"The Accordion Reserve©"

Enlightened Medicine™

GROWN-UPS & KIDS PRIMARY CARE

Alan R. Vinitsky, M.D.

DIPLOMATE OF THE AMERICAN BOARD OF INTERNAL MEDICINE
DIPLOMATE OF THE AMERICAN BOARD OF PEDIATRICS

Welcome to the office of Dr. Alan R. Vinitsky
OFFICE POLICIES

It is our goal to treat you with respect and understanding in the most professional way possible. We have outlined our financial policy below so as to present a clear understanding of each other's responsibilities.

All payments are expected at the time of visit. Our office accepts payments by cash, check, visa, MasterCard, AMEX, and Discover. Unpaid charges in the excess of 90 days are subject to service charges. If a bill goes unpaid for more than 90 days it is subject to be sent to our collection agency. _____(Initial)

Insurance can be very confusing and a time-consuming task for everyone. If we accept your insurance, your visits will be filed to your specific insurance carrier. Not all services will be covered by your plan. If we do not accept your insurance, payment is expected up front and a claim form will be printed for the patient.

Dr. Vinitsky is neither an agent nor an employee of the insurance company. The relationship we have is with you, our patient. If, for any reason, your insurance does **NOT** pay for services rendered by Dr. Vinitsky, you the patient are solely responsible for the balance. **YOU** are ultimately responsible for knowing and understanding your policy; its benefits, exclusions, and limitations. _____(Initial)

Visits are all charged based on time. New patient appointments are **$450 PER HOUR**, Established patients are **$400 PER HOUR. NOT PER VISIT**. _____(Initial)

A fee of $35 will be charged for any returned checks. There will be a $100 charge for any missed appointments without prior notice and will be doubled for each consecutive missed appointment. _____(Initial)

All medical reports and forms will be charged up front before Dr. Vinitsky begins report/form. Charges will be $350 per hour. If time is less a refund will be given. If the form is less complicated, the charge will be $35 up front, such as a school form. _____ (Initial)

Labs must be followed up with either a phone consultation ($50 per every 10 minutes) or an office visit. Emails are considered medical advice. Each email will be charged $25 if there is more than **two** medical questions. If there are more concerns, please call to set up a follow up appointment. _____(Initial)

Respect, patience, and understanding **IS** expected at Enlightened Medicine. Each patient is important and will be helped/treated as soon as humanely possible. Dr. Vinitsky is one man and can only do so much. Each case is complicated and the first visit will not always result in a treatment plan or protocol.

If a patient has a balance on their account, an appointment will not be made nor will any medical advice be given until the balance is paid in full. _____(Initial).

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A patient can be dismissed from the practice if any or all of the following occur. There may be exceptions and the patient will be notified by mail if there is a possibility or will be dismal from the practice.

- patient refuses to pay balance or set up a payment plan_____(Initial)
- patient chronically misses appointments or cancels the day of appointment_____(Initial)
- patient verbally abuses and threatens staff_____(Initial)
- patient is non-compliant of given treatments despite continued visits and complaints_____(Initial)

I, _____, hereby acknowledge that I have read and understand the policies as stated. Any collection fees and attorney's fees that are incurred for breach of this agreement will be sole responsibility of the patient.

AUTO-PAY BILLING

In order to provide you with the highest quality of services while keeping our billing costs low, we now offer paperless billing through AUTO-PAY. We simply maintain your credit card or debit card number in a secured location to satisfy your co-payment, deductible, non-covered services, and co-insurance per your insurance policy. We accept Visa, MasterCard, Discover, and American Express. If you prefer, one of our staff will personally call or email you to explain any balance due prior to charging your card.

Account #_____ exp. date_____ sec code_____

_____Charge Card and send receipt _____Call _____Email

Cardholder Signature_____

Best contact #_____ Email address _____

If you do not check an option, your card will automatically be billed for all applicable deductibles, co-insurances, non-covered services, and/or co-pays according to your insurance policy.
IF YOU ARE CALLED OR EMAILED REGARDING YOUR BILL AND CALL OR EMAIL IS NOT RETURNED WITHIN A WEEK, YOUR CARD WILL AUTOMATICALLY BE CHARGED.

_____ _____
Patient Name Date

_____
Signature of Patient or Guardian

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PLEASE SIGN AND RETURN TO THE OFFICE ALONG WITH THE OFFICE POLICIES2 SHEET BEFORE YOUR SCHEDULED APPOINTMENT

Cancellation / Rescheduling Policy

We welcome you to Enlightened Medicine and are happy to serve you as our patient. We look forward to meeting you on your upcoming consultation.

Your appointment is on _____ at _____ A.M/P.M.

Should you need to reschedule your appointment we require a minimum notice of **72 business hours** to do so, or the full consult fee will be charged. To cancel or reschedule an appointment please call **301.840.0002** during our **telephone hours**, which are listed below:

Monday: 9:00 am – 12:00 pm and 1:30 pm – 4:30 pm
Tuesday: 9:00 am – 12:00 pm and 1:30 pm – 4:30 pm
Wednesday: 9:00 am – 12:00 pm and 1:30 pm – 4:30 pm.
Thursday: 9:00 am – 12:00 pm and 2:00 pm – 4:30 pm
Friday: 9:00 am – 12:00 pm and 1:30 pm – 4:30 pm

Hours are subject to change

Many of our patients have chemical sensitivities, so please do not wear any perfumes, colognes, scented lotions etc. to our office.

By signing below, you agree to comply with our cancellation/rescheduling policy. Please sign and return this form when you arrive to your first appointment. Thank you!

_____

Printed Name Date

_____

Signature Date

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PATIENT RESPONSIBILITY AGREEMENT

I am aware that I am responsible for all charges incurred in the course of my medical care. If I have an insurance company that the doctor is not a provider of, I am responsible for full payment at time of service. Failure to clear my balance in a timely fashion may result in my account being sent to collections. There will be a separate collections fee that will be my responsibility. This will adversely affect my credit rating. Reimbursement for me will be from my insurance company. It is my responsibility to follow-up on denied claims. There may be items that will not be covered by my insurance company.

I understand that I am responsible for all charges that are NOT covered by my insurance.

I understand that if I have difficulty in meeting my financial obligations that is my responsibility to contact the office promptly to arrange for a payment plan. I know that if a check is returned for nonpayment there will be a $35 charge, in accordance with Maryland law.

SIGNED:_____ **DATE:**_____

PRINTED NAME:_____

SOCIALSECURITY #:_____

DRIVERS LICENSE #:_____

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PATIENT INFORMATION

DATE_____

LAST NAME | FIRST | M.I. | MARITAL STATUS

STREET ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE | EMAIL

DOB | SOCIAL SECURITY # | DRIVERS LICENSE # | STATE | EXPIRATION

PRIMARY INSURANCE

INSURANCE CO. NAME | EFFECTIVE DATES

ID# | GROUP# | PHONE# | FAX#

ADDRESS

INSURED PERSON (if not patient) | RELATIONSHIP TO PATIENT | ADDRESS

PHONE(H) | DOB | SOCIAL SECURITY #

SECONDARY INSURANCE

INSURANCE CO. NAME | EFFECTIVE DATES

ID# | GROUP# | PHONE# | FAX#

INSURED PERSON (if not patient) | DOB | SSN# | RELATIONSHIP TO PATIENT

REFERRED BY: _____

PRIMARY CARE PHYSICIAN

NAME | PHONE

AUTHORIZATION

Payment in FULL or co-pay is expected at time of service. If an account is past due, you will be sent to collections. You are responsible for payment of all legal collection fees incurred by past due account. My signature attests that no false information was knowingly supplied above, and that I understand my responsibilities for payment and accept the above stipulations

SIGNATURE_____ DATE_____

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PHYSICAL EXAMINATION DATE FORM completed: DATE of Visit:

NAME: _____ HT_____ WT_____ BP_____
P_____ R_____ T_____
GENDER: M ❑ F ❑ BIRTH DATE _____ AGE _____ MARITAL STATUS S ❑ M ❑ SEP ❑ DIV ❑ WID. ❑
ALLERGIES:_____
STREET ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE: (____) - _____ FAX: (_____) - _____ E-MAIL: _____
DAY PHONE: (____) - _____
WHO REFERRED YOU? HOW DID YOU IDENTIFY THIS OFFICE FOR CONSULTATION?_____
_____
REASON FOR YOUR CONSULTATION?_____
DISABILITY EVALUATION AND RATING: YES ❑ NO ❑ MEDICAL REPORT- LEGAL/TESTIMONY: YES ❑ NO ❑
MEDICAL EVALUATION AND TREATMENT: YES ❑ NO ❑ SECOND OPINION: YES ❑ NO ❑
WHAT ARE YOUR EXPECTATIONS FOR THIS ENCOUNTER? _____
_____
WHAT DO YOU HOPE TO LEARN? _____
_____
DO EXPECT ME TO BE YOUR TREATING PHYSICIAN ? YES ❑ NO ❑
IF NO, WHO IS YOUR PRIMARY PHYSICIAN? _____
ADDRESS/PHONE/FAX/e-mail OF PRIMARY PHYSICIAN: _____
_____
OTHER HEALTH CARE PRACTITIONERS YOU ARE CONSULTING - NAME & SPECIALTY:
_____
_____
_____
_____
_____
OCCUPATION: _____ **OR STUDENT ❑ HOMEMAKER ❑ RETIRED ❑ DISABLED ❑**
COMPANY/CURRENT SCHOOL: _____
ADDRESS: _____
DUTIES OR JOB DESCRIPTION: _____
WORKSPACE/CLASS ROOM(S) LOCATION(S):_____
_____
SUPERVISOR/CONTACT PERSON/TEACHER(S): _____
_____
ADDRESS/PHONE/FAX OF CONTACT PERSON: _____

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INTAKE HISTORY & PHYSICAL DATE of Visit

NAME: _____

EDUCATION (DEGREES/HONORS):_____

_____

LEGAL CONTACT PERSON: _____

ADDRESS/PHONE/FAX OF LEGAL CONTACT:

_____

DATE THIS FORM WAS COMPLETED: _____

SUSPECTED INJURY/EXPOSURE(S): _____

_____

DATES & TIMES OF EXPOSURE: _____

_____

WHERE DID THE INJURY/EXPOSURE(S) OCCUR: _____

_____

SYMPTOMS ATTRIBUTED TO INJURY/EXPOSURE (DATES OF ONSET OF SYMPTOMS AND LEVEL OF DISTURBANCE 1→5; 1=LOW, 5=HIGH):_____

_____

_____

_____

_____

_____

_____

OTHER SYMPTOMS WHICH YOU CURRENTLY EXPERIENCE AND LEVEL OF DISTURBANCE -DID THESE SYMPTOMS PRE-EXIST OR DEVELOP SUBSEQUENT TO THE INJURY/EXPOSURE?:_____

PRE-XIST:_____

SUBSEQUENT:_____

_____

_____

_____

_____

_____

_____

CURRENT VITAMINS/MINERALS/ANTIOXIDANTS/SUPPLEMENTS (DOSE & FREQUENCY):_____

_____

_____

_____

_____

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INTAKE HISTORY DATE of Visit

NAME: _____

CONTD_____

_____

_____

_____

PREVIOUSLY USED **VITAMINS/MINERALS/ANTIOXIDANTS/SUPPLEMENTS**: (INCLUDE DATES OF USE):_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS:_____DOSE:_____FREQ:_____

_____ DOSE:_____ FREQ:_____

_____ DOSE:_____ FREQ:_____

_____ DOSE:_____ FREQ:_____

_____ DOSE:_____ FREQ:_____

PREVIOUSLY USED MEDICATIONS: (DATES OF USE):

_____

_____

_____

_____

_____

PLEASE PROVIDE A CHRONOLOGIC HISTORY FROM THE TIME OF YOUR CONCEPTION. THIS DATA BASE SHOULD INCLUDE DATES, LOCATIONS, SYMPTOMS, AND EXPOSURES BY INHALATION, INGESTION, PHYSICAL CONTACT, OR ASSOCIATION (TRAVEL, SOJOURNS & LENGTH OF STAY, ILLNESSES, IMMUNIZATIONS, HOSPITALIZATIONS, MEDICATIONS, ANESTHETICS, SURGERIES, TRAUMAS - INJURIES, ACCIDENTS , CHEMICALS, SUBSTANCES, BIOLOGICAL EXPOSURES - PETS, INFECTIONS, ALLERGENS, PARASITES, LIVING & WORK LOCATIONS - DISASTERS AT/TO THOSE LOCATIONS, REPAIRS & RENOVATIONS; EMOTIONAL TRAUMA, CHANGES IN PHYSICAL OR EMOTIONAL CONDITIONS: WEIGHT, EXERCISE, SLEEP, NUTRITION, LIVING ARRANGEMENTS, RELATIONSHIPS WITH FAMILY, COWORKERS).

FAMILY HISTORY: IF DECEASED, LIST CAUSE OF DEATH OR UNKNOWN

FATHER: DECEASED ❑ CURRENT AGE _____

ILLNESSES OR CONDITIONS PRIOR TO & DURING YOUR ENTRY INTO THIS WORLD: _____

_____

CURRENT CONDITIONS: _____

MOTHER: DECEASED ❑ CURRENT AGE _____ILLNESSES OR CONDITIONS PRIOR TO & DURING YOUR ENTRY INTO THIS WORLD:

_____

CURRENT CONDITIONS: _____

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INTAKE HISTORY & PHYSICAL DATE of Visit

NAME: _____

_____

____**BROTHER:** DECEASED ❑ CURRENT AGE _____
PAST OR CURRENT CONDITIONS: _____

_____

____**BROTHER:** DECEASED ❑ CURRENT AGE _____
PAST OR CURRENT CONDITIONS: _____

_____

____**SISTER:** DECEASED ❑ CURRENT AGE _____
PAST OR CURRENT CONDITIONS: _____

_____

____**SISTER:** DECEASED ❑ CURRENT AGE _____
PAST OR CURRENT CONDITIONS: _____

_____

____**PATERNAL GRANDFATHER:** DECEASED ❑ CURRENT AGE _____
CURRENT CONDITIONS: _____

_____

____**PATERNAL GRANDMOTHER:** DECEASED ❑ CURRENT AGE _____
CURRENT CONDITIONS: _____

_____

____**MATERNAL GRANDFATHER:** DECEASED ❑ CURRENT AGE _____
CURRENT CONDITIONS: _____

_____

____**MATERNAL GRANDMOTHER:** DECEASED ❑ CURRENT AGE _____
CURRENT CONDITIONS: _____

_____

SOCIAL HISTORY: PLEASE DESCRIBE WHO LIVES AT HOME WITH YOU AND WHAT YOUR RELATIONSHIPS WITH THOSE INDIVIDUALS AND PETS. DESCRIBE RELATIONSHIPS WITH EXTENDED FAMILY. DESCRIBE RELATIONSHIPS YOU HAVE WITH CO-WORKERS, FRIENDS, OR OTHER INDIVIDUALS WHO MAY HAVE A BEARING ON YOUR PRESENT CONDITION. _____

_____

_____

_____

_____

_____

_____

_____

_____

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INTAKE HISTORY DATE of Visit _____

NAME: _____

SCHOOL HISTORY: PLEASE DESCRIBE YOUR EDUCATION CHRONOLOGICALLY, WHAT LEVEL YOU HAVE COMPLETED, WHERE YOU STUDIED, & ANY OTHER PERTINENT INFORMATION. _____

WORK HISTORY: LIST CHRONOLOGICALLY YOUR PREVIOUS WORK ACTIVITIES, LOCATIONS, DUTIES, EXPOSURES, INJURIES: _____

PHYSICAL RELATIONSHIPS: PLEASE DESCRIBE HOW YOUR INJURY/EXPOSURE(S) OCCURRED, INCLUDING WHERE THE EVENTS OCCURRED (LOCATING THE ROOM, SPACE, ETC. TO ANY LARGER LANDMARKS), WHEN (TIME OF DAY), CONDITIONS (WEATHER, INDOOR, OUTDOOR, ETC.). PLEASE PROVIDE A DIAGRAM OR MAP TO CLARIFY. _____

PAST MEDICAL HISTORY: CHILDHOOD ILLNESSES, PREVIOUS ILLNESSES, OPERATIONS, HOSPITALIZATIONS, TRANSFUSIONS, ADVERSE OUTCOMES: _____

LIFE HISTORY:

LOCATIONS YOU HAVE LIVED, DATES YOU LIVED THERE, TYPE OF HOUSING: _____

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INTAKE HISTORY & PHYSICAL DATE of Visit

NAME: _____

TRAVEL DESTINATIONS, DATES, ANY ILLNESSES, ANY EXPOSURES: _____

_____

_____

_____

_____

INJURIES, AUTO ACCIDENTS & DATES: _____

_____

_____

_____

PETS, OTHER ANIMAL EXPOSURES & THEIR ILLNESSES. WHEN? _____

_____

_____

_____

TICK, INSECT, SPIDER & OTHER BITES. WHEN & WHERE WERE YOU? _____

_____

_____

MILITARY SERVICE. WHEN & WHERE? ANY INJURIES, EXPOSURES? _____

_____

_____

BIOLOGICAL EXPOSURES [MOLDS, INFECTIONS – VIRUSES, BACTERIA, WORMS, PARASITES, ALLERGENS.] WHEN & WHERE? _____

_____

_____

_____

CHEMICAL EXPOSURES [PESTICIDES, CARBON MONOXIDE, RADON, DENTAL AMALGAMS; RENOVATIONS TO HOME, WORK, SCHOOL; SOLVENTS – VOC'S, FUMES, GASES, CIGARETTE SMOKE, DIESEL EXHAUST, FAILED HVAC SYSTEMS, CONTAMINATED FOOD & WATER SOURCES] WHEN & WHERE? _____

_____

_____

_____

_____

_____

PHYSICAL EXPOSURES [RADIATION, POWER LINES, CELL PHONES, ELECTRICAL EQUIPMENT IN YOUR BEDROOM.] WHEN & WHERE? _____

_____

_____

_____

EMOTIONAL TRAUMAS. WHEN & WHERE? _____

_____

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INTAKE HISTORY DATE of Visit

NAME: _____

_____

_____

PHYSICAL EXAMINATION: (THIS PORTION TO BE FILLED IN BY THE DOCTOR)

GENERAL APPEARANCE: ❑WELL DEVELOPED, WELL NOURISHED, APPROPRIATE WEIGHT, AGE APPROPRIATE OLDER YOUNGER APPEARANCE; SALLOW PALE RUDDY WRINKLED EMACIATED DEPRESSED ANXIOUS

_____

_____

VITAL SIGNS: HT _____ **WT**_____# **BP**_____/_____ **L R** ARM **P**_____ **R**_____ **T**_____

HEENT: NO ABNORMALITIES

HEAD: SCALP_____ DEFORMITIES_____ HAIR PATTERN_____

FACIAL SKIN:_____**EYEBROWS:**_____

EYES: GLASSES CONTACTS_❑ NL LIDS, CONJUNCTIVAE, FUNDI, PERRLA SHINERS YES NO

PUPILS **L**_____ **R** _____ CORNEAS **L**_____ **R**_____

LIDS **L** _____ **R** _____ CONJUNCTIVAE **L**_____**R**_____

FUNDI **L**_____**R**_____

EARS: CANALS **L**_____**R**_____ TM **L**_____**R**_____

NOSE: NARES **L** _____ **R**_____ TURBINATES **R**_____**L**_____

SEPTUM DEVIATED NO YES L R OTHER FINDINGS:_____

JAW: CLICKS_____OTHER:_____

MOUTH: TEETH_____ # FILLINGS_____ TYPES OF FILLINGS_____

CARIES_____

BITE_____ GUMS_____

ORAL LESIONS_____ TONGUE _____

NECK: THYROID:_____TRACHEA:_____

CAROTIDS: **L**_____**R**_____ JUGULARS: **L**_____**R**_____

MUSCULOSK:_____

CHEST: ❑ **NL** SYMMETRY, RAPID BREATHING,:EXPANSION, NO TENDERNESS OR ADVENTITIOUS SOUNDS

RAPID BREATHING SLOWED____TENDERNESS: YES___ NO__ LOCATION _____

EXPANSION: NL____ ABN__ DESCRIBE_____

DULLNESS: YES___ NO____ LOCATION_____

SOUNDS: NL___ ABN___ INSP_____EXP_____

E→A ABS ___ PRESENT ___ LOCATION_____

CHANGES W/ COUGH _____

HEART: ❑ REGULAR SINUS RHYTHM, NO MURMUR OR GALLOP, NL SIZE AND LOCATION

RATE **T B** RHYTHM REG___ IRREG___ IRREG IRREG___ DESCRIBE_____ PALPATION _____

S1 ABN___ DESCRIBE_____ S2 ABN___ DESCRIBE_____

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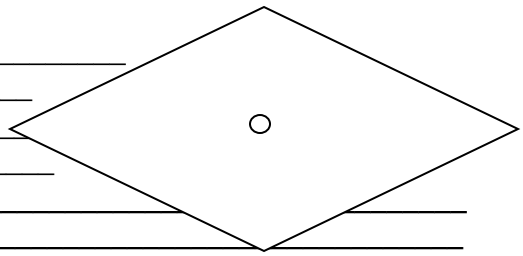
S3 PRESENT ____ S4 PRESENT_____ MURMURS/RUBS____ DESCRIBE_____
_____

INTAKE HISTORY DATE of Visit

NAME: _____

ABDOMEN: ❑ NL SHAPE, SIZE, SOUNDS, NO MASSES OR ORGANOMEGALY.
SHAPE:_____ SCARS:_____
TENDERNESS: N___ Y ___ LOCATION:_____
ORGANOMEGALY_____



GU: ❑ MALE ❑ CIRC ❑ UNCIRC ❑ FEMALE ❑NOT EXAMINED ❑ TANNER_____

LYMPHATICS: _____
_____

SKIN:_____
_____

BACK, NECK, PELVIS, HIPS: _____
_____

ARMS, ELBOWS, WRISTS, FINGERS: _____
_____
_____

LEGS, KNEES, ANKLES, TOES: _____
_____
_____
_____
_____
_____
__

NEURO: ❑ALERT& ORIENTED X 3 ABN PER___PL__TIME___ **AFFECT:** ❑ NL_____**MOOD:** ❑NL_____

HANDEDNESS: R__ L__ AMBI__ PREDOMINANCE_____

CRANIAL ❑ NL
ABN_____
__

REFLEXES: ❑ NL ABN
_____

TOES ❑ DOWNGOING

STRENGTH ❑ NL
ABN:_____
_
_____
_____

SENSORY ❑ ALL NL **VIBRATION** ❑NL LEGS **R**_____**L**_____ARMS **R**_____**L**_____
PIN ❑ NL LEGS **R**_____**L**_____ARMS **R**_____**L**_____

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POSITION ❑ NL TOES **R**_____**L**_____FINGERS **R**_____**L**_____

BALANCE: ROMBERG: NEG___ POS___ DIRECTION_____

INTAKE HISTORY DATE of Visit

NAME: _____

FINGER-NOSE: OPEN: NL___ ABN_____ CLOSED: NL__ ABN_____
FINGER-FINGER: OPEN: NL___ ABN_____ CLOSED: NL__ ABN _____
TREMOR: NONE___ PRESENT:__ L__R__ BOTH__ DESCRIBE_____

BREATHING CHANGES W/ BALANCE: DB=DEEP BREATH, BH=BREATH HOLD; STABILITY: W=WOBBLE

FOOT BALANCE EYES OPEN **R**_____SEC **L**_____ SEC**;** CLOSED **R**_____SEC **L**_____SEC

TOE BALANCE: EYES OPEN:__,__,__,__,__ SEC; CLOSED:__,__,__,__,__ SEC;

OPEN:__,__,__,__,__ SEC; CLOSED:__,__,__,__,__ SEC; OPEN___

HEEL-TOE GAIT: 10 STEPS:
EYES OPEN **F**___ SEC/ ERRORS 0 1 2 3 >3 _____ **R**___ SEC/ ERRORS 0 1 2 3 >3 _____
EYES CLOSED **F**___ SEC **R**___ SEC/ ERRORS 0 1 2 3 >3 ___ **R**___ SEC/ ERRORS 0 1 2 3 >3 ____
❑ CAN'T PERFORM
STATIC BALANCE: **R** FOOT IN FRONT OF **L** OPEN ____SEC CLOSED _____ SEC
L FOOT IN FRONT OF **R** OPEN ____SEC CLOSED _____ SEC