Patient Name: _____

Date:_____ Allergies:_____

Name:_____ Date of Birth:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Name of Employer:_____ Profession:_____

Address:_____ City:_____ State:_____ Zip:_____

Business Phone:_____ Referred by_____

Name of Primary Care Doctor:_____ Phone:_____

QUESTIONS_____

1. Reason for Today's visit:_____

2. How long have you had this problem?_____
3. What was the approximate date of onset?_____
4. Did your symptoms begin suddenly or gradually?_____
5. What symptoms presented on onset?_____
6. Please circle if you have any of the following symptoms:
   Chronic Sore Throat , Tender neck , Muscle pain,Joint Swelling, Headaches
   Un-refreshing Sleep , Post-exertional fatigue lasting more than 24 hours
7. Do you have widespread pain/fatigue for more than 3 months? Yes or No.
8. Have you had tingling, numbness or extreme weakness in any area of your body?_____
9. How many hours do you work now, if any?_____
10. Have you had any severe infections or injury that required hospitalization?

    Year: _____ Reason:_____

    Year:_____ Reason:_____

11. Please list all current medications with dose:
    - _____
    - _____
    - _____
    - _____
    - _____

12.Please list all over-the-counter medications or supplements:

- _____
- _____
- _____
- _____

Women only:

13.Do you have a regular menses (period) or irregular menses?_____
14. Are you menopausal? Yes or No
15. Have you been on birth control pills or hormone replacement therapy? Y N

Disordered Sleep

16. Do you have trouble falling asleep/ or staying asleep? Mild or Severe circle
17.How many hours of sleep do you get? _____
18.Do your legs jump or kick at night? Yes or No.
19.Does your spouse or significant other say you snore? Yes or No.
20. Do you take medication to sleep? Yes or No. If yes, what medication_____

Infections(Viral, Bacteria, Fungal)

21.Do you have a history of tick bites associated with rashes? Yes or No.
22.Have you ever been treated for Lyme disease? Yes or No.
23. Do you get sores around your mouth, lips or genitals? Yes or No.
24. Have you taken Valtrex or any antibiotic for one month or more? Yes or No
25. Does it burn when you urinate? Yes or No.
26. Have you taken acid reflux medications for one month or more? Yes or No
27. Does your stomach get bloated within 2 hours of a meal? Yes or No.
28. Do you have chronic constipation? Yes or No. Chronic Diarrhea? Yes or No.
29. Do you have athlete's foot, jock itch, nail infections? Yes or No.
30. Do you suffer from frequent sinus infections? Yes or No.
31. Do you suffer from bad breath? Yes or No.

Nutrition

32. Are you vegetarian? Yes or No
33.Do you eat red meat? Yes or No. How often? _____
34. Do you eat fish? Yes or No. How often? _____
35.Do you drink alcohol? Yes or No. How many glasses a week? _____

36. Do you drink milk? Yes or No. Do you eat cheese? Yes or No.
37. Do you crave sugar products? Yes or No.
38. Do you crave salt products? Yes or No.
39. Do you drink regular sodas daily? Yes or No. Diet sodas? How many glasses? _____
40. Do you smoke cigarettes? Yes or No. Did you smoke in the past? How much?_____

Cardiovascular/ Health

41. Can you walk several blocks without stopping? Yes or No.
42. Can you walk up 1 or 2 flights of stairs? Yes or No. If no, why not?
    _____
43. Do you get swelling in your legs when walking too long? Yes or No.
44. Can you carry your groceries from the store? Yes or No.
45. Do you ever experience your heart racing or skipping a beat? Yes or No.
46. Do you ever experience chest pain? Yes or No.
47. Has your weight changed in the past 6 months? Yes or No. If so, is it 10 to 15 lbs more or less than before?_____

Family History

48. Please list the medical conditions of your family- if deceased please note cause and age:
    Mother_____ Father_____
    Brother_____ Sisters_____

Please list and forward prior **Radiology** and **Lab reports** to office:

- _____
- _____
- _____

Social/Stress Index

49. Do you live alone? Yes or No.
50. Do you have someone you could call nearby in an emergency? Yes or No.
51. Do you care for a young child or an elderly relative? Yes or No.

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.

Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019

165 North Village Ave., #129
Rockville Centre, NY 11570

Date:_____

PATIENT'S NAME: (Last)_____(First)_____

ADDRESS: (Home)_____

CITY & STATE:_____**ZIP CODE:**_____

SEX: ( ) **M** ( ) **F** **AGE:**_____**BIRTHDATE:**_____**SSN:**_____

PHONE: (Business)_____(Home)_____

CELL PHONE NUMBER:_____

E-MAIL ADDRESS:_____

COMPANY NAME:_____

ADDRESS:_____**OCCUPATION:**_____

CITY & STATE:_____**ZIP CODE:**_____

REASON FOR BEING HERE:_____

HAVE YOU BEEN HERE BEFORE:_____

HOW DID YOU FIND OUT ABOUT OUR PRACTICE:_____

ARE YOU ALLERGIC TO ANY MEDICATION:_____

CURRENT MEDICATION:_____

NAME OF INSURANCE CARRIER:_____

NAME OF POLICY HOLDER:_____**ID#:**_____

POLICY HOLDER'S DATE OF BIRTH:_____**SSN:**_____

ARE YOU OR YOUR SPOUSE COVERED BY ANY OTHER MEDICAL INSURANCE_____**YES**_____**NO**

IF YES, PLEASE GIVE INSURANCE CARRIER AND POLICY NUMBER:_____

_____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED:_____

_____

To the best of my knowledge, the insurance information I have provided is correct. If for any reason, my visit or medical procedure deemed necessary by my physician is denied or if my insurance is not valid, I agree to be fully responsible for the fees and services rendered to me. If I provide any wrong information or if my bill goes to collection, I will be responsible for my bill in its entirety and any collection fees.

ALSO I HAVE REVIEWED AND SEEN THE PRACTICE'S PRIVACY NOTICE

PATIENT'S OR GUARDIAN'S SIGNATURE: _____

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & WRITTEN RECEPIT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Mitchell Medical Group of NY, P.C. to use and disclose Protected Health Information (PHI) about me to carry out **Treatment, Payment and Healthcare Operations (TPO).** Mitchell Medical Group of NY, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Mitchell Medical Group of NY, P.C. reserves the right to change Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained by forwarding a written request to Mitchell Medical Group of NY, P.C., Privacy Officer at 165 N. Village Ave., #129 Rockville Center, NY 11570 or 57 West 57th Street, #601 New York, NY 10019

PLEASE CROSS OFF EACH ITEM BELOW THAT YOU DO NOT WANT TO ALLOW US TO DO! (If any one is a no, then whole number is out)!

With this consent Mitchell Medical Group of NY, P.C. may:

1) Call my home or cell phone and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results among others.
2) At any alternative location, the practice will only leave a message on my personal voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results among others. **However, at any alternative location call Mitchell Medical Group of NY will not leave a message about my medical condition or lab results with any person.**
3) May mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements.
4) May e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements and practice updates.

I have the right to request that Mitchell Medical Group of NY, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Mitchell Medical Group of NY, P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mitchell Medical Group of NY, P.C. may decline to provide treatment to me.

I have received a copy of Mitchell Medical Group of NY, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient's Legal Guardian

_____ _____

Patient's Name | Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019
Tele: 212-586-7400

165 North Village Ave., #129
Rockville Centre, NY 11570
Tele: 516-678-9600

Prescription Form

Patient Name: _____

DOB: _____

By signing this prescription form, I request and authorize the shipment of my compounded medication to office's of Mitchell Medical Group of New York, P.C..

_____
Patient Signature

_____
Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

165 N. VILLAGE AVE, #129
ROCKVILLE CENTRE, NY 11570
TELE: 516/678-9600
FAX: 516/678-9618

57 WEST 57th STREET, #601
NEW YORK, NY 10019
212/586-7400
212/586-6880

ADVANCED BENEFICIARY NOTICE

I, _____, have been made aware by the staff at Mitchell Medical Group of New York, P.C. that I may not be reimbursed for medical services rendered to me.

I fully understand that any procedure not covered by my insurance is my responsibility.

_____
Patient Name

_____
Date

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
Immunology, Alternative and Integrative Medicine

57 West 57th Street, #601
New York, NY 10019

165 North Village Ave., #129
Rockville Centre, NY 11570

DUE TO EXCESSIVE CANCELLATIONS AND

NO SHOWS, WE WILL BE REQUIRING ALL PATIENTS

TO CANCEL WITHIN

48 HOURS INSTEAD OF 24 HOURS.

IF A PATIENT CANCELS OR DOES NOT SHOW,

THEY WILL BE CHARGED FOR THEIR VISIT.

WE NEED TO BE ABLE TO ACCOMMODATE O

THER PATIENTS WHO WISH TO COME IN.

WE ARE SORRY FOR ANY INCONVENIENCE.

_____ _____

Signature of Patient or Legal Guardian Signature of Patient or Legal Guardian

_____ _____

Patient Name Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration pursuant to New York law, and not by a lawsuit or resort to court process except as New York law may provide for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
The filing by Physician of any action in any court by the Physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a New York Supreme Court justice to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed the Federal Arbitration Act (9 U.S.C. §§ 1-4), and otherwise applicable New York law. All claims and defenses related to any claim by the patient shall be governed by New York law.

The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with New York law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Physician's or Duly (Date)
Authorized Representative Signature

By _____
Print or Stamp Name of Physician,
Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Patient's Representative's Signature (Date)

_____
Print Name and Relationship to Patient

ACUERDO DE ARBITRAJE MÉDICO - PACIENTE

Artículo 1: Acuerdo de Arbitraje: Se acuerda que cualquier conflicto en lo referente a negligencia médica, esto es, en lo referente a si los servicios médicos prestados bajo este contrato eran innecesarios o no estaban autorizados o se prestaron de modo incorrecto, negligente, o incompetente, se decidirá sometiéndolo a arbitraje de conformidad con las leyes de Nueva York, y no mediante pleito ni recurriendo a procesos judiciales, excepto cuando las leyes de Nueva York establezcan una revisión judicial de los procesos de arbitraje. Al celebrar este contrato, las dos partes renuncian a su derecho constitucional a que dicho conflicto se resuelva en un tribunal ante un jurado, y en su lugar acuerdan resolverlo mediante el arbitraje.

Artículo 2: Todas las reclamaciones se resuelven mediante Arbitraje: Es voluntad de las partes que este acuerdo cubra todas las reclamaciones o controversias, ya sea que estén expresadas mediante contrato, extracontractualmente o de otra manera, y se consideran vinculantes todas las partes cuyas reclamaciones surjan producto de o de cualquier manera relacionadas con el tratamiento o los servicios prestados o no prestados por el médico, grupo o asociación médica, sus socios, colegas, asociaciones, empresas, sociedades, empleados, representantes, clínicas, y/o proveedores identificados abajo (en adelante referidos en forma conjunta como "Médico") a un paciente, incluidos cualquier cónyuge o herederos del paciente o sus hijos, ya sean nacidos o nonatos, al momento del incidente que da origen a la reclamación. En el caso de cualquier mujer embarazada, el término "paciente" en adelante se referirá tanto a la madre como al/los hijo(s) que espera. Interponer una demanda por el Médico ante cualquier tribunal, para cobrar honorarios al paciente, no anula el derecho al arbitraje obligatorio por cualquier reclamación que surja por cualquier negligencia médica. Sin embargo, luego de la afirmación de cualquier reclamación contra el Médico, cualquier conflicto por honorarios, sea objeto de un proceso ante el tribunal, será resuelto mediante arbitraje.

Artículo 3: Procedimientos y Ley Aplicable: Una petición de arbitraje se debe comunicar por escrito por correo ordinario, porte pagado, a todas las partes, describiendo la reclamación contra el Médico, la cuantía de los daños y perjuicios, y los nombres, direcciones y números de teléfono del paciente, y (si aplica) de su abogado. Las partes, en adelante, podrán elegir un árbitro de equidad quien anteriormente fungía como juez de la Corte Suprema de Nueva York, para presidir este asunto. Las dos partes tienen el derecho incuestionable de arbitrar por separado los asuntos de responsabilidad y daños y perjuicios previa solicitud por escrito al árbitro. El paciente deberá reivindicar sus reclamaciones con diligencia razonable y el arbitraje se regirá por la Ley Federal de Arbitraje (9 U.S.C. §§ 1-4), y demás leyes aplicables de Nueva York. Todas las reclamaciones y defensas relacionadas con cualquier reclamación interpuesta por el paciente se regirán por las leyes del estado de Nueva York.

Las partes correrán con sus propios costos, honorarios y gastos, además de la parte proporcional de los honorarios y gastos del árbitro de equidad.

Artículo 4: Efecto Retroactivo: Es intención del paciente que este acuerdo cubra todos los servicios prestados por el Médico, no sólo posteriores a la fecha en que se firma (incluyendo, entre otros, tratamientos de urgencia), sino anteriores a dicha fecha también.

Artículo 5: Revocación: Este acuerdo puede ser revocado mediante notificación por escrito entregada al Médico dentro de los 30 días posteriores a la firma y en caso de no ser revocado regirá para todos los servicios médicos recibidos por el paciente.

Artículo 6: Cláusula de Divisibilidad: En caso de que alguna cláusula o cláusulas de este Acuerdo se declare nula y/o que no se pueda cumplir, tal(es) cláusula(s) se considerarán separadas del mismo y las cláusulas restantes del Acuerdo se harán cumplir de conformidad con las leyes de Nueva York.

Entiendo que tengo derecho a recibir una copia de este acuerdo. Mediante mi firma, reconozco que he recibido una copia.

AVISO: AL FIRMAR ESTE CONTRATO USTED ACUERDA QUE CUALQUIER ASUNTO DE NEGLIGENCIA MÉDICA SEA RESUELTO POR UN ¡RBI TRO DE EQUIDAD Y RENUNCIA A SU DERECHO A UN JUICIO ANTE UN JURADO O TRIBUNAL. VER ARTÕCULO 1 DE ESTE CONTRATO.

Por: _____
Firma del Médico o Representante (Fecha)
debidamente autorizado

Por: _____
Nombre del Médico, Grupo o Asociación Médica
en letra de molde o sello

Por: _____
Firma del Representante del Paciente (Fecha)

_____
Relación con el Paciente, en letra de molde

Por: _____
Firma del Paciente (Fecha)

_____
Nombre del Paciente en letra de molde

Por: _____
Firma del Traductor (si aplica) (Fecha)

_____
Nombre del traductor, en letra de molde

MITCHELL MEDICAL GROUP OF NEW YORK, P.C.
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Tele: 212/397-0157
Fax: 212/586-6880

165 North Village Ave, #129
Rockville Centre, NY 11570
Tele:516/678-9600
Fax:516/678-9618

Dear Patient:

Our office is an out-of-network facility, which is willing to accept assignment on your claims for services rendered. At every visit or when extracts are received, you are responsible for making co-insurance payments.

If the insurance company issues you a payment, you are then responsible for forwarding the insurance check to the practice within two weeks (14 days).

I authorize payment for services rendered on the below credit card, if I fail to turn over insurance checks to the provider within 21 days of that date of service or if for any reason, my visit or medical procedure deemed necessary by my physician is denied or if my insurance is not valid, I agree to be fully responsible for the fees and services rendered to me. If I provide any wrong information or if my bill goes to collection, I will be responsible for my bill in its entirety and any collection fees.

If there are any concerns or question, please feel free to contact the office.

Patient Credit Card Number _____ Exp. _____

CVV (Security Code – on back on MC/Visa or front of Amex): _____

Name of Card Holder: _____ Date: _____

Signature: _____