Integrative Family Medicine of CT
1435 Bedford Street, Suite 1R
Stamford, CT 06905
(203) 832-6992

General Patient Information

Today's Date: ____/_____/_____

Patient Name: _____

Gender: ❑ M ❑ F ❑ Unspecified **Date of Birth:** ____/____/_____ **Age**: _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Alternate Phone: _____ ❑ Home ❑ Mobile ❑ Work

Email address*: _____

**Email addresses are used for appointment reminders and to provide information requested by the patient. Our office may also send occasional correspondence. We will never sell email addresses or share them with any third parties.*

Relationship Status: ❑ Single ❑ Married ❑ Partnership ❑ Separated ❑ Divorced ❑ Widow(er)

Live With: ❑ Self ❑ Roommates ❑ Spouse ❑ Partner ❑ Other _____

Occupation: _____ **Hours per week:** _____

Emergency Information

Parent/Guardian Name (if patient under 18): _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ ❑ Home ❑ Mobile ❑ Work

Relationship to Patient: ❑ Parent ❑ Sibling ❑ Spouse ❑ Partner ❑ Other_____

Primary Care Physician: _____ **Phone**:_____

Insurance Information

Please provide your insurance card for our office to scan upon check-in.

Name of Health Insurance Provider: _____

Name of Policy Holder: _____ **Date of Birth**: ____/____/_____

General Health Information

List (in order of importance) the major health concerns/what you wish us to address:

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications (including prescription and over-the-counter medications):

_____

_____

_____

Current Supplements (including herbs, homeopathy, vitamins and other supplements):

_____

_____

_____

Any major illnesses, injuries, operations, hospitalizations:

_____

_____

Any known allergies (medications, foods, environmental):

_____

_____

What do you drink during the day and how much? (coffee, tea, soda, water, juice, etc.):

_____

_____

Do you exercise, if so what type(s) and how long?

_____

_____

General Health Information

Current weight: _____lbs. **Ideal weight**: _____lbs. **Height**: _____

How long do you sleep each night? _____

General energy level (circle one, 1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

Do you experience fatigue? ❑ Yes ❑ No If so, when? _____

General stress level (circle one, 1=low, 10=high): 1 2 3 4 5 6 7 8 9 10

We look forward to serving you on your journey to optimal health!

Integrative Family Medicine of Connecticut
TREATMENT CONSENT FORM

PLEASE READ THIS CAREFULLY
Your signature is required to commence treatment.

The goal of Naturopathic Medicine is to **discover the cause** of the imbalances disrupting your health, and to **stimulate your body to heal itself**. Please read the following pages carefully to ensure that you understand the holistic processes used by our office. The Naturopathic Physicians serving you, Dr. Minna Kim ND and/or Dr. Sylvia Cimoch ND, will be represented as "IFMCT" in the paragraphs below.

Ultimately, your return to health and balance will be the result of **your commitment and dedication**. Your choices about diet and physical activity, your commitment to a naturopathic regimen of nutritional and/or herbal supplements, and your consistency in follow-up appointments has a huge impact on your success.

Complicated problems usually do not go away overnight. Even an apparently simple problem may have been brewing for months or years, and may have a complex cause. While some people do see improvement quickly, we cannot promise results.

Diagnosis precedes treatment. While information from other doctors or practitioners will be taken into account, we are most interested in knowing your symptoms – your own subjective experience of what is wrong – and objective signs of illness. What other doctors said, how other doctors have treated your illness, and your own diagnosis or treatment of your condition are of less importance. **Your signs and symptoms are the most important information about your state of health.**

Naturopathic treatment from our physicians involves some combination of the following:

1) **Comprehensive assessment** of health, using time-tested clinical methods and accepted laboratory measurements;
2) **Dietary analysis and recommendations**;
3) **Lifestyle analysis** for health risks;
4) Analysis and/or recommendation of **nutritional supplementation**;
5) **Physical Medicine**, including deep tissue massage, trigger point therapy;
6) Prescription of a **homeopathic remedy and/or flower essence**, or a series thereof, for your unique individual pattern;
7) **Herbal preparations** as indicated for infection, pain or disease process based on the individual;
8) **Acupuncture and other oriental medical modalities**, including but not limited to cupping, moxibustion, electrical stimulation and Chinese herbal formulas.

All medical interventions carry some degree of risk. In general, natural interventions carry far less risks of side effects than do surgery and conventional pharmaceutical treatments. However, anyone can develop an allergy at any time and certain natural substances may not agree with a given person. As a point of comparison, aspirin and other non-steroidal anti-inflammatories cause tens of thousands of cases of serious illness, kidney and liver disease, and death each year even though they are among the safest drugs. Natural therapies and medicines are safe, gentle, and effective, but even benign substances can cause reactions.

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Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases of dysfunction of the body. Acupuncture is a safe method of treatment, but occasionally there may be some bruising, tingling or other skin reactions near the needling sites that last a few hours to days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances of spontaneous miscarriage and pnuemothorax. There may be some bruising after cupping. By signing this form you acknowledge that you do not expect IFMCT to be able to anticipate all risks and complications from any provided treatment methods or therapies. You acknowledge that you wish to rely on IFMCT to exercise judgment during the course of the procedure which we determine at the time, based on the facts then known, is in your best interest.

We never recommend that you discontinue prescribed medication unless you have first consulted with the physician who prescribed it. If you choose to discontinue your medication without first consulting that physician, you acknowledge by signing this form that the doctors of IFMCT have not and do not advocate such action, and that you assume full responsibility and liability for any and all occurrences that may result from such action.

Supplements, herbal tinctures, homeopathic remedies and/or other recommended products are to be taken as described in your treatment plan. Do not take these long-term unless specified, and check in with your physician regularly regarding changes or updates to your recommended protocol.

Following your signature below you will be asked to read two additional pages and sign acknowledgment. The information provided will advise you regarding our office policies and procedures.

By signing below, you are signifying that you have read and understood all conditions above, and that you are undertaking holistic medical treatment of your own free will, with full knowledge of, and taking full responsibility for, whatever risks and benefits may result from proceeding.

Print Patient Name: _____

Patient (or Parent/Guardian) Signature: _____

Date: _____

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PLEASE READ THIS CAREFULLY
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Please read the following pages carefully to ensure that you understand the policies and procedures associated with your visit. The Naturopathic Physicians serving you, Dr. Minna Kim ND and/or Dr. Sylvia Cimoch ND, will be represented as “IFMCT” in the paragraphs below.

IFMCT is contracted with Aetna, Anthem, Cigna, Connecticare, and United Healthcare-Oxford CT. Please note that **the only Oxford plans accepted are those issued in the state of Connecticut**. If you have current coverage with one of these plans, and you provide all information and referrals required for insurance billing, our office will submit the claim on your behalf. You will be held responsible for any amount due specified by your insurance such as copay, coinsurance and/or deductibles.

Even if your insurance is included on our contracted list **we recommend calling your insurance provider in advance to confirm coverage and benefits** as all medical plans may have limitations or exclusions. Our office does NOT pre-authorize eligibility and cannot be held responsible for determining your plan's coverage; it is your responsibility to do so prior to your appointment. **In the event that your insurance is billed by our office and your visit is not covered you will be accountable for the full balance.** Additional non-covered expenses may include herbs/supplements and laboratory tests which may be recommended per your treatment plan.

Oxford patients, when you call your insurance provider please ask the representative if an office visit with a naturopathic physician will be covered, specifically code 99214. If it is not, your visits will instead qualify for Oxford CAM discounted pricing. Claims for your visits will not be submitted to insurance and you will be responsible for payment in full at the time of your appointment. Please speak with a member of our office staff for more details.

We do not participate with, or submit claims to, Medicare. If this is your primary insurance you will be responsible for paying in full at the time of your appointment, however we can issue a claim form or itemized receipt that you may submit for potential reimbursement.

Phone consults are billed with the same pricing and procedure as standard naturopathic office visits. A phone consult with our physicians is treated with the same level of time and attention as an in-office visit. Therefore your standard pricing rate (copay, coinsurance, deductible or self-pay price) will apply.

We do our best to submit all claims in a timely manner. However, **we are not responsible for the time it takes for insurance to receive, process and return claim information.** If you would like to check the status of a claim, please reach out to your insurance directly. Our office will contact you regarding any issues (eg. coverage rejection, balance due or refund owed) 7-10 business days after EOB receipt.

In the event that you are to receive a refund, our office will first apply the credit due to any open balance on your account. Any remaining credit will be issued in the same way payment was initially collected, however cash payments will be refunded via check.

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Our electronic system will automatically send email reminders 72 and 24 hours prior to your appointment. However, these are courtesy reminders only and it is your responsibility to make note of your appointment at the time of scheduling. Please do not rely on these emails.

We make every effort to serve you courteously and efficiently. **We ask that in the event you cannot make it to an appointment you give us a minimum of 24 hours notice.** Cancellations without 24 hour notice that are not the result of an emergency or unavoidable circumstances are subject to a standard fee of $50. Your courtesy allows us to accommodate the maximum number of people who would like to take advantage of holistic medicine.

Some of our patients are sensitive to environmental pollutants such as perfumes and hair sprays; please refrain from wearing these, or other scented products, to your appointment.

Children must be supervised and remain in the waiting room area only. Please do not allow children to enter other areas of the office or open closed doors. Office staff are not responsible for your children and are not available to supervise them during your treatment time. There are books and toys available in the waiting room that children may use or take with them into the treatment room with you.

By signing below, you are signifying that you have read and understood all conditions above, and that you agree to abide by all policies and procedures specified in this document.

We look forward to serving you on your journey to optimal health!

Print Patient Name: _____

Patient (or Parent/Guardian) Signature: _____

Date: _____