



## AppleTree Medical, Wellness & Aesthetics Center

Welcome to AppleTree Medical, Wellness & Aesthetics Center.

Please review all the pages, fill completely and BRING them all at your visit. Please also bring ALL your medications (including prescription and non prescription drugs) at each visit. Several patients are consulting more than one physician and change medication frequently. We ask you to bring your bottles to check if you need refills and to make sure that you are not taking medication that you should not take.

We are often asked why you need to provide your social security number. Simply because until the government (will it ever happen?) develop a Personal Identification Number (UPIN) to identify you, your social security number is the only way to find you in the hospitals and everywhere when we ask records. Name and birth dates are not useful.

### Instructions:

- 1- First page, welcome and time/date of appointment. For you to review and keep.
- 2- Patient Profile. Please fill all and don't forget to bring your driver's license (it happened in the past that the person using the insurance card was not the patient) and your insurance cards. Bring to the office
- 3- Financial Policy. Read it all please and sign, date and bring at the visit.
- 4- Notice. This it just to let you know that you need to know what your insurance provider covers for services. It is impossible for me to know because even if you are all Blue Cross (for example), well your plan may vary because YOUR EMPLOYER decides of your benefits. You are responsible of knowing your benefits. Keep in your records
- 4- Consent and disclosure (HIPAA). This it the form that protects your information. You are asked to provide a name for "notification of Family Member". Remember that if you leave it blank, we will not be able to give ANY information to anyone if you have an accident and you cannot talk. We could not call your family members. SO, you can put someone but restrict the information to be provided on the line below.  
I do clinical research and my staff may call you to ask if you are interested from time to time. If you are not, simply let us know. Bring at the visit (we will update yearly)
- 5- Medical release. Please give us the name and phone number if possible of your previous primary care physician, or specialists. Any physician that you think I should get the information from. The more I know about you, the better I can help you. Do copies for each specialist/PCP and bring all at the visit.
- 6- Medical History and Review of systems: Fill as much as possible. We will update yearly. Bring at the visit
- 7- Signatures: Please sign only the sections that apply to you. Bring at the visit.

THANK YOU  
Christine Laramée MD CPI



## AppleTree Medical, Wellness & Aesthetics Center

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

(Last) (First) (MI)

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security\*\*\*: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Marital Status: (Circle One) Single-Married-Divorced-Widowed-Other /Spouse/Guardian: \_\_\_\_\_

Local Mailing Address: \_\_\_\_\_

(Street/Apt) (City) (State) (Zip)

Alternative Mailing Address: \_\_\_\_\_

(Street/Apt) (City) (State) (Zip)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cell: \_\_\_\_\_

e-Mail: \_\_\_\_\_ *Please circle how you preferred being reached in the future*

Emergency Contacts:

Name	Relationship	Phone
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Name	Relationship	Phone
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WHO REFERRED YOU TO OUR CLINIC? \_\_\_\_\_

**PATIENT EMPLOYMENT:**  Employed  Retired  Self Employed  Other

**EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**PRIMARY INSURANCE:**

Policy Holder:  Same as patient  Other – Complete Below if Different from Patient

Name of Insured: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Employer: \_\_\_\_\_

**INSURANCE NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**GROUP # / NAME:** \_\_\_\_\_ **CERTIFICATE / ID #:** \_\_\_\_\_

**SECONDARY INSURANCE:** Policy Holder:  Same as patient  Same as above  Other

**INSURANCE NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**GROUP # / NAME:** \_\_\_\_\_ **CERTIFICATE / ID #:** \_\_\_\_\_

**TERTIARY INSURANCE (3<sup>RD</sup> Payer):** YES / NO

\*\* A COPY OF ALL INSURANCE CARDS AND DRIVER'S LICENCE WILL BE TAKEN YEARLY.

\*\*\* We understand that several of you (including us) are concerned about identity theft and giving your social security number. Unfortunately, as of today, there is often no other way of identifying patients within the systems (hospital records, insurance companies).



## AppleTree Medical, Wellness & Aesthetics Center Financial Policy

AppleTree Medical is a professional business providing health-related diagnostic and therapeutic services to its patients with the expectation of making the profit needed to financially support its employees, to pay its necessary expenses and to develop future new services. A professional relationship requires honest financial accountability. This document states the policy by which AppleTree Medical will hold itself and its patients accountable.

### **Charges for Professional Services:**

Every professional service and associated expense rendered will be charged to the patient according to a fee schedule prospectively determined by the practice. Contractual discounts to third parties prospectively agreed to by the practice will be honored in good faith. No fee or charge can be reduced or waived without the permission of only Christine Laramée. An estimate of these fees can be requested prospectively. A statement of charges will be given to the patient on the day of service. Monthly statements of payment transactions and the total amount owed will be sent until the debt is totally satisfied.

### **Payment:**

Payment for services rendered is due on the date of service and is part of the professional relationship. AppleTree Medical reserves the right to request payment of the total negotiated fee on the date due unless directed otherwise by contract. Cash, check, money order and credit cards (Visa and MasterCard) will be acceptable methods of payment. All co-payments and deductible will be collected at the time of service. Unless insured patients can provide documentation that the deductible has been met, then payment for services will be based on the deductible having not been met. Unless insured patients can provide documentation of the co-payment amount, then 20% of the fee will be due at the time of service. Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient noncompliance with this financial policy. Only Christine Laramée can amend this policy.

### **Insurance:**

Health insurance is primarily a contract between the patient and the insurance company; however AppleTree Medical also has mutually agreed contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. AppleTree Medical will make available substantial resources to facilitate insurance payment and will dedicate its resources toward its own contractual obligations with these entities.



## **AppleTree Medical, Wellness & Aesthetics Center**

### **Credit:**

Credit will be extended for 60 days to patients with valid insurance policies applicable to the charges for services after fulfillment of appropriate deductibles and co-payments. After 60 days, this credit will be revoked and all payments will be immediately due.

### **Collection:**

AppleTree Medical will use all reasonable means to collect owed funds. Defaults in payments of agreed amounts will be automatically referred our collection agency and a note will be inserted on your credit history.

### **Responsibilities of the patient:**

The patient is ultimately responsible to make sure that the insurance company has been contacted for necessary pre-certification needed for insurance payment prior to the office visit or with a specialist visit. A telephone number on the back of the insurance card can usually be used to obtain this information. The patient is responsible of notifying AppleTree Medical of the date and name of the specialist to see. At each visit, the patient will provide a current mailing address and telephone number as well as current third-party information necessary for billing purposes. This information must be given primarily to the check-in employee. The staff will need to know the identity of the insurance company to make proper referrals under the managed care contract. The patient is to contact his or her insurance company if payment is not made within 45 days. The patient is to immediately make total payment when the debt is due. The patient is to discuss extenuating circumstances with the Clinic.

### **Responsibilities of AppleTree Medical**

The Clinic will provide an accurate statement of charges on the day of office service. The practice will make a best effort to obtain necessary pre-certification for requested procedures required by contracted third parties to facilitate approval for payment. Failure to obtain pre-certifications or approval from the insurance company does not necessarily mean that the requested procedure is not medically necessary; in this circumstance, the patient may be financially responsible for services ordered or rendered. The clinic will file and appropriate claim to the appropriate entity. The clinic will uniformly and fairly enforce this policy and procedure upon all patients.

**I attest that I have read this financial policy and procedure and have been given an opportunity to ask questions. I accept this policy and procedure and will comply with it as part of my professional relationship with the Clinic.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_



## AppleTree Medical, Wellness & Aesthetics Center Consent for Treatment

I understand that as part of my healthcare, AppleTree Medical originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment - A means of communication among the many health professionals who contribute to my care - A source of information for applying my diagnosis and surgical information to my bill - A means by which a third party payer can verify that services billed were actually provided - And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

**Notification of Family Members:** Please share information with (If left blank, we will not contact anyone even in case of an emergency):

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I request the following restrictions to the use or disclosure of my health information:

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**Messages Or Appointment Reminders:**

May we leave a message at your **home** using doctor's/ practice name: Yes { } No { }

May we leave a message at your **work** using doctor's / practice name: Yes{ } No { }



## AppleTree Medical, Wellness & Aesthetics Center Consent for Treatment-*con't*

### COMMISSION

I may recommend you to use, as part of my treatment program, on or more nutritional supplements. I recommend the supplements because I believe your health will benefit from your use of them. I want you to know that, because of my belief in the integrity and effectiveness of these supplements, that I am a distributor of these products and, in that role, I may receive commission from your purchase of these supplements. These products are available outside of my practice if you wish to purchase them elsewhere, for your convenience, I have allowed them to be sold here in my practice to make it easier for you to implement the overall health program I see fit for you. Please speak with me if you have any concerns about my recommendation in light of this information.

### CLINICAL RESEARCH

Our practice may use and disclose your PHI for research purposes in certain limited circumstances, such as review of records for study recruitment purposes. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI. By signing this form, you are authorizing Dr Laramée and her support ting research staff to review your medical records.

\_\_\_\_\_  
Signature of Patient or Legal Representative    SS number    Date

\_\_\_\_\_  
Witness Signature



## AppleTree Medical, Wellness & Aesthetics Center Medical History

**PLEASE HELP US HELPING YOU: FILL THE FOLLOWING HISTORY AS COMPLETELY AS POSSIBLE.**

### ALLERGIES

- a) medication(s)  No  Yes, what drug(s) and reaction(s):
- b) food(s):  No  Yes, what food(s) and reaction(s):
- c) Environment (pollens etc.)  No  Yes, what allergen(s) and reaction(s):
- d) animal(s):  No  Yes, what animal(s) and reaction(s):
- e) other(s):  No  Yes, what allergen(s) and reaction(s):

### IMMUNIZATIONS

Fill this table if you are MORE THAN 18 years old.

Vaccine	1 (date)	2 (date)	3 (date)
Last Flu shot			
Pneumovax			
Tuberculosis test			
Varicella			
Hepatitis A			
Meningococcal			
dT (booster or initial)			
Hepatitis B			
HPV			
MMR			
Shingles			

Fill this table if you are LESS THAN 18 years old.

<b>Vaccine</b>	1 (date)	2 (date)	3 (date)	4 (date)	5 (date)
<b>DTaP/dT</b>					
Hib					
Tdap					
IPV (Polio)					
MMR					
Hep B					
Varicella					
Pneumococcal					
Influenza					
Hepatitis A					
Meningoccal					



## AppleTree Medical, Wellness & Aesthetics Center

### FAMILY HISTORY

RELATIONSHIP	YEAR OF BIRTH	ALIVE	DECEASED	
		Any illnesses?	Cause of death	Age of death
<b>Father</b>				
Mother				
Brother				
Brother				
Sister				
Sister				
Son				
Son				
Daughter				
Daughter				

### MEDICAL HISTORY

ILLNESS	DATE	ILLNESS	DATE
Anemia, what type?		Hernia back (neck, lumbar, thoracic)	
Allergic rhinitis		Hernia groin (which side)	
Asthma		High blood pressure	
Blood clots legs or arms		Irritable bowel disease (IBS)	
Bronchitis, chronic		Kidney stones	
Heart Failure		Migraines	
Depression		Osteoporosis	
Cataracts		Pneumonia	
Cancer (what kind?)		Polyyps Colon	
Bleeding problems		Prostate enlargement (BPH)	
Heart murmur taking SBE prophylaxis		Psoriasis	
Heart Attack		Pulmonary Embolism	
Cholesterol problems		Rheumatic fever	
Hepatitis A, B or C (which?)		Rhumatoid Arthritis	
Heart Disease (blockage)		Sexually transmitted disease	
Diabetes		Stroke (paralysis more than 24 h)	
GERD (Gastro-esophageal reflux)		Thyroid problems (hyper/hypo?)	
Diverticulosis/Diverticulitis		TIA (paralysis less than 24 h)	
Glaucoma		Tuberculosis	
Emphysema		Ulcers stomach (bleeding?)	

Do you have any other unlisted illness?  No  Yes please list:

\_\_\_\_\_

Did you have blood transfusions in your life?  No  Yes, when and reason:

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## AppleTree Medical, Wellness & Aesthetics Center

SURGERY	DATE	SURGERY	DATE
Appendectomy		Lumpectomy breast (cancer or no)	
Arthroscopy (which joint)		Mastectomy (what side)	
Breast augmentation/reduction		Ovary only (what side)	
C-section		Prostatectomy total (cancer)	
CABG/Heart bypasses		Prostate reduction (TURP)	
Carotid surgery		PTCA (angioplasty, where)	
Cataracts		Replacement knee	
Cholecystectomy (Gallbladder)		Replacement hip	
Dilatation&Curettage (D&C)		Stones kidney	
Hemorrhoids		Thyroid	
Hernia		Tonsillectomy	
Hysterectomy (uterus)		Tubal ligation	
Hysterectomy/ovaries(total)		Vasectomy	

Did you have any other unlisted surgery(ies)?  No  Yes, please list:

\_\_\_\_\_

<b>SOCIAL HISTORY</b>
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**A) Housing :**

- a. Who are you living with?  Self  Spouse only  Spouse & Children  Parents  
 Significant other  Sibling  Friend/Roommate  Other

**B) Habits:**

- a. Special diet \_\_\_\_\_
- b. Exercise (type, frequency/week, duration) :  
 \_\_\_\_\_
- c. Tobacco use (type, how much, how many years): \_\_\_\_\_
- d. Alcohol use (type, how much, how frequently):  
 \_\_\_\_\_
- e. Illicit drugs (type, how frequently, how many years): \_\_\_\_\_

**C) Education:**

- a. What is your most recent occupation?  
 \_\_\_\_\_
- b. What is your highest level of education:  High School  College  Post-graduate

**D) Sexual behavior:**

- a. What is your sexual preference  Heterosexual  Homosexual  Bi-sexual
- b. How many sexual partners did you have in your life (estimate) \_\_\_\_\_
- c. What is your primary mean of contraception? \_\_\_\_\_

**E) Advanced Directives (Please bring us a copy for your file)**

- a. Do you have a living will  Yes (please make sure to provide us with a copy)  No
- b. Do you have a Surrogate of Health Care Affairs?  Yes  No
- c. Do you have DO NOT Resuscitate (DNR) Orders (Yellow form) ?  Yes  No
- d. Do you have a Contribution of Organs (Donation on your driver's license)  Yes  No





## AppleTree Medical, Wellness & Aesthetics Center

### REVIEW OF SYSTEMS

The Review of systems is made to help us understanding all the symptoms that you suffer of today or Daily. For us, your symptoms may be an added clue to your actual problem(s). You may have repeated symptoms in a different system. For us, it would mean something different and it is not a mistake. Please circle the pertinent symptoms.

**General/Constitutional:** Chronic Fatigue, Fever, Night Sweats, Unexplained Weight Loss and Unexplained weight gain.

**Skin:** Lumps skin (new), Excessive dryness, Excessive Sweating, Hair Loss, Nail Changes, Itching of the skin, Rash, Skin Color Changes and Skin tear/open wound.

**Head Ears Eyes Nose & Throat:** Headache, Head Injury, Glasses/contacts/LASIK, Color Blindness, double vision, Eye(s) watering/excessive tearing, Eye(s) pain/burning, Eye Redness, Eye(s) Discharge, Visual disturbance/blurred vision, Visual Loss, Impression of a sudden shade in front of ONE eye, Last visual exam: \_\_\_\_\_ and name of the ophthalmologist \_\_\_\_\_  
Deafness, Decreased Hearing, Ear Discharge, Earache, "buzzing" in the ears, Vertigo, Nasal discharge, Nasal Congestion, Post nasal drip, Sneezing regularly, Nose bleeding, Sinus Pain, Loss of smell, Loss of taste, Soreness lips/gums/mouth/gums, Bleeding lips/gums/mouth/tongue, Dentures, Dry mouth, Toothache, Mouth (oral) ulcers, Regular sore throat and Voice Changes.

**Neck:** Neck Mass, Neck Pain, Neck Stiffness and Swollen Glands.

**Respiratory:** Cough for less than one month, Cough for more than one month, Shortness of breath, Coughing of blood, Sputum Production, Wheezing, Pain with deep breathing, Professional exposure.

**Breast/chest:** Breast Mass, Breast Pain, Enlarged breasts (men), Nipple Discharge, Nipple Pain and Skin Changes. Chest deformity.

**Cardiovascular and extremities:** Chest pain at rest, Chest pain with exertion, Palpitations, Shortness of breath with laying down, Sudden awakening by shortness of breath during the night, Shortness of breath on exertion, Syncope (sudden passing out without warning), Lower extremity swelling at the end of the day (bilateral), Lower extremity edema in the morning (bilateral), Lower extremity edema (unilateral), Leg pain/cramps at rest, Pain in the calves when walking for a few blocks or less, Varicose veins, Leg(s) cramps at night.

**Gastrointestinal:** Loss of appetite, Weight gain, Weight loss, Pain with swallowing (solids/liquids/both), Difficulty with swallowing (solids, liquids, both), Regurgitation of digested/undigested food, Heartburn, Nausea, Vomiting, Vomiting of blood, Abdominal Pain, Recent change of bowel habits, Constipation, Diarrhea, Food Intolerance, Jaundice, Rectal Bleeding, Unexplained black stools, Very pale (white) stools Rectal pain with defecation.



## AppleTree Medical, Wellness & Aesthetics Center

**Female Genitourinary (Women only) :** Difficulty urinating, Burning with urination, Change of urinary stream, Frequency, Blood in the urine, Flank pain, Urge incontinence, Stress incontinence, Awaken at night by the need to urinate, Urethral discharge, Urine retention, Complete absence of periods for more than 6 months (non post-menopausal), Irregular cycles, Vaginal discharge, Vaginal itching, Pain with menstrual periods, Heavy periods, Vaginal bleeding between periods, Pelvic pain, Pain with intercourse, Change of libido, Hot flashes, Night sweats and Vaginal dryness.

**Male Genitourinary (Men only) :** Awaken at night with the need to urinate, Retention, Urinary frequency, Hesitancy, Urgency, Change in Urinary Stream, Difficulty with urination, Painful urination, Flank Pain, Blood in the urine, Impotence, Incontinence, Penile Lesions, Penis discharge, Testicular Mass, Swelling/pain of the scrotum and Change of libido.

**Musculoskeletal:** Low back pain/stiffness, Joint stiffness less than 30 min. in am, Joint stiffness more than 30 min. in am, Joint pain, Joint redness, Joint swelling, Muscle weakness, Muscles aches more than usual, Bone pain, Numbness of the arm or leg, Weakness or the arm or leg, Decreased Range of Motion and Muscle Cramps.

**Neurological:** Dizziness, Difficulty with speech, Change of sensations of a part of the body, Paralysis, Headaches, Lack of coordination, Gait disturbance, Memory impairment, Seizures and Tremor.

**Psychiatric:** Anxiety, Irritability, Sleeping disturbance, Change of interest in daily activities, Change of appetite, Guilt feelings, Lack of energy, Inability to Concentrate, Excessive worry, Suicidal Ideation and Suicidal Planning.

**Endocrine:** Unusual intolerance to heat, unusual intolerance to cold, unusual thirst, unusual hunger, Excessive fatigue and Excessive nervousness.

**Hematology:** Easy Bruising, Enlarged Lymph Nodes, Frequent infections, Spontaneous Bleeding, Skin/eyes/nose/ears itching , Allergy shots and Seasonal sneezing.

***\*THANK YOU VERY MUCH FOR TAKING THE TIME TO REVIEW YOU HEALTH HISTORY. FROM NOW ON, IT WILL BE KEPT IN YOUR ELECTRONIC MEDICAL RECORD AND WE WILL UPDATE IT TOGETHER ONCE PER YER.***

***\*THE MORE YOUR PHYSICIAN AND HER ASSISTANT KNOW ABOUT YOU, THE BETTER THEY CAN HELP YOU.***

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