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. <u>If you choose to cancel your appointment in less than 48 hours, we will collect a $185.00 fee.</u> <u>"No shows" for your appointment will be subject to a full charge equal to the hourly rate of time you were scheduled for.</u>
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._____

4._____

5._____

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:

_____
_____
_____
_____
_____

Name: _____ Date of Birth: _____ Date: _____

FORGOTTEN SURGERIES (TONSILLECTOMIES, LASY EYE, TUMMY TUCK, OTHER COSMETIC PROCEDURES, UNDESCENDED TESTICLE, CIRCUMSICION): _____

_____

_____

_____

DENTAL PROCEDULES (ROOT CANALS, EXTRACTIONS, DENTAL APPLIEANCES, MERCURY REMOVAL):

_____

_____

_____

_____

OCCUPATIONAL OR OTHER KNOWS ENVIRONMENTAL EXPOSURES (mold, fumes, etc.):

_____

_____

_____

_____

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)_____

_____

☐ Rheumatic fever (or scarlet fever) _____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_____

☐ Have you been on antibiotics and /or steroids for prolonged periods of time (if yes, for how long and when) _____

_____

_____

_____

_____

Name: _____ Date of Birth: _____ Date: _____

Current Prescription Medications (names and doses)

Current Supplements

Allergies to medications

Sensitivities: Foods, environmental, etc.–Ever tested? Copies of reports?

Occupational Exposures:

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

Date of last physical examination: _____Name of the doctor_____
Facility_____

Last laboratory/Blood work (date and significant results):

Name: _____ Date of Birth: _____ Date: _____

Women:
Last Pap_____ First day of last menstrual period_____

No. of Pregnancies_____Deliveries_____complications_____

Last Mammogram_____ Last Thermogram _____Last Breast Ultrasound_____
Findings_____
_____
_____

Men:
Last prostate exam_____ Last PSA result_____Date_____
Findings_____
_____
_____

Social History:

Married_____ Divorced _____ Single_____ Any relationship stressors _____
_____

Do you have children? _____If yes, number of children: _____Ages? _____
Any problems with children? _____
Occupation/ Job Title_____ Hours of Work Per Week_____

Lifestyle factors:

	Never	Occasionally	Weekly	Daily
Coffee	□	□	□	□
Tobacco	□	□	□	□
Alcohol	□	□	□	□
Marijuana	□	□	□	□

Exercise Activities:

Please describe your exercise activities and how often you do them, also include any form of meditation, and well as sexual activities (frequency and quality) _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Name: _____ Date of Birth: _____ Date: _____

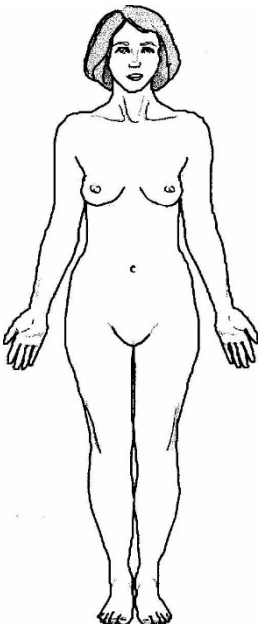
Metabolic Questionnaire

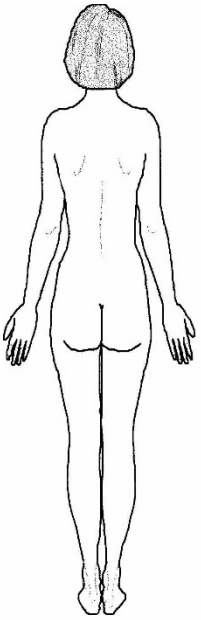
	Yes	No	In the middle
Are you ambitious?	□	□	□
Do you like to exercise?	□	□	□
Do you have anxiety?	□	□	□
Can you go long periods without eating?	□	□	□
Do you have insomnia?	□	□	□
Do you crave sugar?	□	□	□
Are you a morning person?	□	□	□
Do you tend to have a high blood pressure?	□	□	□
Do you tend to have a fast heart rate?	□	□	□
Do you have a strong libido?	□	□	□

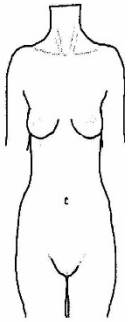
Are you a creative person?	□	□	□
Do you struggle with fatigue?	□	□	□
Do you struggle with depression?	□	□	□
Do you feel cloudy?	□	□	□
Do you enjoy/crave red meat?	□	□	□
Do you have allergies?	□	□	□
Are you always hungry?	□	□	□
Do you remember your dreams?	□	□	□
Do you sweat easily?	□	□	□
Do you have dandruff?	□	□	□

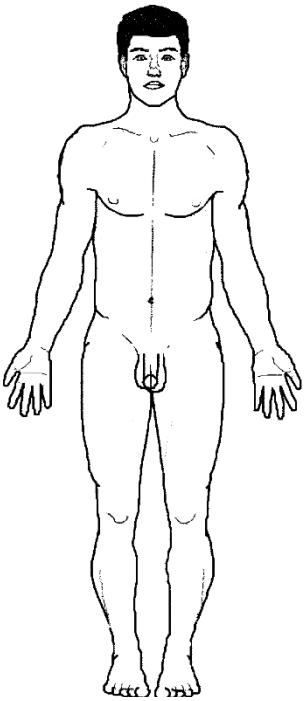
Name: _____ Date of Birth: _____ Date: _____

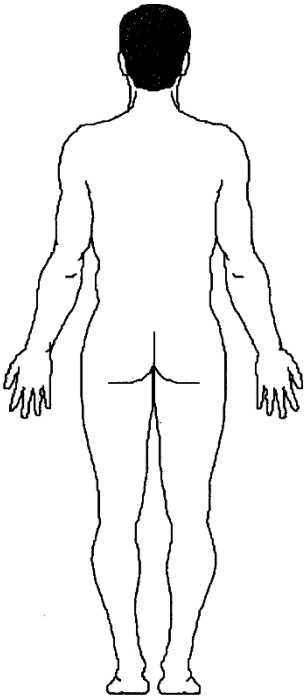
Please circle any current areas of pain on the following diagrams:

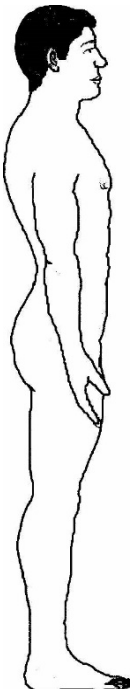












Name: _____ Date of Birth: _____ Date: _____

FAMILY HISTORY:

Please check the box if a family member (mother, father, brother, sister, aunt, uncle, grandmother, grandfather, or child) has one of the following conditions, write which family member in a space provided their age of diagnosis. If deceased, list cause of death and age of death.

☐ Cancer(type) _____ ☐ Diabetes (Type I) _____
☐ Diabetes (Type II) _____ ☐ Arthritis _____
☐ Heart disease_____ ☐ Inherited blood disorder_____
☐ High cholesterol_____ ☐ Stroke_____
☐ Seizures_____ ☐ Asthma_____ ☐ Allergies_____
☐ Alcoholism_____ ☐ Mental illness (type)_____
☐ Lupus_____ ☐ Multiple Sclerosis_____
☐ Psoriasis_____ ☐ Dementia/Alzheimer's_____
☐ Parkinson disease_____ Liver disease (what type)_____
☐ Crohn's disease_____ ☐ High blood pressure_____
☐ Gall Bladder problems_____ ☐ Kidney Disease_____
☐ Thyroid disorder(type)_____ ☐ Autism_____
☐ Drug abuse_____ ☐ Glaucoma_____ ☐ Hearing loss_____
☐ Celiac disease_____ ADHD_____
☐ Skin disease (Type)_____ ☐ Other conditions_____
_____
_____

DIET:

Please list a typical day and any food restrictions or food sensitivities

_____
_____
_____
_____
_____
_____
_____
_____

What would you like to change about your health and/or life? What are your goals?

_____
_____
_____
_____
_____
_____
_____
_____
_____

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 $185.00 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. **I agree not to submit a claim to Medicare or any secondary insurance (such as Aetna or Anthem) if my primary insurance is Medicare, or to ask the physician to submit a claim to Medicare or any secondary insurance on my behalf.** 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. HIPPA 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/mailing/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_____

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

INFORMED CONSENT FOR TELEHEALTH

This Informed Consent for Telehealth contains important information focusing on providing healthcare services using the phone or the Internet.

Benefits and Risks of Telehealth
Telehealth refers to providing health services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful during certain circumstances such as the pandemic or long distance. It ensures continuity of care as the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks. For example:

Risks to confidentiality. As telehealth sessions take place outside of the office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important; however, for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device.

Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention.

Electronic Communications
You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth.

Communication between sessions
For communication between sessions, I only use email communication for clarification of already discussed matters. This means that email exchanges with me should be limited what has already been discussed during the office or a telehealth visit. You should be aware that I cannot guarantee the confidentiality of any information communicated by email. Therefore, I will not discuss any new clinical information by email. Also, I do not regularly check my email, and do not respond immediately, therefore, these methods **should not** be used if there is an emergency.

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of telehealth services. The nature of electronic communications technologies, however, is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent for Treatment still apply in telehealth.

Appropriateness of Telehealth

I will inform you know if I decide that telehealth is no longer the most appropriate form of treatment for you. If you decide telehealth is not optimal for you, it is important to let me know.

Technology

If the session is interrupted for any reason, such as technological connection failure, and you are having an emergency, do not call me back; instead, call 9-1-1, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-connect you via the telehealth platform on which we agreed to conduct treatment. If I do not connect via the telehealth platform within two (2) minutes, then call me on the phone number I provided you with.

Fees

The same fee rates will apply for telehealth as apply for in-person therapy. If you have insurance, and plan to use it for a session, it is important that you contact your insurer to determine if there are applicable co-pays or fees which you are responsible for. Insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic therapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether these sessions will be covered.

If there is a technological failure and we are unable to resume the connection, you will still be charged for the amount of time scheduled, and will be credited the amount of time that was missed due to a technological failure at a later time when the connection is working.

Records

The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our treatment together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Patient /Representaive Date

_____ _____

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 ode _____

_____ _____ _____
Credit Card Number CVVI (3 last digit on back) Exp. Date

_____ _____
Authorized Signature Date

_____ _____
Witness Signature Date