recognized by the insurance industry. It is viewed as a form of General Health and/or Aesthetic 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.
- \_\_\_\_\_ 4. Transmit any information to any insurance company or their representatives.

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Print full name

today's date.

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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:

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**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