Michael Cheikin M.D.
Holistic Medicine and Physiatry
Center for Optimal Health
832 Germantown Pike, Suite 3
Plymouth Meeting, PA 19462
610-239-9901 www.cheikin.com

Dear New Patient,

Thank you for giving our Center the opportunity to serve your holistic health and wellness needs. This letter will help you prepare for our initial consultation, which will include a check-in and and check-out, in addition to spending between 45-80 minutes with the doctor.

Since our relationship is very important to your trust and healing, **we will reserve an hour of physician time** for your initial consultation. We want to learn as much about you as possible, and explain more about the healing process that Holistic Medicine has to offer. **We require 2 full business days notice of cancellation (i.e. Thursday 10am for a Monday 10am appointment).** If you cancel (or don't show) with less than this notice, **you will be billed $250**. You will also be billed if you do not have a required HMO referral or cancel within 2 business days because you cannot get a referral.

For your first visit:
O Please plan to arrive **at least 30 minutes early** to complete the registration process which may include educational videos. Parking is easy and free! You will also need time after the first visit to check out. **Plan on being at our office a total of 120 minutes.**

Please bring:
O **completed paperwork--16 pages** (website: "New Patient" page; use "form" and "healthy9876" to log on)
O your insurance card
O photo ID
O HMO referral (if required; you will be billed for the visit without this or if you cancel (see below))
O required co-pay
O copies of ALL lab reports, if you have them (you can bring discs but these may not be useful)
O **a chronological history in electronic format if your history is complex**. You can use **history.doc on the website. DON'T print or bring a hand-written copy as you will be updating the information soon.**

It would be helpful for you to think about in advance, and write down for the consultation:
O any burning questions that you have
O any strange symptoms that you may be embarrassed to tell other practitioners and do not fit on forms
O any urgent issues that you need to be addressed on the first visit

We also strongly recommend that you review our website, www.cheikin.com, which has information about our credentials, treatment philosophy, many helpful articles and other information. Three articles that might help you understand this process are "CSI of Health Care", "Courage to Heal" and "Fallacy of Diagnosis".

We take your concerns, your time and other resources very seriously. We look forward to facilitating the learning and healing that within you. You wouldn't have contacted us if you didn't believe this was true!

We look forward to serving you.

Sincerely,

Michael Cheikin MD
Medical Director

PRACTICE POLICIES

M Cheikin MD

Dear Patient:

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Welcome! We are glad to have the opportunity to work with you. Our mission is to provide high quality holistic medicine and physiatry within the constraints of the current health care system. This page will review our policies and procedures. Please see our website, www.cheikin.com for more information about Holistic Medicine and Physiatry.

1. In most cases, your health plan will cover:
   - Initial office visits up to 60 minutes (only "face-to-face time" is covered; and you will need a referral at the time of visit if you have an HMO)
   - Follow-up office visits between 15-40 minutes (same requirements as initial visit)
   - Conventional lab tests and their review during office visits
   - Conventional medications and treatments prescribed by a physician if on the plan's formulary (and subject to the plan's copays, deductibles and other restrictions)
   - Phone calls to other physicians and practitioners during office visits
   - Counseling of patient
   - Coordination of care with family members during office visits

2. **Your health insurance plan will not cover (but a Healthcare Savings Account may cover) these and other services for which there are fees:**
   - Holistic Services such as educational materials, coaching, nutrition, acupuncture, yoga, special programs etc. for which there are separate fees
   - "Non-covered" lab tests
   - Interpretation of lab tests for which there is no established code or reimbursement by insurance plans
   - Access to special web site materials
   - Copays (due at time of visit) and Deductibles
   - Office visits that go over time
   - "Case Management" assistance with health carrier issues (such as coverage, referrals) and legal/administrative matters
   - Phone and email services
   - Phone calls to other practitioners not during office visit time
   - Review of tests and other information not during visit time (see lab policy, other side)
   - Visit cancellations or time lost due to lateness on your part
   - Copying costs
   - Completion of forms

3. Here are additional policies and procedures that will allow us to provide the best and most cost-effective care:
   a. We will schedule office visits for 30-45 minutes. If you need more time, we can schedule more frequent visits to cover your medical needs. You can also elect to pay privately if you want an extended visit, but this must be scheduled in advance.
   b. Because we reserve 30-45 minutes for your visit, for a no-show or cancelled visit with less than two full business days (i.e. Thursday 10 am for a Monday 10am visit), there will be a fee of $150. Lateness of more than 15 minutes will cause your appointment to be cancelled with this fee. If making appointments in advance is difficult for you, you can call the day of your next needed visit for any open appointment slots or to be placed on a waiting list.
   c. **Because of the complex needs of many of our patients, we sometimes run late up to 45 minutes and cannot guarantee time slots. Please plan your appointment accordingly, including time for checkout after the visit with the physician. If you cannot work within this parameter, then we can discuss options during our first visit.**
   d. **If your insurance carrier requires a referral, it is your responsibility to make sure the referral is obtained from your primary care physician before the visit. You will be financially responsible for the office visit if a referral is not obtained. If an office visit is cancelled due to lack of referral, you will be charged a $150 cancellation fee.**
   e. During office visits, let's be sure to renew prescriptions. There may be a fee for non-urgent phone renewals.
   f. You will be required to provide copies of any documents that are pertinent to your care or that you want me to review. Our staff cannot provide such services due to time constraints.
   g. While I will try to handle urgent issues related to the care I am providing, over the phone, you may need to come in (I will do my best to see you soon) or you will need to go to a local emergency room, urgent care center or primary doctor.
   h. Forms will be completed at our discretion. Some must be filled by your primary doctor.
   i. Returned checks will be charged a $30 fee.
   j. Unfortunately with the increase in deductibles and copays, patient responsibility for charges is increasing. We are required to notify you about our collection policies. Past due balances will be charged 1.5% per month after 30 days. Our collection company charges 26%, to which a handling fee of 6% is added for a total collection fee of 32%. Charges go into collection ONLY AFTER multiple attempts to collect from you. Please be sure to update us with changes of address and health insurance to help avoid such a scenario.
   k. You are expected to maintain a relationship with a primary care physician to handle routine medical issues such as medication renewals (for medications not prescribed or adjusted by me) vaccines, colds, and related conventional care.
   l. Nutriceutical supplements are provided in the same way as pharmaceuticals. We make our best effort to provide effective agents for your problems. We cannot guarantee results and cannot accept returns except in the case of clear manufacturing defects. Small portions are available to test some agents at a reduced cost.
   m. Many of our patients are very sensitive to chemicals. Therefore, please do not wear any commercial scents or lotions, including those that may remain on previously worn clothes.

Due to the ongoing malpractice and health insurance crisis in Pennsylvania, many doctors have left the state and/or have stopped participating in insurance plans. Agreeing to these mutual commitments at the beginning of our relationship will allow us to make the most of our visits, and allow us to focus on providing you with the best quality we can. Thank you in advance for your understanding and cooperation. Please feel free to discuss any concerns you have about the above during our visit(s).

I have read and agree to be bound by the above policies. I understand that I can print a copy from the website.

PLEASE ALSO REVIEW AND SIGN OTHER SIDE

_____

Patient's (or BOTH parent/guardian's) signature Date

HMO & LAB POLICIES

M Cheikin MD

Dear Patient:

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With the ever-deteriorating "coverage" by insurance carriers, there has been confusion and frustration over responsibility for visit referrals and payment and interpretation of laboratory studies. Most holistic practices do not participate in health insurance plans because of these difficulties. While we "accept" most insurance plans for medically necessary office visits, our patients are required to be pro-active regarding their coverage and their laboratory studies. The following policies apply:

1. It is your responsibility to understand your coverage, and to review your policy with your carrier before accepting any services, whether medical, lab or other. Because of the huge numbers of insurance plans, we are unable to manage the specifics of your plan. It is your responsibility and entitlement to know how your plan works. There is no guarantee that any service will be covered by your carrier. Some plans capitate to specific labs (i.e. Quest or LabCorp).

2. We have no input or control over your insurance carrier's policies regarding coverage, deductibles, co-pays, exclusions or what they deem (often arbitrarily) to be "experimental". We will do our best to provide appropriate diagnostic codes and treatment codes to medically justify the services provided and the labs ordered. Only medically necessary and conventional services and labs will be ordered for coverage by your insurance.

3. Non-conventional services and labs (i.e. acupuncture, yoga, heavy metal tests, halide tests, etc.) that we believe are not covered by insurance (such as homocysteine not covered by Aetna) will be your responsibility. As best as we dknow, we will tell you in advance before such services or studies are performed.

4. If you know that your carrier does not "cover" certain important labs (such as homocysteine by Aetna) that are provided by conventional labs such as Quest or LabCorp, we can often perform the lab at a discount compared to what you might pay. In such cases, we must work out the details in advance.

5. Some of the "non-covered" lab costs, including co-pays, deductibles, and non-conventional labs may be submitted for reimbursement if you have a HSA (Health Care Savings Account) or MSA (Medical Savings Account).

6. **Fees for "non-covered" labs provided by our office, which include handling and interpretation, are non-refundable**. Under extenuating circumstances, and with prior approval by Dr. Cheikin, there may be a partial refund provided. You are required to complete any test kits within 30 days or by any provided expiration date.

7. There will be a minimum fee of $30 to be paid in advance if you request the office staff to assist you in rectifying issues related to your individual carrier's policies and not within the scope of physician's services (i.e. appropriate diagnostic and lab codes, referrals, etc.)

8. **You are responsible for returning for an office visit within 3-4 weeks after having labs performed**, to interpret the labs and to adjust your program accordingly. We cannot send you copies of labs without review and interpretation, because of the medico-legal responsibility for acting upon these studies. **Furthermore, no insurance company pays for interpretation of many of the labs ordered within the scope of this holistic practice**. If you wish for a interpretation between visits, or do not return for a visit within 6 weeks after having labs done, there will be a $175 fee to cover the cost of the interpretation without your presence. This fee cannot be charged to your insurance company and will be your responsibility. For your safety, without review, labs will only be released to a physician who is assuming responsibility for you continued care (i.e. your primary care or other).

9. LabCorp, Quest and most other labs now provide a patient portal to enable you to review and print your results as they become available. If available, you are responsible for providing a copy to your primary care physician.

10. The "reference ranges" provided by most labs are based on a "typical" American population and DO NOT represent "normal" or "healthy". It is potentially dangerous to self-interpret labs that are within and outside of the reference range to self-diagnose without the participation of a licensed physician.

I have read and agree to be bound by the above policies. I understand that I can print a copy from the website).

PLEASE ALSO REVIEW AND SIGN OTHER SIDE

_____

Patient's (or both guardian's) signature Date

Michael Cheikin MD
Holistic Medicine & Physiatry
832 Germantown Pike, Suite 3
Plymouth Meeting, Pennsylvania 19462
610-239-9901 cheikin.com
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REQUEST AND CONSENT FOR PARTICIPATION IN THE HOLISTIC MEDICINE PROGRAM

I consent and request to participate in the HOLISTIC MEDICINE Program. HOLISTIC MEDICINE is an art of healing involving the evaluation and treatment of the body, mind and spirit, using a program that is specifically tailored to re-establishing balance in the body. Modalities may include, but are not limited to, conventional (standard) diagnostic testing and treatment, special (non-covered) diagnostic testing, special diets, special supplements, herbs, acupuncture, yoga, energy medicine techniques, ayurvedic and Chinese medical treatments, mind-body techniques such as meditation, hypnosis, journaling, and breathing exercises.

I have been advised to discuss the risks and benefits of HOLISTIC MEDICINE with my doctor(s) and other health care practitioner(s), especially if I have any questions about participation. I understand that I am expected to continue my usual medical care. I understand that the HOLISTIC MEDICINE Program will not replace, substitute for, or provide the routine medical care that should be provided by my primary care physician. I understand that I might be referred back to my primary care physician if the HOLISTIC MEDICINE evaluation suggests an underlying medical condition that requires further conventional and/or urgent medical evaluation and treatment.

I recognize that significant sickness or even death could occur as a remote but real possibility of this therapy which alters function of the body, mind or spirit. I am also aware that HOLISTIC MEDICINE may mask an underlying condition or retard a more exact diagnosis where conventional or standard therapy(ies) may be known to be indicated.

Contra-indications for HOLISTIC MEDICINE may include but are not limited to pregnancy, active chemotherapy and active treatment by another provider. I will inform my treating physician if any of these conditions exist.

Certain medications or social habits are known to affect the potential results of HOLISTIC MEDICINE and these include alcohol, tobacco, steroids or narcotics. I will inform my treating physician of use of any such substances.

The undersigned understands the hazards and potential dangers involved in treatment by means of HOLISTIC MEDICINE. The nature and consequences of the above treatment have been fully explained, and the undersigned is convinced that the treatment is in the best interest of the patient, but that no guarantee of results has been made. I understand that I may withdraw this consent at any time.

I understand that it usually requires a series of treatments to significantly change my condition. I have discussed the charges and have made payment arrangements to complete this series of treatments.

NOTICE OF NON-COVERAGE: Most (if not all) insurance companies (such as Medicare, Medical Assistance, HMO's, etc.) will not cover some or all of the services that this HOLISTIC MEDICINE Program provides. As such, I understand and agree to be personally and fully responsible for payment for such non-covered services, or the non-covered portion of such services. I understand that there are Holistic Membership and Program fees for services that are not covered, and that such fees can not be submitted for reimbursement by my carrier.

RESPONSIBILITY AND RELEASE FOR PARTICIPATION IN HOLISTIC MEDICINE PROGRAM

I understand that I have certain responsibilities in participating in the HOLISTIC MEDICINE PROGRAM. These include, but are not limited to: providing a complete and honest history, following through on recommended tests and treatments, returning for follow-up visits as scheduled, abiding by the practice policies and procedures, recognizing the limits of my health insurance plan, and advising my other health care practitioners of my participation in this program.

In consideration of my being able to participate in this program, I agree to release all liability and to indemnify Michael Cheikin MD, Wyndmoor Rehabilitation Associates PC, Wyndmoor Physical Medicine Group PC, the Plymouth Meeting Center for Optimum Health LLC, and their respective affiliated companies, including the owners and operators of the facility in which these services will be provided, their officers, directors, shareholders, agents including independent contractors, employees, representatives and their successors and assigns, from and against all claims, actions, judgment, cost, expenses and demands with representatives and their successors and assigns, from and against all claims, actions, judgments, cost, expenses, and demand with respect to injury, loss, death or damage to my person or property in connection with my taking part in the above stated program. It is understood and agreed that this release is to be binding on myself, my heirs, executor, administrators and assigns.

I certify that I have read the above and understood it. Intending to be legally bound hereby, I make this agreement.

_____

Patient's (or BOTH parent/guardian's) signature Date

PLEASE ALSO REVIEW AND SIGN OTHER SIDE

WYNDMOOR REHABILITATION ASSOCIATES, P.C. ("WRA")
and
WYNDMOOR PHYSICAL MEDICINE GROUP, P.C. ("WPMG")

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 14, 2003

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.

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI is personal information about you, including demographic information that we collect from you, that may be used to identify you and relates to your past, present or future physical or mental health or condition, including treatment and payment for the provision of healthcare.

This Notice explains our legal duties and privacy practice with regard to your PHI. We are required by federal law to provide you with a copy of this Notice and to abide by the terms of this Notice. Accordingly, we will ask you to sign a statement acknowledging that we have provided you with a copy of the Notice. If you have elected to receive a copy electronically, you still have the right to obtain a paper copy upon request.

We reserve the right to change the terms of this Notice at any time. The change may be retroactive and cover PHI that we received or created prior to the revision. If we do change the Notice, a copy of the new Notice will be posted in the waiting room and on our website, if any. We will provide you with a copy of the revised Notice upon your request.

I. PATIENT RIGHTS

You have six rights as a patient of WRA and/or WPMG:

1. The right to consider and sign an authorization for a non-authorized use. The law only allows us to use or disclose your PHI in certain circumstances, as explained more fully below. If we need to make a use or disclosure that does not fall into one of those exceptions–including the disclosure of immunization records to schools or results of work physicals to employers–we will ask you to sign an authorization. If we do not have a valid authorization on file specifically authorizing the proposed use or disclosure, then we will not make that use or disclosure. You may revoke an authorization at any time in writing, but the revocation will not apply to uses or disclosures we have already made in reliance on your original authorization.

2. *The right to access your PHI.* You have a right to access and receive a copy, summary or explanation of your PHI. If you want to exercise this right, please ask one of our employees for a Request to Access Medical Records form. You will need to complete this form and submit it to us. This right does not extend to psychotherapy notes, information compiled in reasonable anticipation of legal action and confidential information relating to certain lab tests. *We have the right to deny you access, but you will be notified of* the reason for denial and be given the right to have the denial reviewed under certain circumstances.

3.*The right to request restrictions on certain uses and disclosures. You may request* restrictions of uses or disclosures of your PHI when it is used to carry out your treatment, obtain payment for your treatment or perform healthcare operations of our practice. You must request the restriction before we have used or disclosed the relevant information. *We are not required to agree to the restriction, and we have the right to decide not to accept the restriction and not to treat you.*

4. *The right to receive confidential communications. You may request that we make confidential* communications to you by an alternative means or at an alternative location. The request must be in writing, but we will not ask for an explanation from you. We will accommodate reasonable requests, but we may condition the accommodation on information as to how payment, if any, will be handled and specification of an alternative address or other method of contact.

5. *The right to amend PHI.* You have the right to ask us to amend your PHI. If you want to exercise this right, please ask one of our employees for a Request for Amendment of Medical Records form. You will need to complete this form, provide a reason for the request and submit it to us. *We have the right deny your request for amendment, if we determine that your record was not created by us, is not* maintained by us, would not be available for access, or is accurate and complete. Your records will not be changed or deleted as a result of our granting your request, but the amendment will be attached to your record and its existence noted in your record as necessary. (Note: use of this procedure is not necessary for routine changes to your demographic information, such as address, phone number, etc.)

6. *The right to receive an accounting.* You have the right to receive an accounting of our uses and disclosures of your PHI. If you want to exercise this right, please ask one of our employees for a Request for Accounting form. You will need to complete this form and submit it to us. *The accounting does not have to list* disclosures made (i) to carry out treatment, payment and healthcare operations; (ii) to you; (iii) pursuant to an authorization; (iv) for national security or intelligence purposes; (v) to correctional institutions or law enforcement personnel or (vi) that occurred prior to April 14, 2003. (Note: compliance with this right is time-consuming, and so we reserve the right to charge you a fee if you request more than one accounting in a twelve-month period.)

II. USES AND DISCLOSURES

We intend to limit the disclosure of your PHI to that necessary for Treatment, Payment and Operations:

Treatment refers to specific sharing and use of your PHI relating to your direct care by our employees, including consulting other professionals and the use of disease management programs. For example, we will disclose your PHI to another health care professional or a testing facility to whom you have been referred for care or for assistance with treatment.

Payment refers to specific sharing and use of your PHI for purposes of obtaining payment for our treatment of you, including billing and collection activities, related data processing and disclosure to consumer reporting agencies. For example, your PHI will be disclosed on

forms we submit to your insurance to receive payment.

Operations refers to specific sharing and use of your PHI necessary for our administrative and technical operations, within the limitations imposed by professional ethics. Permissible activities would include, but are not limited to, accounting or legal activities, quality assessment, employee review, student training and other business activities. For example, we might need to disclose your PHI to a medical student as part of the educational process.

We will not permit the following disclosures *without your written authorization*, and your refusal to provide such authorization will not affect our duty to treat you:

Marketing.
To your employer, except where necessary for provision of care or payment purposes (for example, if your employer is self-insured).
Disclosures outside our offices, unless for treatment, payment or operations.
For research purposes, unless certain safeguards are taken.

We may make disclosures in certain situations as required by law, even without your written authorization. These situations include, but are not limited to:

If all identifying information is removed so your identity cannot be ascertained from the information disclosed, *i.e., on a completely anonymous basis.*
When required by law, for example, public health reporting purposes or to a person who may be affected by a communicable disease.
To your employer, if we are providing care to you at your employer's request to evaluate a work-related illness or injury, or medical surveillance of your workplace.
Pursuant to a warrant or court order.
For health oversight purposes as authorized by law, for example, an investigation of our practice for purposes unrelated to your treatment.
To a public health authority as required by law, including those designated to receive notification of abuse or neglect.
To the U.S. Food and Drug Administration, in the event of an adverse event.
To law enforcement for certain purposes.
Related to a judicial or administrative proceeding, including subpoenas.
For national security and intelligence purposes, or to correctional institutions.
For purposes of worker's compensation law (or a similar law).
Regarding a decedent, including to a funeral director.
For military or veteran's activities.

III. ORGANIZATIONAL POLICIES

To facilitate the smooth and efficient operation of our practice, we engage in certain practices and policies that you should understand. You can avoid any of the following practices by discussing your concerns with us and working out an alternative:

We contact our patients by telephone (which might include leaving a message on an answering machine or voice mail) or mail to provide appointment reminders or routine test results.

We use sign-in sheets and call out names in our waiting room to manage patient flow.

Our staff will conduct routine discussions at our front desk with patients.

We may contact our patients by telephone or mail to provide information about treatment alternatives or other health-related benefits and services that may be of interest.

We may use your name and address to send you a newsletter about our practice and the services we offer.

We may disclose your PHI to a member of your family or a close friend that relates directly to that person's involvement in your healthcare.

You should also be aware of the following policies regarding our uses and disclosures of your PHI. You cannot avoid these uses and disclosures, but you should discuss any questions or concerns you might have with us:

We share PHI with third-party "business associates" that perform various functions for us (for example, billing and transcription), but we have written contracts with those entities containing terms that require the protection of your PHI.

We will disclose your PHI to your personal representative(s), if any, unless we determine in the exercise of our professional judgment that such disclosure should not be made.

IV. QUESTIONS AND COMPLAINTS

If you have any questions about this Notice, the matters discussed herein or anything else related to our privacy policy, please feel free to ask for an appointment or call 610-239-9901 to speak with our Privacy and Security Officer.

You may complain to our Privacy and Security Officer or the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. To complain to the Secretary, your complaint must be in writing, name us, describe the acts or omissions believed to be in violation of your privacy rights and be filed within 180 days of when you knew or should have known that the act or omission occurred.

You can file a complaint with us by asking for a Complaint Reporting Form. We will not retaliate against you for filing a complaint. If you want further information about the complaint process, please talk to our Privacy and Security Officer.

HIPAA FORM A

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

WYNDMOOR REHABILITATION ASSOCIATES, P.C. ("WRA")
and
WYNDMOOR PHYSICAL MEDICINE GROUP, P.C. ("WPMG")

Patient Name: _____ Date: _____

Name of Personal Representative, if applicable: _____

I hereby acknowledge that I have received a copy of Notice of Privacy Practices of WRA and WPMG.

Patient or Personal Representative Signature: _____

Note: If a copy of the Notice was provided by mail, please return this signed document at your earliest convenience in the self-addressed, stamped envelope provided.

OFFICE USE ONLY

Date of receipt of signed acknowledgment: _____

If signed acknowledgment not received, document good faith efforts used to obtain:

_____

_____

_____

Michael Cheikin MD
832 Germantown Pike, Suite 3
Plymouth Meeting, Pennsylvania 19462
610-239-9901 Fax 866-217-0158 drc@c4oh.org

Initial Adult Registration

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Patient Name:_____ **Date of Birth:** _____ **Age:** _____
Last First Middle

Address:_____

Social Security #: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W **Gender: ☐ M ☐ F**

Phones: Home: ☐ _____ Work:☐ _____ Cell: ☐ _____

Emails: Home: ☐ _____ Work/Other: ☐ _____

Preferred Contact (check ONE Phone and Email above)

Pref. Language: ☐ English ☐ Spanish ☐ Other: _____ **Smoking: ☐ Never ☐ Past ☐ Current: Packs/d:**_____

Emergency Contact Name:	Relationship
Home Phone:	Cell Phone:

Primary Insurance:	Name of Insured	Secondary Insurance:
	Relationship to Patient	
Plan Type (PPO, HMO, etc):	Insured Date of Birth	Plan Type:
	Insured Occupation	
High Deductible: ☐ N ☐ Y ☐ ?	Employer	Group #
Group #	Employer Address	ID #
ID #		Plan Name
Plan Name:	Employer Contact name/phone:	

Please provide the name, address, phone & fax # of the following providers, if applicable

Referring Person/Practitioner	**Primary Physician**	**Pharmacy**
Specialty (if applicable)	How many years under their care?:	
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:

Neurologist or Orthopedist	**Cardiologist**	**Hospital** **Physical Therapist or Chiropractor**
Phone:	Phone:	
Fax:	Fax:	

Do you have a Workman's Claim open? ☐ No ☐ Yes	If yes, Claim #
Insurance Carrier:	Contact Person:
Address:	Contact's Phone
Was patient involved in a motor vehicle accident? ☐ No ☐ Yes	If yes, Claim #:
Insurance Carrier:	
Is an attorney involved in your case? ☐ No ☐ Yes	If yes, Name:
Address	Phone

I understand that the practice of medicine is not an exact science, and that the results cannot be anticipated. I acknowledge that no guarantees have or will be made to me as the result of examination, procedures or treatment.

The undersigned authorizes the release of medical information to healthcare providers, insurance companies, and/or regulatory agencies, which may be necessary for continuity of care and completion of doctor and hospital claims.

I hereby authorize payment directly to Wyndmoor Rehabilitation Associates, PC of the physician insurance benefits otherwise payable to me for care rendered during the care provided. I understand that I am financially responsible for all charges not covered by my insurance. I agree to be assessed an interest fee of 1.5% per month for unpaid balances beginning at 30 days and a collection fee of 36% for payments past 60 days due.

I certify that I understand the contents of this form, or will ask for and receive explanation before signing below.

_____ _____

Patient Signature (or both parents/guardians if a minor) Date Witness Signature and Date

MEDICAL HISTORY PAGE 1

Michael Cheikin MD

Last Name	First Name:	Today's Date

Date of Birth:	Age	Height	Weight	Dominance: R L

How did you learn about our practice?	**LEAVE BLANK**
Please describe the problem(s) that brought you here:	
(☐ more on back)	
When did THIS episode begin?	
How did THIS episode begin?	
If recurrent or intermittent, when did the FIRST episode begin?	
What is your theory (or "internet diagnosis") of how this developed (even if strange or rejected by others)	
What are your main goal(s) in seeking our services?	
1)	
2)	
3)	
In what time frame do you wish to achieve your main goal(s)?	
What percentage improvement in your problem(s) will satisfy you?	

PAST MEDICAL HISTORY

		LEAVE BLANK
Do you have allergy to LATEX?	No Yes	
... to any MEDICATIONS? (if yes, please list on back)	No Yes	
... to any ENVIRONMENTAL AGENTS (such as pollen, if yes please list)	No Yes	
Have you seen any OTHER PRACTITIONERS in the last 5 years? (if yes, list on Medical Survey)	No Yes	
Have you had any INPATIENT SURGERY? (if yes, please note on Medical Record Survey)	No Yes	
Have you had any OUTPATIENT SURGERY? (if yes, please note on Medical Record Survey)	No Yes	
Have you had any HOSPITALIZATION(S)? (if yes, please note on Medical Record Survey)	No Yes	
Have you had any ER VISITS in the last 5 years (if yes, please note on Medical Record Survey)	No Yes	
Have you had any URGENT CARE CENTER VISITS in the last 2 years	No Yes	

Please list the MOST RECENT TESTS:	**Date**	**Reason**	LEAVE BLANK
Blood Tests in the past year			
XRay			
CAT Scan			
Colonscopy/Endoscopy			
Dexascan (Bone Density Test)			
EKG			
EMG			
Mammogram/Prostate Exam			
MRI			
Stress Test			
Other:			

Michael Cheikin MD
Holistic Medicine & Physiatry
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Medical Records Survey

2/1/2016
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Name:

Date:

	Other Practitioners	Name	Last Seen	Can Provide records?	Date Requested	Date Rec /Scanned	Date Reviewed	Results (on back)
	Holistic Doctors							
	PCP (OB/GYN)							
	Pain / Neurology							
	Orthopedics/Rheum							
	Cardiology							
	GI / ENT							
	Endocrine/ Surgeon							
	Dentist							
	Chiropractor							
	Acupuncturist/Massage							
	Nutritionist							
	Surgeries/Procedures	Description	Done	Can Provide records?	Date Requested	Date Rec /Scanned	Date Reviewed	Notes (on back)
	Conventional Studies	Description	Last Done	Can Provide records?	Date Requested	Date Rec /Scanned	Date Reviewed	Results (on back)
	Quest/LabCorp							
	XRay							
	MRI/MRA							
	CAT							
	Echo							
	EKG							
	EMG/EEG							
	Allergy Testing							
	Colonoscopy							
	Mammo/Pap							
	Sleep Study							
	Ultrasound							
	Special Studies	Description	Last Done	Can Provide records?	Date Requested	Date Rec /Scanned	Date Reviewed	Results (on back)
	Allergy IgG and/or other							
	Energy Testing Machine							
	by Kinesiology							
	Essentl Fatty Acids RBC							
	Estrogen							
	Genetic Testing (23 & Me)							
	Halide							
	Heavy Metal Test Hair							
	Heavy Metal Test Urine	P/P A:						
	Minerals Hair							
	Minerals RBC							
	Minerals Urine							
	Organic Acids							
	Porphyrins							
	Saliva							
	SpectraCell							
	Stool							
	Thermography							
	Thyroid							

PAST MEDICAL AND FAMILY HISTORY

Michael Cheikin MD

Last Name	First Name:	Today's Date

Please check if yes	You	Father	Mother	Father's Family	Mother's Family	Brothers	Sisters	Spouse	Children	LEAVE BLANK
Age(s) (if living)										
Health G=good, B=bad										
Allergies										
Alzheimer's/Dementia										
Anemia										
Arthritis (Osteo-)										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Broken Bones: Patient only, age, location:										
Cancer/Leukemia										
Colitis/Crohns/IBS										
Daily Wine/Spirits										
Dementia/Alzheimers										
Depression/Anxiety										
Diabetes										
Eczema/Psoriasis										
Epilepsy/Seizures										
Fibromyalgia/Chronic Fatigue										
Gallbladder Disease										
Heart Disease										
Hepatitis										
High Blood Pressure										
High Cholesterol										
Kidney Disease/Stones										
Liver/Gallbladder Disease										
Lupus										
Migraines/Headaches (circle which)										
Multiple Sclerosis										
Obesity										
Pain Syndrome (Neck, Back, etc)										
PolyCystic Ovarian Syndrome										
Prior Work/Auto Injury, Patient only, dates:										
Psychiatric Illness										
Raynauds										
Rheumatoid Arthritis										
Root Canals, Patient only, dates:										
Sinusitis/Ear Infections										
Stomach Ulcers/Reflux										
Street Drug Use (Pot, Cocaine, etc)										
Stroke										
Scoliosis										
Smoke (now or past)										
Suicide										
Thyroid Disease/Goiter/Graves										
Toxic Exposure										
Urinary Tract Infections										
Yeast Infection(s)										
Infections within the last five years requiring treatment (patient only,list)										
Other Important Conditions: list: (use back for more)										
Age(s) at death										
Cause(s) of Death										

PLEASE LEAVE BLANK

REVIEW OF SYMPTOMS

Name: Date:

(symptoms within the past 12 months; "in past' = > 12 months ago)		Never	In past	Mild/ Occ	Moderate /Regular	Severe/ Frequent	Please describe	PLEASE LEAVE BLANK
Const	Not feeling well							
	Weight loss							
	Weight gain							
	Low body temperature							
	Fevers							
	Fatigue							
	Night sweats							
Psych	Anxiety							
	Irritability							
	Panic							
	Depression							
Musc-Skel	Joint pain							
	Joint heat or swelling							
	Weakness							
	Muscle pains/spasms							
Neuro	Numbness							
	Tingling							
	Poor Memory/Concentration							
	Falls							
	Fainting							
	Headache							
ADL's	Difficulty with Buttons/Laces							
	Difficulty Climbing Stairs							
	Difficulty Walking							
	Difficulty Lifting							
	Difficulty Changing Position							
	Difficulty Driving							
Heme	Bruising							
	Bleeding							
	Calf Tenderness							
Eyes	Blurred vision							
	Double vision							
	"Floaters"							
	Dry Eyes							
ENT	Sore throat							
	Difficulty Swallowing							
	Dizzyness							
	TMJ							
	Dental Work							
	Silver (Amalgum) Fillings Removed							
Cardiac	Chest Pain							
	Palpitations							
	Shortness of Breath with Exertion							
	Shortness of Breath at rest							
Vasc	Swelling in Extremities							
	Calf Tenderness							
	Swollen veins							
	Cold/Hot/Red/Blue Extremities							
Resp	Cough							
	Chest Tight/ Difficult Catching Breath							
	Wheezes							
GU	Urgency to void urine							
	Difficulty voiding							
	Losing urine (cough, sneeze, etc.)							
Immun	Enlarged lymph nodes							
	Yeast/Fungal infection(s)							
	Cold sores/Herpes mouth / genitals							
	Easily get colds or sinus infection							
	Other infections (please list)							

REVIEW OF SYMPTOMS

Name:						Date:		
(symptoms within the past 12 months)		Never	In past	Mild/ Occ	Moderate /Regular	Severe/ Frequent	Please describe	**PLEASE LEAVE BLANK**
Sleep	Problems falling asleep							
	Problems staying asleep							
	Early awakening							
	Snoring							
	Restlessness							
	Not refreshed in am							
	Daytime sleepyness							
	Need/takes naps							
	Average # hours/night							
GI	Pain							
	Bad Breath							
	Burping							
	Heartburn							
	Problems Swallowing							
	Reflux/repeating (list foods)							
	Nausea/Vomiting							
	Bloating after meals							
	Gas/Flatulence							
	Constipation							
	Diarrhea							
	Hemorrhoids							
	Itchy Anus							
	Stools float/Yellow stools							
	Blood in Stools/Stools Black							
Endo	Heat/Cold Intolerance							
	Frequent thirst							
	Frequent hunger							
	Irritable/shaky when hungry							
	Frequent urination							
	Loss of height							
	Grey Hair (age first noticed)							
	Decreased libido							
Skin	Rashes							
	Dry							
	Itchy							
	Hair Loss							
	Fragile Nails							
	Yellow/thick nails							
	Other lesions							
Women	Fibrocystic breasts							
	Periods irregular/stopped							
	PMS							
	Increased hair							
	Acne							
	Hot flashes							
	Age periods started/ended							
	Days of cycle/period (i.e. 28/4)							
	# of pregnancies/miscarriages							
	Pill/Hormones (list ages)							
Men	Frequent Urination							
	Waking to Urinate							
	Erectile Dysfunction							
	Other (Pain):							
Other Strange or Recurrent Symptoms, even if dismissed by other doctors: Please describe on back of page: symptom, location in body, how often, how severe, what makes it better or worse.							☐ see back	

PLEASE LEAVE BLANK (Complete >= 10, Extended 2-9, Brief 1)

☐ Without interval change from ROS obtained (give date):	☐ All other systems negative
☐ Unable to obtain from patient due to	Signature

MEDICATIONS AND SUPPLEMENTS

M Cheikin MD

Name: Date:

List CURRENT medications and supplements you are taking on a regular or intermittent basis

Medication/ Supplement	Date Started (Approx)	Purpose	Dose and Frequency	Effectiveness	Side Effects	Leave Blank

☐ Continued on Back

List DISCONTINUED medications and supplements you have taken over the past 2 years

Medication/ Supplement	Date Started (Approx)	Date Stopped	Reason for Stopping	Side Effects	Leave Blank

☐ Continued on Back

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Treatment History:

Conventional and alternative treatments
at different periods of your life

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Name & Date:	No	Don't Know	Age 0-10	Age 11-19	Age 20-29	Age 30-39	Age 40-49	Age 50-59	Age 60-69	Age 70+	**Last 2 years**	Your Notes more on back ☐	Leave Blank more on back ☐
Rx=prescription, OTC=over the counter													
1 Antibiotics for ears	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2 Antibiotics for tonsils/phrynx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3 Antibiotics for sinuses	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4 Antibiotics for stomach or gut	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5 Antibiotics for bladder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6 Antibiotics for skin	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7 Antibiotics for mouth/gums	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8 Anti-fungal medications OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9 Anti-fungal medications Rx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10 Anti-parasite medications	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11 Sleep medications OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12 Sleep medication Rx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13 Stomach medication OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14 Stomach medication Rx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15 Bowel meds OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16 Bowel meds Rx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17 Allergy testing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18 Allergy shots	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19 Anti-histamine OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20 Anti-histamine Rx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21 Nasal steroids	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22 Topical steroid OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23 Topical steroid Rx	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24 Nasal steroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25 Inhaled steroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26 Oral steroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27 IV steroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28 Injection (excluding vaccines)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29 Asthma medication	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30 Anxiety medication	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31 Anti-depressant medication	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32 Pain medication OTC	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33 Pain meds, Rx, non-narcotic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34 Pain meds Rx, narcotic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
35 Tylenol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
36 Muscle relaxants	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
37 Other Rx (list on back)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
38 ER visits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
39 Outpatient surgery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
40 Inpatient surgery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
41 Chiropractic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
42 Psychotherapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
43 Psychiatry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
44 Dietician/Nutritionist	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
45 Massage	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
46 Acupuncture/Chinese Medicine	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
47 Ayurveda	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
48 Yoga	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
49 Homeopathy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
50 Holistic Practitioner	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
51 Energy Healer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
52 Spiritual Healer/Therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
53 Other Therapies (list on back)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
54 Supplements—self prescribed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
55 Supplements-prescribed by other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
56 Detox proctols	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
57 Elimination-challenge trials	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
58 Other: (describe on back)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Holistic Healing Readiness Survey

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Name:

Date:

Name Date	Strongly Disagree	Disagree	Neutral or Not Applicable	Agree	Strongly Agree
1) My current symptom(s) and/or problems are interfering with the quality of my life	☐	☐	☐	☐	☐
2) I am concerned about my future health and am willing to forgo some comforts and habits today to improve the quality of my life in the future	☐	☐	☐	☐	☐
3) I need to see some results within a few weeks or month to keep going with a treatment	☐	☐	☐	☐	☐
4) I believe that I can heal at least 90% without drugs or surgery	☐	☐	☐	☐	☐
5) I am seeking holistic medical care because I am trying to avoid medications, surgery, or other conventional care	☐	☐	☐	☐	☐
6) I want to take control of my health and have already read about and tried "alternative medicine"	☐	☐	☐	☐	☐
7) My holistic doctor should be able to figure out my diagnosis and find medication(s) or supplement(s) to cure my problem(s)	☐	☐	☐	☐	☐
8) I can find 30-60 minutes per day to invest in my healing	☐	☐	☐	☐	☐
9) I am able and willing to invest $150-$500 per month for 4-12 months for a holistic program if it will allow me to heal 50%	☐	☐	☐	☐	☐
10) I am able and willing to eliminate some or all of my favorite foods, alcohol, soda and caffeine from my diet for at least three months	☐	☐	☐	☐	☐
11) I am willing to trial a regimen of supplements twice a day for three to six months to test the effect on my healing	☐	☐	☐	☐	☐
12) I am willing commit to at least 8 hours of sleep per night (or stay in bed 8 hours if I have a sleep problem)	☐	☐	☐	☐	☐
13) I am willing to go to a gentle yoga or other recommended movement class once per week for three to six months to test the effect on my healing	☐	☐	☐	☐	☐
14) I am willing to try a course of acupuncture, massage or other recommended body work for one to three months to test the effect on my healing	☐	☐	☐	☐	☐
15) My family and friends will support changes that will enable me to heal	☐	☐	☐	☐	☐
16) My employer and coworker(s) will support changes, including time off, that will enable me to heal	☐	☐	☐	☐	☐
17) I am willing to read educational materials if such knowledge will enable me to heal	☐	☐	☐	☐	☐
18) I am willing to explore the relationship between my mind and body, which might require psychotherapy, journaling and/or other psycho-spiritual work	☐	☐	☐	☐	☐