

William Shevin M.D., D.Ht.

50 Applewood Drive
Woodstock, CT 06281
www.drshevin.com

tel: (860) 928-4040
fax: (860) 928-0733
email: drshevin@drshevin.com

Welcome to my medical practice. I look forward to seeing and working with you, and to make things work more efficiently, I've put together some forms:

Please read the "How to Report Symptoms" page carefully, and complete the questionnaire. This will help to make our time together more valuable and enable me to provide the best possible care.

Please also read carefully and sign the enclosed document that describes my fees and policies. I ask for payment at the time of the visit unless prior arrangements have been made. If you have Medicare, or for another reason are unable to submit your own medical insurance claims, I will offer you assistance. Please give your cards and relevant information to my receptionist so that she may make copies for our records.

Effective January 1, 2010, I will be a covered entity under the HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations. Please print and read the Privacy Practices Policies (see www.drshevin.com/my_practice), and sign the "Receipt of Privacy Notice" form and bring it with you to your appointment). I apologize for the length and complexity of these policies, but I am legally required to abide by these regulations.

If, for some reason, you will be unable to keep your appointment, please give me 3 working days notice so that I can fill your slot with another new patient. I do not overbook, so a "no show" is difficult for me.

Directions for reaching the office can be found elsewhere on my website.. As my office is in my home, and in a residential neighborhood with young children and dogs, I ask that you drive slowly once you turn into Sunrise Drive. Please do not speed to be on time for your appointment.

I also ask that you respect the privacy of my family and remain either in the waiting room or on the walkway until I can see you. Please feel free to enjoy the garden out front, but please stay on the stone path and around the bench, and if you have children, please do not let them disturb the plants or stones.

If you have any questions, please give me a call.

Sincerely,

William Shevin M.D., D.Ht.

PATIENT INTAKE SHEET

Patient's Name _____ DOB _____ SS# _____

Patient's Address _____ Phone # _____

_____ Cell # _____

Insured's Name _____ DOB _____ SS# _____

Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other _____

Patient's Employer _____ Address _____ Phone # _____

Insured's Employer _____ Address _____ Phone # _____

Person to Contact in Case of Emergency _____

PLEASE FILL IN INFORMATION REGARDING YOUR TYPE OF INSURANCE COVERAGE

MEDICARE COVERAGE

Medicare Identification # _____

Do you have Supplemental Insurance, what company _____

What is your Supplemental Insurance Identification # _____

BLUE CROSS/BLUE SHIELD COVERAGE

Blue Cross/Blue Shield Identification # _____

Group # _____ Type of Coverage _____

Policy Holder's Name _____

ALL OTHER GROUP HEALTH INSURANCE COVERAGE

Group Health Insurance Carrier _____

Insurance Identification # _____ Group # _____

Policy Holder's Name _____

Do you have Secondary Insurance? _____ Yes _____ No

Is it thru you or your spouse's employment? _____

Name of Secondary Insurance Company _____

Identification # _____ Group # _____

Medical History Questionnaire

[Please print all information]

Today's date: _____

Name _____ Birth date _____

Address _____

Telephone _____ Occupation _____

Work address _____ Phone _____

Marital Status _____ Education _____ Email _____

Family Medical History: Please give the following information about your immediate family:

RELATIONSHIP	NAME	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH/CAUSE OF DEATH
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Grandparents (specify maternal or paternal):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any blood relatives had any of the following illnesses? If so, indicate relationship (mother, brother, etc.)

Diabetes / Hypoglycemia _____	Tuberculosis _____
Cancer _____	Alcoholism _____
Eczema _____	High Blood Pressure _____
Epilepsy _____	Heart Disease _____
Arthritis _____	Allergy, Asthma _____
Other _____	

Allergies: List anything that have are allergic to such as certain foods, medications, dust, chemicals or soaps, household items, pollens, insect stings, etc., and indicate how each affects you:

Allergic to:	Effect:
_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY QUESTIONNAIRE

NAME:

PRESENT HEALTH (Please briefly describe all current problems):

<u>Problem/Complaint</u>	<u>Date of Onset</u>	<u>Health Care Provider</u>

CURRENT MEDICATIONS AND NUTRITIONAL SUPPLEMENTS (with dosages):

PAST HISTORY (hospitalizations, operations, significant injuries):

FOOD DIARY (all food and drink for two recent days):

Day 1:	Breakfast		Liquids	
	Lunch			
	Dinner			
	Snack			
Day 2:	Breakfast		Liquids	
	Lunch			
	Dinner			
	Snack			

Circle the Following Words which apply to you:

Worthy	Unassertive	Meaningful like	Anxious
Confused	Naive	Happy childhood	Relaxed
Guilty	Repulsive	Morally good	Nightmares
Misunderstood	Unattractive	Concentrate well	Patient
Unloved	Suicidal ideas	Emphatic	Bored
Sleep well	Unhappy childhood	Confident	Full of regrets
Helpful	Intelligent	Attractive	In conflict

Please prepare a chronological history of your medical problems, dating back to childhood, if necessary. It may be essential to understand the development over time of your problems. Use a separate sheet of paper.

Past Medical History: Please check YES or NO on any of the following illnesses or problems you have, or have had, and indicate the year when each started. If you are not certain when an illness started, write an approximate date:

YES	NO	ILLNESS	YEAR	YES	NO	ILLNESS	YEAR	YES	NO	ILLNESS	YEAR
___	___	Skin Problems	___	___	___	Gallbladder Trouble	___	___	___	Diverticulitis	___
___	___	Eye Problems	___	___	___	Hernia	___	___	___	Colitis	___
___	___	Hearing Loss-Ear Problem	___	___	___	Hemorrhoids	___	___	___	Gout	___
___	___	Bronchitis-Pneumonia	___	___	___	Kidney-Bladder Disease	___	___	___	Chicken Pox-Measles	___
___	___	Emphysema	___	___	___	Prostate Problems	___	___	___	Mumps-German Measles	___
___	___	Allergies or Asthma	___	___	___	Headaches	___	___	___	Arthritis	___
___	___	Tuberculosis	___	___	___	Seizures	___	___	___	Cancer or Tumor	___
___	___	Other Lung Problems	___	___	___	Head Injury	___	___	___	Bleeding Tendency	___
___	___	High Blood Pressure	___	___	___	Stroke	___	___	___	Diabetes	___
___	___	Heart Attack	___	___	___	High Cholesterol	___	___	___	Mononucleosis	___
___	___	Venereal Disease	___	___	___	Other Heart Conditions	___	___	___	Mental-Emotion Difficulty	___
___	___	Liver Trouble	___	___	___	Stomach-Duodenal Ulcer	___	___	___	Other _____	___

Review of Systems: Place a check mark in front of any general term only if you now, or have recently (6-12 months) had a problem:

General health now? Poor _____ Fair _____ Good _____
 In your Past? Poor _____ Fair _____ Good _____
 Weight Change? Yes _____ Gain or Loss ____ How much? ____

Please check yes or no, on each line below.

Yes No

- ___ ___ Sleep ? Hrs./night _____
- ___ ___ Falling Asleep
- ___ ___ Early Waking
- ___ ___ Dreaming
- ___ ___ Refreshed in A.M.
- ___ ___ Recurrent Fever
- ___ ___ Chills
- ___ ___ Night Sweats
- ___ ___ Frequent Infections
- ___ ___ Skin : Rash
- ___ ___ Itching
- ___ ___ Discoloration
- ___ ___ Infections
- ___ ___ Slow Healing
- ___ ___ Joint Pain-Swelling-Stiffness
- ___ ___ Lumps-Masses
- ___ ___ Bleeding Disorder
- ___ ___ Vision
- ___ ___ Hearing
- ___ ___ Balance
- ___ ___ Taste
- ___ ___ Touch
- ___ ___ Ringing in Ears
- ___ ___ Dizziness
- ___ ___ Sneezing

Yes No

- ___ ___ Coughing
- ___ ___ Breathing
- ___ ___ Sore Throat
- ___ ___ Chest Pain
- ___ ___ Shortness of Breath
- ___ ___ Fainting
- ___ ___ Heart Beat
- ___ ___ Swelling
- ___ ___ Nausea
- ___ ___ Gas
- ___ ___ Heartburn
- ___ ___ Swallowing
- ___ ___ Vomiting
- ___ ___ Constipation
- ___ ___ Diarrhea
- ___ ___ Rectal Pain
- ___ ___ Stomach Pain
- ___ ___ Blood in Stool
- ___ ___ Speech
- ___ ___ Walking
- ___ ___ Weakness
- ___ ___ Shaking
- ___ ___ Mood Changes
- ___ ___ Personality Changes
- ___ ___ Headache
- ___ ___ Thought Processes

Yes No

- ___ ___ Memory
- ___ ___ Numbness/Tingling

Men Only

- ___ ___ Prostate
- ___ ___ Sexual Difficulties
- ___ ___ Lump
- ___ ___ Pain/Swelling
- ___ ___ Discharge
- ___ ___ Urination

Women Only

- ___ ___ Menstrual Periods
- ___ ___ Mood Changes
- ___ ___ Heavy Bleeding
- ___ ___ Pain
- ___ ___ Discharge
- ___ ___ Urination
- ___ ___ Breast Lumps
- ___ ___ Breast Pain
- ___ ___ Breast Discharge

Number of Pregnancies? _____

Children _____

Type of Birth Control? _____

Do You Smoke? Yes ___ No ___

How Much? _____

EXERCISE: Please briefly describe, with an estimate of hrs./wk., any regular exercise.

SPIRITUAL PRACTICE: Describe any regular activity.

FEES AND POLICIES

Initial Consultation (adult, 1.5 hr.)	\$315.00
Initial Consultation (child, 1 hr.)	\$220.00
Standard re-visit (1/2 hour)	\$110.00
Intermediate re-visit (15 min.)	\$70.00
Brief visit (time and complexity dependent) ..	\$42 - 60.00
"Escrow Fund" Voluntary Contribution	\$1.00

The Escrow Fund is created by my taking a dollar from each charge, and once a month transferring that amount to a homeopathic organization of my choice. Organizations to whom I have contributed from this fund include the National Center for Homeopathy, the Homeopathic Pharmacopoeia Convention of the United States, the Homeopathic Community Fund, Physicians for Human Rights, and Doctors Without Borders. Your contribution is voluntary and if you do not wish to make it, please let me know. You may increase your contribution.

Medical services are highly individualized and the benefits of treatment depend on a thorough understanding of your case. In complicated cases more than the usual amount of time may be necessary to arrive at this understanding, and the charge may therefore be greater.

APPOINTMENTS: An appointment is an agreement between us. I am responsible to be present and to provide services to the best of my ability, or inform you otherwise. You are responsible for keeping the appointment, or giving me at least 24 hours notice of cancellation (3 working days in the case of a first visit.) I do not overbook appointments, and reserve the right to charge for missed appointments without adequate notice of cancellation.

PAYMENT: Payment is required at the time of service unless other arrangements have been made in advance. We will submit a claim to your insurance carrier, which will then reimburse you according to the terms of your contract. I am not a Medicaid provider, and therefore cannot bill to or receive payment from Connecticut Title 19. I ask that Medicare patients pay at the time of service - I will, as required by law, submit the claims for your visit to Medicare. I do not accept "assignment" except by special arrangement. In case of financial hardship, I will endeavor to work out a payment plan with you.

OVERDUE ACCOUNTS: If your account becomes more than 90 days overdue, I will contact you to arrange a payment plan. I understand that circumstances change, and am very tolerant in terms of payment if I can trust that you are acting in good faith. For me, that means that you will inform me that you are not able to pay in full and will arrange a payment plan, and then follow that plan.

AFTER HOURS COVERAGE: I am not able to provide "primary care" at this time. I will not always be available in emergencies, and I do not admit patients to hospitals. I will endeavor to have another homeopathic physician available to you when I am away, but distance from that practitioner may make providing emergency services problematic. In the case of an emergency you may need to go to the hospital emergency department. Please use your judgment in this matter.

TELEPHONE or EMAIL CONSULTATION: I will generally not charge for a telephone or email consultation when it is short, and involves a simple judgment or a quick follow-up to a previous visit. Otherwise, I reserve the right to charge for consultations made over the telephone, or via email, based upon time and the complexity of the problem. These will generally not be reimbursable through your insurance.

RIGHTS: You have the right to be treated with courtesy, respect, and dignity, and to understand my analysis of your problems and the treatment plan. Please feel free to ask any questions necessary to achieve this understanding. I sometimes have health professionals and medical students as visitors or in training, who wish to be exposed to or learn homeopathic medicine. You have the right to refuse such observation. Your medical records are confidential and I will require a written release from you before I give them to any outside agency. Should I wish to prepare journal articles or give talks at professional meetings utilizing information regarding your case and your treatment, neither your name nor address will be used.

Your signature below indicates that you have read and have understood these policies:

Signature: _____ Date: _____

HOW TO REPORT YOUR SYMPTOMS

This is reprinted from an old brochure distributed by the National Center for Homeopathy. Although the language is a bit archaic, it will serve nicely to orient you towards the detail and nuances that are often important in describing your symptoms. Do not be limited by these descriptions, however. What is most important is to be accurate and thorough.

1. Always describe the beginning of your complaints (or those of your child, if the child is the patient); state just how they began as well as the changes that may have taken place since.
2. Mention all previous illnesses. A complete history of your health is important, even of such things as skin diseases, children's diseases and their after-effects; tell of fevers, colds, flus, sores, ulcers, etc.; also injuries, if any. Tell their location and what treatment was used.
3. Tell, if you can, all treatments that have been used.
4. Describe all mental or "nervous" feelings and conditions, such as likes and dislikes, desires, fears. Timidity, hurried feeling, lack of interest, persistent thoughts, discouragements, discontent, over-conscientiousness, whether critical, irritable, easily confused, aversion to business or work, absentmindedness, changeable mood, difficulty of concentration, dullness of mind, whether easily startled or starting from sleep or when falling asleep, or from noise or being touched; whether annoyed by noise or talk of others or by children; whether easily affected by bad news; whether better or worse from mental exertion, or when occupied; whether sensitive to offense or contradiction. Describe the state or mind as to the future or to threatening troubles; attitude of mind as to associates and relatives, and the effects of same, and whether better alone or with company. Tell the peculiarities of memory; whether desire to be silent or to talk much. Tell of any emotional shocks, frights, disappointments, etc. of the present or past; how affected by a room full of people.
5. As to appetite, tell what is craved or disliked, including such things as salt, sweets, fats, sour, spicy things, eggs, etc. Also, thirst for much, little or nothing, and what drink is preferred.
6. Do the symptoms remain the same or do they change, character or shift from one place to another?
7. Describe all pain; what kind, what it feels like and whether constant, changeable, or periodical; also in what direction it may go or extend, if any; whether it comes slowly or suddenly and how it leaves.
8. Write the time of day, night, month or season that you are better or worse; whether before or after eating, sleeping, moving, resting, when occupied, when thinking of your complaint, etc. Write just what things or conditions make you worse and whatever relieves the pain or sickness. This is important.
9. Just how are you affected by different kinds of weather, by cold, heat, dryness, storm coming, thunderstorms, frost, cloudiness, seashore, low or high altitudes, etc?
10. Sensations are important. State just what kind, where, at what time they are better or worse, and whatever makes them better or worse. Tell all sensations, however slight or peculiar such as "as if--" so and so.

11. In skin, scalp, or nail problems, tell the exact location, color, whether dry or moist, thick or thin, scaly, crippled, pimply, with or without matter, warts or growths, appearance of surrounding skin; whether itching, burning, worse or better from scratching, and what else makes it better such as heat, heat of bed, cold, exercise, wool, water, etc. Tell of any enlarged veins, etc.
12. Describe discharges of any part, whether slight or heavy, the color, odor, thick or thin, gluey or sticky, causing redness or burning, rawness, color of stain; and what makes it better or worse and when.
13. Urine: whether pain before, during or after passing, color, odor, appearance, quantity, sediment, frequency, urgency (if hurried).
14. Bowel condition: color, odor, hard, dry, large, pasty, bloody, frothy, slimy, thin, watery, slender, flat etc. How often, at what times worse or better, or how affected by certain circumstances; whether difficult, incomplete, urging without result or stool slips back in, prevented by spasm of rectum, anything else peculiar.
15. Women are to give age at first menstrual period, how far apart then and now; whether pain before, during, or after, then and now, and where; also where the pain may extend to, as to the back, sides, groins, thighs, etc. What kind of pain (see No. 7), what relieves or aggravates, how often the pains come. Tell whether there have been miscarriages. Tell how you feel in general, before, during and after the periods; sex desire or aversion, whether intercourse is normal, unsatisfactory or painful.
16. Men are to give particulars as to male organs, if anything is not normal; whether any former disease or abuse; effect of intercourse, whether night emissions, etc.
17. Tell as to the effects of heat, cold, bathing, lying down, beginning or motion, worse or better from perspiring, from lying, whether lassitude, weakness or weariness, and how affected by activity.
18. *Similia similibus curentur* (let likes be cured by likes) implies strict individualization. In other words, the curative remedy is the one that has produced in healthy human beings symptoms most similar to those which distinguish the patient from all others suffering from the same ailment. They are the more striking, singular. Uncommon, and peculiar symptoms -- the more striking because they are more notable and remarkable; singular because they belong to the individual and to the remedy that will cure him; uncommon because seldom found in other individuals or in the pathogenesis of other remedies. They are the "characteristics".

National Center for Homeopathy

801 North Fairfax Street - Suite 306

Alexandria, Virginia 22314

(703) 548-7790

William Shevin, M.D., D.Ht.

50 Applewood Drive
Woodstock, CT 06281
www.drshevin.com

tel: (860) 9284040
fax: (860) 9280733
email: drshevin@drshevin.com

RECEIPT OF NOTICE OF HIPAA PRIVACY POLICIES
WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy Dr. Shevin's Notice of Privacy Practices.

Signature of Patient

Date

Print Name