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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):

Problem/Complaint	Date of Onset	Health Care Provider

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 life	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		Yes	No		Yes	No	
__	__	Sleep ? Hrs./night _____	__	__	Coughing	__	__	Memory
__	__	Falling Asleep	__	__	Breathing	__	__	Numbness/Tingling
__	__	Early Waking	__	__	Sore Throat			
__	__	Dreaming	__	__	Chest Pain			Men Only
__	__	Refreshed in A.M.	__	__	Shortness of Breath	__	__	Prostate
			__	__	Fainting	__	__	Sexual Difficulties
__	__	Recurrent Fever	__	__	Heart Beat	__	__	Lump
__	__	Chills	__	__	Swelling	__	__	Pain/Swelling
__	__	Night Sweats	__	__	Nausea	__	__	Discharge
__	__	Frequent Infections	__	__	Gas	__	__	Urination
__	__	Skin : Rash	__	__	Heartburn			
__	__	Itching	__	__	Swallowing			Women Only
__	__	Discoloration	__	__	Vomiting	__	__	Menstrual Periods
__	__	Infections	__	__	Constipation	__	__	Mood Changes
__	__	Slow Healing	__	__	Diarrhea	__	__	Heavy Bleeding
__	__	Joint Pain-Swelling-Stiffness	__	__	Rectal Pain	__	__	Pain
__	__	Lumps-Masses	__	__	Stomach Pain	__	__	Discharge
__	__	Bleeding Disorder	__	__	Blood in Stool	__	__	Urination
__	__	Vision				__	__	Breast Lumps
__	__	Hearing	__	__	Speech	__	__	Breast Pain
__	__	Balance	__	__	Walking	__	__	Breast Discharge
__	__	Taste	__	__	Weakness			Number of Pregnancies? _____
__	__	Touch	__	__	Shaking			Children _____
__	__	Ringing in Ears	__	__	Mood Changes			Type of Birth Control? _____
__	__	Dizziness	__	__	Personality Changes			
			__	__	Headache			Do You Smoke? Yes ___ No___
__	__	Sneezing	__	__	Thought Processes			How Much? _____

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

_____

_____

SPIRITUAL PRACTICE: Describe any regular activity.

_____

DIET SURVEY

Following is a list of foods and serving sizes in parentheses. Please complete as follows:

a) For each food you consume, fill out how you eat that specific serving size. Fill in only one box, daily, weekly, or monthly for each food. Include snacks.

b) If you do not use a particular food at all, or have discontinued the use of a food, leave thatspace blank.

c) If you are not certain about your consumption of a certain food, it may help to discuss your answer with someone familiar with your eating habits.

EXAMPLE 1: Yogurt - plain (one 8 oz. cup) Daily Weekly Monthly

This would indicate that you eat 2 cups of plain yogurt each day __2__ _____ _____

EXAMPLE 2: Doughnut (one) Daily Weekly Monthly

If you eat 2 doughnuts on Monday and 2 on Thursday, but none the rest of the week, your response would be: ____ __4___ _____

NUTRITIONAL SUPPLEMENTS	Daily	Weekly	Monthly
Wheat Germ (2 Tbsp)			
Bran (2 Tbsp)			
Brewer's Yeast (2 Tbsp)			
Protein Powder (1 Tsp)			
DAIRY PRODUCTS			
Whole Milk (1 cup)			
Skim/Low Fat Milk (1 cup)			
Yogurt (1 cup)			
Cottage Cheese (1/2 cup, 4 oz)			
Cream Cheese (1 oz)			
Other Cheeses (1 oz slice)			
Ice Cream w/Sugar (1/2 cup)			
Egg (one)			
BREADS AND PASTA			
White Bread (1 slice)			
Whole Wheat Bread (1 slice)			
Crackers (2 medium size)			
Popcorn (1 cup)			
Oatmeal (1 cup)			
Packaged Breakfast Cereals (1 cup)			
Waffle (1) or Pancakes (3)			
French Toast (2 slices)			
Pastry, Sweet Roll (1)			
Spaghetti w/Tomato Sauce (1 cup)			
Macaroni & Cheese (1 cup)			
Macaroni Plain (1 cup)			
Pasta, Whole Wheat (1 cup)			
Pizza (1 slice)			
Potato Chips (10)			
Doughnut/Cupcake or Cookie (1)			
Cake/Pie/Cookie w/Refined Sugar (1 sl)			
Cake/Pie/Cookie w/Honey (1 slice)			
FATS AND OILS			
Butter (1 Tbsp)			
Margarine (1 Tbsp)			
Vegetable Oil, Refined (1 Tbsp)			
Vegetable Oil, Cold Pressed (1 Tbsp)			
Prepared Salad Dressing (2 Tbsp)			
MEAT			
Steak (6 oz)			
Hamburger or Hot Dog (1)			
Chicken, Turkey, Poultry (6 oz)			
Lamb, Beef (6 oz)			
Pork, Ham, Sausage or Bacon (6 oz)			
Veal (6 oz)			
Organ Meat: Liver/Kidney/Heart (3 oz)			
Cold Cuts, Luncheon Meats (2 oz)			
Chicken or Beef Pot Pie (1)			
FISH			
Oysters, Clams (6 oz)			
Shrimp, Crab, Lobster (3 oz)			

FISH (continued)	Daily	Weekly	Monthly
Salmon, Tuna, Canned (3 oz)			
Fresh Fish (6 oz)			
Sardines			
BEANS			
Tofu (1/2 cup)			
Dried Beans (1/2 cup)			
Green Beans (1/2 cup)			
NUTS AND SEEDS			
Peanuts (1/2 c)/ Peanut Butter (5 Tbsp)			
Sunflower Seeds (1/2 cup)			
Pecans/Walnuts (1/2 cup)			
SWEETS			
Jam, Jelly, Syrup w/Sugar (2 Tbsp)			
Honey (2 Tbsp)			
Maple Syrup (pure) (2 Tbsp)			
GRAINS			
Brown Rice (1 cup)			
White Rice (1 cup)			
Millet (1 cup)			
Barley (1 cup)			
Bran (1 cup)			
Oats (1 cup)			
Corn (1 cup)			
Seaweed (1 cup)			
VEGETABLES			
Dark Green Vegetables (1/2 cup)			
Green Leafy Vegetables (1/2 cup)			
Squash, Summer (1/2 cup)			
Squash, Winter (1/2 cup)			
Potatoes (1 medium)			
Yams/Sweet Potatoes (1 medium)			
Avocado (1/2 large)			
Olives, Pickles (6)			
Tomatoes (1 medium)			
Salads (1 cup)			
Sprouts (1/2 cup)			
Soup: Meat (1 cup)			
Soup: Vegetable (1 cup)			
Liquids: Water (1 cup)			
Liquids: Fruit Juices (1 cup)			
Vegetable Juices (1 cup)			
Coffee (1 cup)			
Alcohol (1 beer or 1 drink)			
Other _____			
FRUITS			
Acid: Orange/Grapefruit/Pineapple			
Sub-Acid: Apple/Pears/Peaches/etc			
Tropical: Banana/Mango(1)Papaya(1/2)			
Melon (1 slice)			
Dried Fruit: Dates/Raisins/Figs(1/2cup)			

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FEES AND POLICIES

Initial Consultation (1.5 - 2 hr.)	$415.00
Initial Consultation (1 hr.) ……..……..	$260.00
Standard re-visit (1/2 hour) .....……	$130.00
Extended re-visit (45 min.) .....……	$190.00
Intermediate re-visit (15 min.) …….	$80.00
Brief visit (time and complexity dependent) ……..	$50.00
"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 polices:

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. Teel 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".

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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