



1720 Post Road East-Suit 213
Westport, CT 06880
203-255-5005

Patient Name: _____ Date: _____

This is to confirm my appointment on: _____ at: _____

Welcome to the Big Apple Health Center!

We are honored that you have chosen us to help in your search for health and wellbeing. This is your New Patient Information Packet. Please read, fill out the attached forms and bring them with you to your appointment or email it to us if your appointment is not in person. This first page is a confirmation of your appointment and is due ASAP via email, or fax 203-259-2005.

If you wish to cancel or reschedule your appointment, please notify our office 48 hours or more before your appointment. If you choose to cancel your appointment in less than 48 hours, we will collect a \$100.00 fee. "No shows" for your appointment will be subject to a full charge equal to the hourly rate of time you were scheduled for.

It is our office policy to confirm appointments by phone two days before your appointment. If you have an answering machine or voice mail, a message will be left.

If you have any questions, feel free to call us 203-255-5005.

The directions to our office are on the website <https://bigapplehealth.com>

We are a holistic medical practice and many of our patients are environmentally sensitive, therefore we ask all patients to refrain from wearing perfumes, etc. on the days of your appointment.

Also, if you have a cold, fever, or not sure if it's a cold or allergies, due to the current situation, we ask you not come to the office and have a telehealth appointment instead. Please notify us and we will arrange a telehealth appointment. If you are not sure, please call us before coming and we will make a decision with you.

If you are here while you are experiencing cold symptoms such as sneezing, coughing, fever, etc., we will kindly ask you to leave and reschedule.

We look forward to meeting you!

This is to confirm my appointment on the date indicated above

Your Signature _____ Date _____

BIG APPLE HEALTH CENTER, LLC

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

This Notice applies to Big Apple Health Center, LLC and its participating physicians. We share your protected health information among us to provide you with the health care services, to treat you, to pay for your care and to conduct our business operations (e.g., quality assurance, compliance, and utilization review).

What is “Protected Health Information” or “PHI”?

“Protected health information,” or “PHI” for short, is information that identifies who you are and relates to, your past, present, or future physical or mental health or condition, the provision of health care to you, or past, present, or future payment for the provision of health care to you. PHI does not include information about you that is publicly available, or that is in a summary form that does not identify who you are. If you are an employee of our participating physician’s office, PHI does not include your health information in your personnel file.

Purpose of this Notice

In the course of doing business, we gather and maintain PHI about our members. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This Notice describes our privacy practices and how we protect the confidentiality of your PHI. We are obligated to maintain the privacy of your PHI by implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this Notice about our legal obligations to maintain the privacy of your PHI. We must follow our Notice that is currently in effect.

How We Protect Your PHI

We restrict access to your PHI to those employees who need access in order to provide services to our members. We have established and maintain appropriate physical, electronic and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a Privacy Office, which has overall responsibility for developing, training and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use and disclosure.

Types of Use and Disclosure of PHI We May Make Without Your Authorization

Treatment; Payment; Health Care Operations

Federal and state law allows us to use and disclose your PHI in order to provide health care services to you, as well as to bill and collect payments for the health care services provided to you by our participating physicians. For example, we may use your PHI to authorize referrals to specialists and to review the quality of care provided by your participating physician. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our participating physicians.

We may also use or disclose your PHI, for example, to recommend to you treatment alternatives, to inform you about health-related benefits and services that we offer, or to contact you to remind you of your appointments. We conduct these activities to provide health care to you, and not as marketing.

Federal and state law also allows us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use your PHI in connection with population-based disease management programs. We may use or disclose your PHI to perform certain business functions to our business associates, who must also agree to safeguard your PHI as required by law.

We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law – In some circumstances, we are required by federal or state laws to disclose certain PHI to others, such as public agencies for various reasons;
2. For public health activities – Such as reports about communicable diseases, defective medical devices to the FDA or work-related health issues;
3. Reports about child and other types of abuse or neglect, or domestic violence;
4. For health oversight activities – Such as reports to governmental agencies that are responsible for licensing physicians or other health care providers;
5. For lawsuits and other legal disputes – In connection with court proceedings or proceedings before administrative agencies, or to defend us or our participating physicians in a legal dispute;
6. For law enforcement purposes – Such as responding to a warrant, or reporting a crime;
7. Reports to coroners, medical examiners, or funeral directors – To assist them in performance of their legal duties;
8. For tissue or organ donations – To organ procurement or transplant organizations to assist them;
9. For research – To medical researchers with an approval of an institutional review board (IRB) or privacy board that oversees studies on human subjects. Researchers are also required to safeguard your PHI;
10. To avert a serious threat to the health or safety of you or other members of the public;
11. For national security and intelligence/military activities – Such as protection of the President or foreign dignitaries; and
12. In connection with services provided under workers’ compensation laws.

We may disclose your PHI, without your written authorization, to your family members or other persons if they are involved in your care or payment for that care. We may also notify disaster relief organizations to assist them with their relief efforts. When you are a patient at a hospital or medical facility with which we are affiliated, we may create a directory that includes your name, your location at the facility, your general condition and your religious affiliation. Information in this directory may be disclosed to visitors and clergy. However, we must first provide you with an opportunity to agree or object to such disclosure. If you cannot agree or object because you are incapacitated or otherwise unavailable, we will use our professional judgment.

You, as a parent, can generally control your minor child's PHI. In some cases, however, we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission.

There are some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. However, even such PHI may be used or disclosed without your written authorization if required or permitted by law.

Authorizations

All other uses and disclosures of your PHI must be made with your written authorization.

If you need an authorization form, we will send you one for you or your personal representative to complete. When you receive the form, please fill it out and send it to the following address:

Big Apple Health Center, LLC
1720 Post Rd East, Suite 213
Westport, CT, 06880

You may revoke or modify your authorization at any time by writing to us at the same address. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

Your Rights Regarding Your PHI

Access to Your PHI

You have the right to review and copy your PHI we maintain. If you wish to access to your PHI please write to us. We will respond to your request and tell you when and where you can review your PHI in our possession within our normal business hours. If you would like a copy of the information we have, please write to us at the same address. If we provide you with a copy, we may charge a reasonable administrative fee for copying your PHI to the extent permitted by applicable law. If we deny your request for review or copy of your PHI, we will explain the reason in writing. If we don't have your PHI, but know who does, we will tell you who to contact.

Right to Amend Your PHI

You have the right to request amendments to your PHI. If you wish to have your PHI corrected or updated, please write to us and tell us what you want changed and why. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why. You may also send us an addendum that is no longer than 250 words in length for each item you believe is incorrect. Please clearly indicate that you want the addendum to be included in your PHI. We will attach your addendum to the record(s) of your PHI. Your amended PHI will be available for your review upon request.

Right to Receive an Accounting of Disclosures of Your PHI

You have the right to request an accounting of certain disclosures that we make of your PHI. You can request an accounting by writing to us. Please note that certain disclosures, such as those made for treatment, payment, or health care operations, need not be included in the accounting we provide to you. We will respond to your request within a reasonable period of time, but no later than 60 days after we receive your written request.

Right to Receive a Copy of This Notice

You have the right to request and receive a paper copy of this Notice. You may contact us for a copy, and one will be provided to you at no charge.

Right to Request Restrictions

You have the right to request restrictions on how we use and disclose your PHI for our treatment, payment, and health care operations. All requests must be made in writing. Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Please note that we are not required to accept your request for restrictions. Your PHI is critical for providing you with quality health care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI, and that additional restrictions may be harmful to your care.

Right to Confidential Communications

You have the right to request that we provide your PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternate means (e.g., sending by a sealed envelope, rather than a post card) or to an alternate address (e.g., calling you at a different telephone number, or sending a letter to you at your office address rather than your home address). We will accommodate any reasonable requests, unless they are administratively too burdensome, or prohibited by law.

You may contact your Health Plan or the California Department of Managed Care with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Service. We will not retaliate against you for filing a complaint against us.

Rights Reserved by Big Apple Health Center, LLC

We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in this Notice. We reserve the right to revise our privacy practices consistent with law and make them applicable to your entire PHI we maintain, regardless of when it was received or created. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Unless the changes are required by law, we will not implement material changes to our privacy practices before we revise our Notice.

PATIENT INFORMATION - page 1

Name: _____ Date of Birth: _____ Date: _____

Address: _____

(City, State, Zip code)

Phone Numbers: (Home) _____ (Cell) _____ (Work) _____

Emergency Contact: _____ Phone _____

Email address: _____

Medical insurance company & plan _____

Insurance ID (if applicable) _____

Referred by: a friend or family or a professional (please tell us who we should thank) _____

Or Please Circle: Internet Insurance Company Other _____

Primary care physician (name, location & phone number):

List other physicians that are important to you and you think should be listed here as a possible contact

Permission to contact you regarding reminder calls, laboratory results, and supplement pick up information (please indicate preferred method) _____

Allergies: _____

Have you been under the care of a Naturopathic, Holistic, Integrative doctor or Acupuncturist before? If yes, or what reason?

WHAT ARE YOUR REASONS FOR THIS VISIT?

1. _____

2. _____

3. _____

4. _____

Name: _____ Date of Birth: _____ Date: _____

PLEASE LIST CURRENT MEDICAL CONDITIONS WITH DATES OF DIAGNOSIS:

1. _____
2. _____
3. _____

THINGS HAVE NOT BEEN THE SAME SINCE... (in your own words please describe when you think your problem(s) begun, when do you remember feeling well, and what was your turning point when you started getting worse, what was happening in your life at that time physically, emotionally and socially) :

ACCIDENTS AND/OR MAJOR TRAUMAS (CONCUSSIONS, FALLS):

SCARS (Please specify how old and locations):

HOSPITALIZATIONS/SURGERIES– please give month/year if possible:

PAST MEDICAL HISTORY: (check boxes if yes and include date)

- Premature birth (more than 2 weeks) _____ Heart surgery, if yes, how old were you _____
- Asthma, if yes, when (how old were you) _____ Heart disease, if yes, time of diagnosis _____
- Hepatitis (specify, and when) _____ HIV/AIDS _____ Lung disease (please specify) _____
- Cancer (if yes, what kind, the date of diagnosis, and the treatment received) _____

Autoimmune disorder (please specify and when) _____

- Thyroid disease (please specify and when) _____ Seizures _____
- Lyme disease (please indicate when first developed and treatments received) _____
- COVID (including long haul) if yes, when and list symptoms if still present _____
- Diabetes (Type I or II) _____
- High blood pressure _____ Ulcers _____ Colitis _____
- Other _____

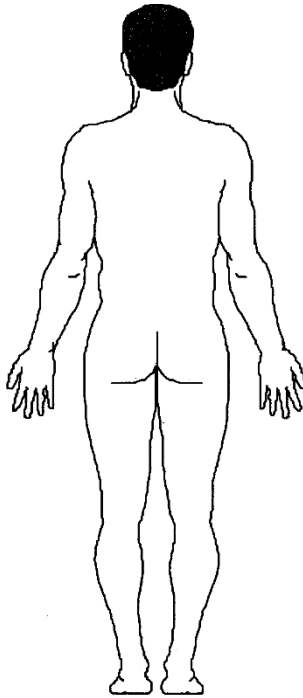
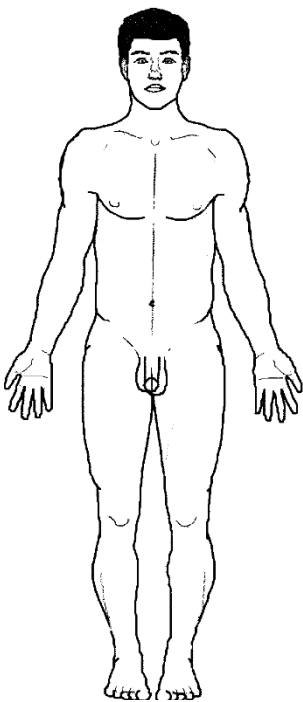
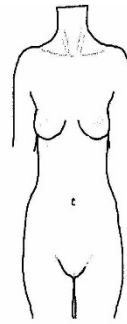
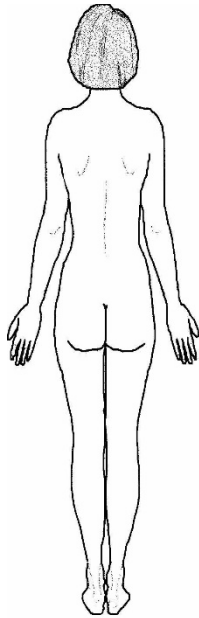
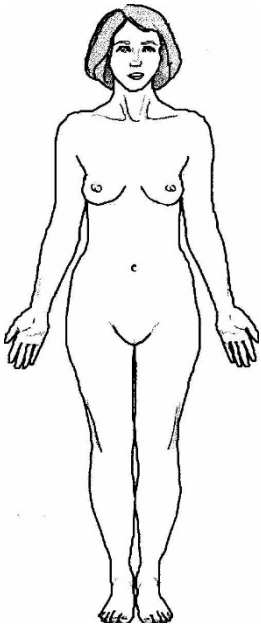
Allergies to medications _____

Vaccinations:
When was the last time you received vaccine(s), what kind? _____

Women:
First day of last menstrual period _____ No.Pregnancies _____ Deliveries _____

Name: _____ Date of Birth: _____ Date: _____

Please circle any current areas of pain on the following diagrams:



BIG APPLE HEALTH CENTER, LLC
Dr. Marina Yanover, ND, LAc

Please Read Carefully, Initial and Sign After Reading

PAYMENT POLICY

Appointments must be paid for at time of service. We accept Visa and MasterCard, Cash, and Checks. Any services rendered at the Big Apple Health Center must be paid directly to them. Initial _____

FEE STRUCTURE

Charges are based on actual time and services used. This means that each appointment and service is billed separately. Sometimes we offer discounted rates for the combines services (received on the same day).

*****Phone or virtual appointments are charged the same as in-person appointments.**

Initial _____

CANCELLATION

If unable to keep your appointment, a 2-business day cancellation is required in order to avoid the charge. Cancellations made within less than 2-business days will be charged a fee of \$175.00 for new patients, and \$100.00 for the returned patients. "No shows" for your appointment will be subject to a full charge equal to the hourly rate of time you were scheduled for. We are committed in helping you to achieve great health. We also require you to be committed as well. If you cancel three times in a row without a valid reason, you will not be accepted into our practice in the future.

Initial _____

RELEASE OF INFORMATION

I authorize the physician to provide from my records any and all information requested by my insurance company, or other third-party payer, in connection with payment for my incurred charges. I also authorize the physician to provide any Quality Review organization affiliated with my insurer the information it requests for use in Utilization Management/Review.

Initial _____

INSURANCE AND MEDICARE

We are currently considered providers with the following insurance companies: Anthem BC/BS and Aetna. However, if you are insured by one of these companies, it is your responsibility to check with your insurance to make sure Dr. Yanover is a participating provider with your particular plan. Also, some procedures /programs that we provide are not covered by insurance. If this is the case, we will inform you ahead of time and will have you sign a waiver. If you have out of network benefits and we are not on your plan, we will be able to bill on your behalf or give you a form to submit to your insurance. We are not a Medicare provider. Medicare does not cover naturopathic care. Medicare will not reimburse you for services rendered at the Big Apple Health Center and you should not seek reimbursement from Medicare. Co-payments are due at the time of visit. Some plans may require a referral from your primary care physician and is the patient's responsibility.

Initial _____

ASSIGNMENT OF BENEFITS

I understand I am always responsible for payment regardless of the insurance coverage I may have. I assign any insurance benefits to which I may be entitled to the physician providing the services. I understand that I am responsible for any charges not covered by this assignment. If my policy has a deductible which has not yet been satisfied at the time of my visit, I understand that a claim will be filed with my insurance company. Upon Big Apple Health Center receiving notification from my insurance company as to the \$ amount of my responsibility for visits still under my deductible, I will be billed by Big Apple Health Center. Any invoices I receive from Big Apple Health not paid within 30 days will be subject to a finance charge of 18%. I authorize release of any medical or other information necessary to process my insurance claims. Reimbursement from other insurance companies we do not directly bill is the responsibility of the patient. A bill/ receipt will be provided upon request. I authorize disclosure of records to my insurance carrier, lawyer, or referring practitioner. Hipaa rules dictate my signing a release each time I request records be sent from Big Apple Health Center to another party.

Initial _____

PATIENT PRIVACY AGREEMENT

I give the physician the authority to share with any consultant all information deemed necessary to coordinate my medical care. This includes sharing/mailling/faxing information such as office notes, EKGs, laboratory results, x-ray reports, medication lists and other consultant's notes to physicians, hospitals, pharmacists and insurance companies. The signature below also gives informed consent for the holistic treatment (Naturopathic medicine, Acupuncture, Craniosacral therapy, herbal medicine, and supplementation) of the individual or the minor for whom they are legally in charge.

Initial_____

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Signature denotes understanding and agreement with all statements above.

Initial_____

SUPPLEMENT RETURN POLICY

We try to provide the best supplements to ensure the highest quality products. We spend hours of research to make sure our products work. Unfortunately, because of the size of our practice, and restrictions and fees we have to incur by our vendors, no **returns or exchanges on unopened supplements will be made after 30 days. Returns will be accepted within 30 days of purchase minus a 20% restocking fee. We cannot accept returns on opened supplements. Special orders or tinctures specifically made for a patient cannot be returned. All special orders require prepayment.**

Initial_____

LABORATORY ORDERS

Ordering lab tests has been a part of our practice, as one of the tools to properly diagnose you and get an insight about your health. We find that on some occasions your insurance company may not make payment in full to the lab performing these tests, and the lab will determine you are responsible for the balance due and bill you directly. The claims for these tests are submitted to your insurance company by the lab, completely independent of our office, and determination of payment to the lab is made solely by your insurance company.

To prevent this from happening, you should call you insurance company in advance, to ensure that your lab tests are covered. When calling, have your lab requisition form in front of you so that you can mention each test that is ordered. In the end it is your responsibility to pay for the lab tests if not covered by insurance.

Initial_____

I understand that I will have asked Dr. Yanover for help and that she will help to the best of her ability.

I have read and understand the above statements.

Print Name_____

Signature (signed by guardian if under-age) _____ **Date**_____

BIG APPLE HEALTH CENTER, LLC
Marina Yanover, ND, LAc

INFORMED CONSENT FOR TREATMENT

1. _____ I understand that the treatment options provided at Big Apple Health Center might be experimental. I hereby request and consent to the treatment provided by Dr. Yanover including all procedures and programs currently offered at Big Apple Health Center by Dr. Yanover. I understand that methods of treatment may include, but are not limited to, nutritional counseling, supplement regimen, detoxification guidance, acupuncture, moxibustion, cupping, electrical stimulation, craniosacral therapy, massage, Western and Chinese herbal medicine, and infra-red heat.
2. _____ Neither Dr. Yanover nor any of her staff members, have made any guarantees that the treatments and /or programs will cure or benefit me.
3. _____ I understand that my compliance will influence the result of the treatment and if I am not following the protocol exactly as instructed, I may not expect the intended results.
4. _____ I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping.
5. _____ I understand that allergic reactions to some of the prescribed herbs or supplements are possible.
6. _____ I understand that some herbs and /or supplements may be inappropriate during pregnancy. I will notify Dr. Yanover if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from Dr. Yanover or my obstetrician.
7. _____ I understand that there are other treatment options available for my condition.
8. _____ I agree to hereby waive any legal action against Dr. Yanover, the Big Apple Health Center, their affiliates and their respective directors, managers, officers, employees, agents, and staff members and release the aforementioned of and from any and all liability, claims for injuries or harm, any and all damages, and causes of action whatsoever whether based on negligence or otherwise, either in law or in equity, which have arisen or may arise out of or relate in any way to Dr. Yanover's treatment, including but not limited to claims arising from allegations that methods of evaluation are not accepted by the medical community or alleging a lack of informed consent.
9. _____ By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of the treatment modalities offered by Dr. Yanover, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and or recommendations from Dr. Yanover.
10. _____ I hereby acknowledge that I have read the informed consent form and have been adequately informed of the expected benefits and risks of the treatments provided by Dr. Yanover, alternative methods of treatment, and the risks of not treating my condition. I have read and understand each paragraph above and have had an opportunity to ask questions and raise any concerns regarding them. All of my questions have been answered to my satisfaction.

PATIENT NAME: _____

PATIENT SIGNATURE (Or Patient Representative) _____

Physician/Witness _____

Date _____

CREDIT CARD AUTHORIZATION

This is our office policy to keep credit card authorizations on file just in case you have any outstanding balances (co pay or uncovered charges). We will not share this information with any third party. It will be kept confidential. We can inform you of any balances or charges before we apply them to your credit card if you so request.

I, _____, hereby authorize Big Apple Health Center LLC, to utilize my credit card on file for any outstanding balance.

Patient's Name (print)

Date

Credit Card Type: Visa
 MasterCard

My address: _____

_____ Street _____ City _____ State _____ Zip code _____

Credit Card Number

CVVI (3 last digit on back)

Exp. Date

Authorized Signature

Date

Witness Signature

Date