New Patient Instructions

Life Extension Center 425 Main Street, 2nd Floor Ridgefield, Connecticut 06877 Phone (203) 431-6165 Fax (203) 431-6167	The Center for Integrative Medicine at the Myrna Brind Center at Thomas Jefferson Hospital Phone (215) 955-8711

George P. Zabrecky, D.C., Ph.D.
Marcia Wolinsky-Friedland, M.D.

Please read, fill out and mail or fax back to us ALL information prior to your appointment. If this is not possible, then you may bring paperwork the day of your appointment.

1. Personal Assessment Questionnaire
2. Patient Introduction Card
3. All pages requiring your signature
4. Recent relevant medical records

Doing so will allow the doctor and staff ample time to review your records and set up your patient chart.

Due to our long waiting list of new and current patients, our office policy requires a non-refundable deposit of $150.00 upon scheduling your appointment. This deposit will be forfeited unless you cancel your appointment 48 business hours or more before your scheduled appointment. If you keep your appointment as scheduled, your deposit will be credited to the charges for your initial visit.

If you decide to have our office review your medical records to verify candidacy for treatment, please enclose a check for $450.00 made out to Life Extension Center along with all pertinent medical records. This option is only determined by the New Patient Coordinator and the candidate for treatment or his/her family.

Thank you for taking the time to prepare for your appointment. We look forward to meeting you! If you have any questions, please do not hesitate to call the office. We will be happy to answer any questions you may have for our staff.

Sincerely,

Life Extension Center Office Staff

PATIENT INTRODUCTION CARD

(Please Print) Date _____

Name _____ Phone _____
(last) (first) (middle)

Address _____ City _____ State _____ Zip _____

Birth date _____ SS No. _____ ❑ Male ❑ Female No. of children _____

Occupation _____ ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Employed by _____ Business phone _____

Address _____ City _____ State _____ Zip _____

Name of spouse (name of parent, if minor) _____

Occupation _____ Birth date _____ SS No. _____

Parent's address _____ City _____ State _____ Zip _____

Person responsible for account ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

If other, name _____ Phone _____ SS No. _____

Address _____ City _____ State _____ Zip _____

Referred by _____

Have you had chiropractic care before? ❑ Yes ❑ No When? _____ Dr.? _____

FEES PAYABLE WHEN SERVICE RECEIVED

ATTENTION PATIENTS AND VISITORS:

Please refrain from wearing perfume of cologne in the office. There are many people (both patients and staff) who are chemically sensitive.

Thank you for your understanding and consideration

Life Extension Center 425 Main Street, 2nd Floor Ridgefield, Connecticut 06877 Phone (203) 431-6165 Fax (203) 431-6167	The Center for Integrative Medicine at the Myrna Brind Center at Thomas Jefferson Hospital Phone (215) 955-8711

GEORGE P. ZABRECKY, D.C.
MARCIE WOLINSKY-FRIEDLAND, M.D.

The primary goals of the Life Extension Center are threefold:

1) To discover and inhibit degeneration of the body's systems
2) To support a healthful constitution through homeostatic mechanisms
3) To improve and/or maintain quality of life

These are accomplished through extensive evaluation of the individual. Everyone has a biochemical distinction. Even identical twins do not age at the same rate or die of like diseases, but there are similarities.

Stress, in any form (trauma, negative emotions, temperature changes and extremes, etc.) stimulates specific adaptations in each of us. If we have the energy to adapt or cope quickly enough, we regain homeostasis and total recovery is achieved. If our regulatory systems are overwhelmed, then we maladapt and enter a phase of imbalance. In acute injury, this is usually the formation of scar tissue followed by incomplete recovery. However, in ***chronic disease***, the maladaption process may persist for months, years or decades. This situation produces most ***chronic degenerative disease*** such as arthritis, maturity onset diabetes, heart disease and cancer.

Many stresses burden us daily - such as poor diet, high pressure occupations, constant air travel and emotional upsets (divorce, death of a friend or family member). Many chronic diseases develop from maladaptation due to deficiency (malnutrition), mutation, infection and/or poisoning (environmental/ecological toxicity).

A major part of how our bodies react to stress is genetic. This is why diseases follow a family in its history. All chronic diseases have one common denominator; they are all forms of ***degeneration***. Whether they are called atherosclerosis, arteriosclerosis or multiple sclerosis, they are all forms of ***degeneration***.

Abnormal degeneration is inhibited in our bodies by maintaining biological efficiency and developing mature defense mechanisms (homeostatic mechanisms). To maintain highly efficient body responses, we must have the energy from our food to express the genetic potential necessary for rapid and complete adaptation. Our food must be properly ingested, digested, absorbed and utilized to provide the energy needed to suppress disease. This is why a competent hormonal system and intact nerve transmission are necessary to recognize and activate proper adaptive responses. This balance is maintained by recognizing and activating proper adaptive responses. Imbalance may be corrected through chiropractic, adjunctive nutritional support, aggressive vitamin and supplement therapy, acupuncture, intravenous nutrient therapy and health changes to lifestyle. Severe chronic disease states can be improved and palliated with medication.

We do not age and deteriorate at the same rate. The evaluation at the Life Extension Center often yields significant information which we use to increase control of this rate by our patients.

Evaluation at the Life Extension Center is expressly devoted to the following:

- To evaluate the body's current risk for disease
- To evaluate for interfering structural, biochemical and environmental factors
- To treat any active disease process
- To recommend a referral to other physicians or health care professionals for co-treatment, as required
- To support genetic weaknesses through prevention, which helps fortify and maintain the body's reserves
- To educate the patient to make changes which will reverse the degenerative process

APPOINTMENTS AT OUR OFFICE

Due to the nature of our practice, there may be a three week wait for a new patient appointment with Dr. Zabrecky. In our effort to accommodate our patients, a new patient may be given an earlier appointment with our associate, Dr. Marcie Wolinsky. This appointment will allow a new patient to begin initial contact with a health care provider in our office. A history, physical exam, blood testing or other laboratory testing will be taken at this appointment. If records are reviewed in advance by our office, therapy may be initiated during this first appointment based on these medical records ***(please see Medical Records)***. A new patient is always given a follow-up appointment with Dr. Zabrecky two to three weeks later to allow for all testing to return for his review ***(please see Follow-Up Appointments)***. The new patient will be charged accordingly for laboratory testing and supplements upon the completion of this visit.

FEE STRUCTURE

The standard health evaluation for a new patient with the physician runs anywhere from one hour to an hour and a half. Fees are charged at the rate of $450.00 per hour. A $150.00 deposit is required at the time the appointment is scheduled. Cancellations must be made 48 business hours prior to your appointment or your $150.00 deposit will be forfeited. Any lab tests will be billed in addition to the evaluation. We urge patients to bring any previous testing that they have from other health care providers for the physicians to review. We will not repeat lab work that has already been performed to reduce charges for the patient.

If results of testing or symptomatology warrant, further testing will be recommended. This may consist of food allergy testing, cardiac or diabetic risk factor assessment, specific mineral/toxic metal testing, functional vitamin assays for deficiencies, immune system or endocrine systems evaluations, evaluation for malignant/pre-malignant states or suspected chronic infections. The costs of these tests are an additional charge and the necessity will be discussed in detail if recommended to the patient. The charges for any specific, non-routine tests are in addition to the initial visit cost. An average New Patient visit with lab testes and/or supplements could range from $650 - $1,200.00.

Please Initial _____

TELEPHONE CONSULTATIONS

Telephone consultations are utilized in place of follow-up office visits or to provide an initial assessment of new patients who live long distances from our office in Connecticut.

If you are a new patient and are planning to schedule a telephone consultation with Dr. Zabrecky or Dr. Wolinsky, the following is required for your appointment:

1. All medical records pertinent to the patient's diagnosis or disorder are required to be sent to our offices via fax or mail. An office staff member will instruct a patient on how to obtain your medical records from your other physicians if you do not have copies on hand.
2. The new patient letter must be read thoroughly, signed and sent or faxed back to our offices with the patient's medical records.
3. Fees for a new patient telephone consultation are billed at the rate of $450.00 per hour. ***A prepayment is required for all new patient Telephone Consultations.*** An Easy Pay Consent form is to be filled out, signed and returned to our office with a patient's medical records and signed new patient letter.

When the above items are received from the patient, an office staff member will telephone the prospective patient to schedule the telephone consultation date and time that the physician will call.

After a new patient telephone consultation, a patient will be given recommendations and referrals, or this information will be reviewed during a follow-up appointment. A patient may be requested to make a follow-up appointment to come to the Ridgefield office, see one of our associated physicians or attend a treatment session at another medical facility. These options are discussed with the patient during the initial contact and during the

telephone consult. All patients are given specific therapies conjunctive to their specific case and diagnosis. Treatment may not be recommended to start before a follow-up appointment. A patient's credit card is charged *after* the appointment date, *not before*.

FOLLOW-UP APPOINTMENTS

A report of findings and their significance will be given at a subsequent visit. This second visit will be scheduled for two to three weeks after your initial visit with one of our health care providers. This will allow sufficient time for all laboratory testing to be completed and returned to our office for your follow-up visit. Consultation fees for follow-up appointments and telephone consultations are $225.00 per half hour for Dr. Zabrecky and/or Dr. Wolinsky. If you need to cancel your appointment, we require 24 hours notice or there will be a missed appointment fee charged for your allotted scheduled time. Requests for information from an insurance carrier may require additional work, copying of records, etc. and will be billed at the rate of $30.00 per hour.
Please Initial _____

INSURANCE AND BILLING

Our offices do not accept assignment for insurance. Our offices are not affiliated with HMO or Managed Care Networks. Some insurance companies may reimburse for nutritional support, preventative health care, diagnostic testing and chiropractic services. We recommend you contact Member Services at your insurance company. They will be able to provide you with information regarding your eligibility for services performed at our offices. *All referrals, pre-certification and out-of-network benefits are the responsibility of the patient and NOT this office. MEDICARE DOES NOT COVER OUR SERVICES. If you are covered by Medicare, you must sign the enclosed form regarding our opting out of Medicare.*

Our office will provide a superbill for your submittal, with all information necessary for insurance reimbursement. This is not a guarantee of coverage. In order to keep our services as affordable as possible, our office is on a fee-for-service basis. Payment is expected at the time of the visit.
Please Initial _____

MEDICAL RECORDS

If you have been treated in the past by your Primary Care Physician, or any other health care provider, you may obtain copies of your medical records to bring to your first appointment. This may prove to be cost effective. We will not repeat a laboratory test unnecessarily. This may actually lower the cost of your first appointment.

To obtain medical records from another physician or medical facility, we suggest that you contact your physician's office or hospital where the testing was performed and request your medical records. As general office procedure, most offices request a signed medical release form from the patient to protect your confidential records. In some states, a medical office or hospital may require thirty (30) days notice to release your medical records or require records to be sent directly to the physician at the office address. There may be a charge for this service. You may call your physician's office or make a request in writing (via fax or mail) to forward or fax your records directly to Dr. Zabrecky for more immediate results. It is always best to fax a written request to the medical facility or travel to your physician's office to pick-up copies of your records and sign the release. One of our staff members will assist you in obtaining records for an immediate appointment.

You may decide to copy your records for your own personal file. On your first appointment, our office will be happy to copy records, at no charge, that Dr. Zabrecky will keep on file. Copies of your testing performed in our office are available at no charge to the patient. Additional copies of your testing performed in our office are available for a small fee.

After careful review of your records, Dr. Zabrecky reserves the right not to accept a patient for care if he feels this patient cannot be benefited by treatments. A patient may be referred to our medical staff members or a physician outside of this office.

Most patients are accepted for treatment at our facility. If further treatment or medication is required, a patient may be referred to an outside medical facility that handles such critical care

Our offices do not handle emergency situations. If you have a medical emergency, please report to the nearest emergency room.
Please Intial _____

FORMS OF PAYMENT

Our offices are on a fee-for-service basis. Payment is expected in FULL at the time of each visit. As stated earlier in this letter, our office does not accept insurance assignment.
Please Initial_____

Forms of payment are cash, checks, and all major credit cards. An Easy Pay Consent Form is available for download via our web site. It is to be filled out and returned with all other paperwork and medical records for your file. This form will allow our offices to charge telephone consultations, supplement orders and any monthly balances that you may incur at our office.

All medical and financial records are kept completely confidential. If you have any questions concerning our office payment policy, please do not hesitate to speak to a staff member.

PREPARATION FOR YOUR FIRST VISIT

For your first in-office appointment, please do the following:

1. Please read this information CAREFULLY!
2. Fasting is not required for any blood testing you may receive on your first appointment.
3. Mail enclosed paperwork, signed forms, laboratory results and medical records pertinent to your diagnosis or major complaint back to this office prior to your scheduled appointment.
4. You may wish to bring a tape recorder. Some patients find it helpful to replay the information at home.
5. Make sure you or anyone that accompanies you does not wear perfume or cologne.

For your first telephone consultation, please do the following:

1. Please read this information CAREFULLY!
2. Please mail all paperwork, i.e. signed forms, laboratory results and medical records pertinent to your diagnosis or major complaint. These must be received prior to your scheduled appointment.

I have read this letter and understand its content. I have been informed that Dr. George Zabrecky utilizes chiropractic, nutrition and other conservative health care measures within the scope of his Connecticut chiropractic license. I understand if prescription medication, intravenous therapy or surgery is needed, I will be referred to the appropriate medical practitioner. I also understand that this facility does not provide insurance services, Medicare coverage, emergency or critical/crisis care.

_____

Patient Name (Print) Patient Signature

_____

Parent/Guardian Signature Date

Please remember to sign the introductory letter and fill out the questionnaire. Please bring all paperwork to your first appointment or fax back to our offices for a phone consultation. Please remember, the maintenance of health requires some discipline, moderation and maturity. The resolution of disease also requires vigilance and patient. I look forward to meeting with you!
George P. Zabrecky, D.C.
Marcie Wolinsky-Friedland, M.D.

Life Extension Center 425 Main Street, 2nd Floor Ridgefield, Connecticut 06877 Phone (203) 431-6165 Fax (203) 431-6167	The Center for Integrative Medicine at the Myrna Brind Center at Thomas Jefferson Hospital Phone (215) 955-8711

GEORGE P. ZABRECKY, D.C.
MARCIE WOLINSKY-FRIEDLAND, M.D.

Directions to our **Connecticut** office:

From New York: Take the Hutchinson Parkway from New York to 684 North. Follow 684N to Exit 6, Katonah, Route 35. Take a right onto Route 35 and follow all the way to Ridgefield, CT. As you approach the center of Ridgefield, you will come to a fork in the road by a large water fountain. Bear left at this fork which is Route 35, Main Street, Ridgefield. Second traffic light is directly in front of Town Hall on Main Street, Ridgefield. Our office is located at 425 Main Street, 2nd floor, directly across the street from The Gap. On and off street parking is available.

From I-95 and the Merritt Parkway: Traveling on the Merritt Parkway, follow to Exit 39B, Danbury, Route 7 North. Traveling on I-95, follow to the Danbury, Route 7 North Exit. Turn right at the first light. At the next light at the bottom of the ramp, the Dept of Motor Vehicles is straight ahead and the ramp end. At the light, take a left onto Route 7 N, Ethan Allen Highway. Make a left onto Route 102, follow to the end. You will arrive at a stop sign directly facing the Jesse Lee Memorial Church. Take a right hand turn onto Route 35, Main St., Ridgefield. Second traffic light is directly in front of Town Hall on Main Street, Ridgefield. Our office is located at 425 Main Street, 2nd floor, directly across the street from The Gap. On and off street parking is available.

From Northern New England – Route 84: Traveling from Hartford, CT, take Route 85 West to Exit 3. Follow the signs to Norwalk and South. You will pass the Danbury Mall and Airport on the right. Follow Route 7 South to Route 35. At the traffic light, turn right onto Route 35 and follow into Ridgefield. Route 35 is Danbury Road and as you enter Ridgefield, it will become Main Street, Ridgefield. At the seventh traffic light, you will have arrived at the center of the Town or Ridgefield. Second traffic light is directly in front of Town Hall on Main Street, Ridgefield. Our office is located at 425 Main Street, 2nd floor, directly across the street from The Gap. On and off street parking is available.

LIFE EXTENSION CENTER
425 Main Street
Ridgefield, Connecticut 06877
Phone (203) 431-6165
Fax (203) 431-6167

The Center for Integrative Medicine at the
Myrna Brind Center at Thomas Jefferson
Hospital
Phone (215) 955-8711

Patient's Name _____Sex _____ Age _____

Height _____ Weight _____ Date _____
Please bring this in with you on your first visit; or mail it. **We would appreciate a 48 hour cancellation notice.**

Your appointment is: _____

Patient Selection

At the Life Extension Center, we understand that many of our patients…

● Are unresponsive or are poorly responsive to the conventional standard of care.

● Have acute or chronic conditions which have not been fully explored or diagnosed with conventional approaches.

● Have conditions which can be managed, in part, by conventional medicine, but with continued progression of the disease process and deterioration in quality of life.

● Have conditions for which no conventional standard of care is currently available.

The Life Extension Center has limitations, as do all providers of medical care. In order to provide more effective care for our patients, we strive to accept those individuals we believe can benefit the most through our integrative medicine approach. Therefore, patient selection is a critical aspect of our progress. As a result, all prospective new patients are interviewed by our staff and screened to determine if they are appropriate candidates for treatment at the Life Extension Center.

QUESTIONNAIRE

Please circle (NO) or (YES) if you have had any of the following life changes within the last two (2) years.

1.	Death of spouse ……..	NO	YES	22.	Major revision of personal habit……..	NO	YES
2.	Divorce……	NO	YES	23.	Changing to a new	NO	YES
3.	Marital separation……	NO	YES	24.	Change in	NO	YES
4.	Death of close family member……	NO	YES	25.	Major change in	NO	YES
5.	Marriage……	NO	YES	26.	Major change in church activities……	NO	YES
6.	Marital reconciliation……	NO	YES	27.	Major change in social	NO	YES
7.	Major change in health of family……	NO	YES	28.	Major change in sleeping habits……	NO	YES
8.	Pregnancy……	NO	YES	29	Major change in eating habits……	NO	YES
9.	Addition of new family member……	NO	YES	30.	Vacation in the last 3	NO	YES
10.	Major change in arguments with wife/husband	NO	YES	31.	Christmas in the last 3	NO	YES
11.	Son or daughter leaving home……	NO	YES	32.	Minor violations of the	NO	YES
12.	In-law troubles……	NO	YES	33.	Being fire from	NO	YES
13.	Wife/husband starting or ending work……	NO	YES	34.	Retirement from	NO	YES
14.	Major change in family get-togethers……	NO	YES	35.	Major business	NO	YES
15.	Detention in jail……	NO	YES	36.	Changing to different line of work……	NO	YES
16.	Major personal injury or illness……	NO	YES	37.	Major change in work responsibility……..	NO	YES
17.	Sexual difficulties……	NO	YES	38.	Trouble with boss……	NO	YES
18.	Death of a close friend……	NO	YES	39.	Major change in working conditions…..…	NO	YES
19.	Outstanding personal achievement……	NO	YES	40.	Major change in financial	NO	YES
20.	Start or end of formal schooling……	NO	YES	41.	Mortgage or loan over	NO	YES
21.	Major change of living conditions……	NO	YES	42.	Mortgage	NO	YES
				43.	Mortgage or loan less than 50,000……..…	NO	YES

Please circle appropriate answer.

1. If female, are you pregnant? NO YES
2. Have you any of the following diagnosed health history problems?
   - Heart disease NO YES
   - Cancer NO YES
   - Diabetes NO YES
   - High blood pressure NO YES
   - Kidney problems NO YES
   - Obesity NO YES
   - Stroke NO YES
   - Arthritis NO YES
   - Periodontal disease (oral, gum and bone problems) NO YES
3. Have you had a family history of any of the following conditions?
   - Heart disease NO YES
   - Cancer NO YES
   - Diabetes NO YES
   - High blood pressure NO YES
   - Kidney problems NO YES
   - Obesity NO YES
   - Stroke NO YES
4. Are you now taking any of the following medications?
   - Antihypertensive (blood pressure) NO YES
   - Antidiabetic NO YES
   - Antibiotic NO YES
   - Anticancer NO YES
   - Antidepressants NO YES
   - Drugs for ulcers or stomach upsets NO YES
   - Sleeping pills or muscle relaxants NO YES
   - Oral contraceptives NO YES
5. Do you exercise at least three times per week? NO YES
6. Do you use a seatbelt when in a car? NO YES
7. Do you have a history of high blood pressure? NO YES
8. Are you currently under greater than normal amounts of stress? NO YES
9. Do you brush your teeth after meals? NO YES
10. Do you floss your teeth each day? NO YES
11. What is your average daily alcoholic drink consumption? (1 drink = 1 ounce hard liquor, 1 beer or 1 glass of wine)
    1. none 2. 1-2 drinks 3. 3-4 drinks 4. 5 or more drinks
12. How much do you smoke daily?
    1. none 2. less than 1/2 pack 3. less than 1 1/2 packs 4. greater than 1 1/2 packs
13. Please give the daily overall hours for the following (should equal 24 hours):
    Sleep: _____ Rest: _____
    Physical Activity: Vigorous _____ Moderate _____ Light _____ Sedentary _____
14. What is your daily coffee, tea or cola consumption?
    1. one cup _____ 2. two to three cups _____ 3. more than three cups _____

Please place the appropriate number of your answer in the box to the right.

1.	If female, do you have irregular menstrual periods or menstrual pain? 1. no 2. slight 3. moderate 4. significant……	
2.	If female, do you have excess hair on your face, arms or legs? 1. no 2. slight 3. moderate 4. significant……	
3.	If male, are you subject to impotence, premature ejaculation, or difficulty in maintaining an erection? 1. no 2. slight 3. moderate 4. significant……	
4.	Do you have a history of a weight problem? 1. no 2. slight 3. moderate 4. significant……	
5.	Do you have white spots under your fingernails or ridges in your nails? 1. no 2. slight 3. moderate 4. significant……	
6.	Do you feel consistently cold or have cold hands and/or feet? 1. no 2. slight 3. moderate 4. significant……	
7.	Do you have allergies, asthma, or a chronic sniffle? 1. no 2. slight 3. moderate 4. significant……	
8.	Is it difficult for you to get started in the morning? Do you feel tired? 1. no 2. slight 3. moderate 4. significant……	
9.	Do you have dryness of the hair or skin or persistent dandruff? 1. no 2. slight 3. moderate 4. significant……	
10.	Do you get frequent colds or infections? 1. no 2. slight 3. moderate 4. significant……	
11.	Are you subject to constipation? 1. no 2. slight 3. moderate 4. significant……	
12.	Do you often have bloating, gas, or abdominal pain; particularly after eating? 1. no 2. slight 3. moderate 4. significant……	
13.	Do you suffer from aching and/or stiffness of the muscles and joints? 1. no 2. slight 3. moderate 4. significant……	
14.	Do you get headaches? 1. no 2. slight 3. moderate 4. significant……	
15.	After walking, do you have chest pain, a heaviness in your legs, or feel short of breath? 1. no 2. slight 3. moderate 4. significant……	
16.	Do you have frequent bad breath or bad tastes in your mouth? 1. no 2. slight 3. moderate 4. significant……	
17.	Does your stool appear yellow or clay-colored, foul-odored, or contain undigested foods? 1. no 2. slight 3. moderate 4. significant……	
18.	Do you have a history of anemia? 1. no 2. slight 3. moderate 4. significant……	
19.	Do you have symptoms aggravated by worry and/or tension? 1. no 2. slight 3. moderate 4. significant……	
20.	Are your eyes sensitive to light or dark? 1. no 2. slight 3. moderate 4. significant……	
21.	Does your heart pound and are you easily "shaken up" or startled by an unexpected noise? 1. no 2. slight 3. moderate 4. significant……	
22.	How long can you hold your breath? 1. < 60-75 seconds 2. 76-90 seconds 3. 10-30 seconds 4. > 110……	
23.	Does your heart seem to miss beats occasionally? 1. no 2. slight 3. moderate 4. significant……	
24.	At rest, what is your heart beat per minute? 1. < 60-75 seconds 2. 76-90 3. 91-110 4. > 110……	

25. Is your tongue cracked, bluish-red in color, or very smooth (no bumps)?
    1. no 2. slight 3. moderate 4. significant……

26. Are your teeth and gums infected, loose, or subject to periodontal disease?
    1. no 2. slight 3. moderate 4. significant……

27. Have you had major surgery including hysterectomy, coronary bypass, mastectomy, or other cancer surgery?
    1. no 2. yes……

28. Do you have difficulty urinating due to pain or poor flow?
    1. no 2. slight 3. moderate 4. significant……

29. Do you have muscle weakness?
    1. no 2. slight 3. moderate 4. significant……

30. Do you have bloodshot eyes or a feeling of sand in your eyes?
    1. no 2. slight 3. moderate 4. significant……

31. Do you have redness at the corners of your nose or mouth, cracked lips, or dermatitis?
    1. no 2. slight 3. moderate 4. significant……

32 Do you often feel drowsy after eating or feel shaky before meals?
    1. no 2. slight 3. moderate 4. significant……

33. Do your ankles swell in hot weather or do you have hay fever?
    1. no 2. slight 3. moderate 4. significant……

34. Is your skin rough or bumpy, particularly on the back of your arms?
    1. no 2. slight 3. moderate 4. significant……

35. To your knowledge, have you ever passed albumin (protein) in your urine?
    1. no 2. slight 3. moderate 4. significant……

36. Do you have night thirst or night sweats or are you constantly thirsty?
    1. no 2. slight 3. moderate 4. significant……

37. Do you have a history of boils, sores that do not heal, or acne?
    1. no 2. slight 3. moderate 4. significant……

38. Do you feel lightheaded when you stand up quickly?
    1. no 2. slight 3. moderate 4. significant……

39. Do you have recurring vaginal or urinary infections?
    1. no 2. slight 3. moderate 4. significant……

40. Do you have a history of kidney stones or blood in the urine?
    1. no 2. slight 3. moderate 4. significant……

41. Any further information important to your health:

CREDIT CARD PREAUTHORIZATION

LIFE EXTENSION CENTER
425 Main Street
Ridgefield, Connecticut 06877
Phone (203) 431-6165
Fax (203) 431-6167

The Center for Integrative Medicine
at the Myrna Brind Center
at Thomas Jefferson Hospital
Phone (215) 955-8711

Dear Patient,

For your convenience, you may pay your account balance with your credit card. Please complete the information below:

Patient Name:_____ Date:_____

I authorize the health care provider shown above to charge my credit card account for my balance due for:

- ❑ Past services
- ❑ This visit only
- ❑ All visits this year
- ❑ Recurring charges for ongoing treatments:
  $_____ per _____
  Amount Week or Month

  from_____ to _____
  Date Date
- ❑ Other_____
  _____
  _____

❑ Mastercard ❑ VISA ❑ American Express

❑ Other_____

Charge Account Number_____Exp. Date_____

Cardholder Name_____

I understand that this form is valid for one year unless I cancel the authorization with written notice to the health care provider.

Cardholder Signature_____

Life Extension Center
425 Main Street, 2nd Floor
Ridgefield, Connecticut 06877
Phone (203) 431-6165 Fax (203) 431-6167

The Center for Integrative Medicine
at the Myrna Brind Center
at Thomas Jefferson Hospital
Phone (215) 955-8711

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name _____
Last First Middle Initial

Address_____
Street City State

Home Phone_____DOB_____Patient #_____

I,_____, authorize the release of medical information from my medical records to:

- ☐ Dr. George P. Zabrecky and Dr. Marcie Wolinsky-Friedland
- ☐ Myself: _____
- ☐ Other: _____
  Please specify name or organization where records are being sent
- ☐ My Insurance Company:_____

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

- ☐ Entire Record
- ☐ Specific Information:_____
- ☐ Old Records from Previous Physicians:_____

I give special Permissions to release and information regarding: (initial on applicable line(s) below)

_____Substance Abuse _____ Psychiatatric/Mental Health Information _____ HIV Information
Reason for request

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date_____
If not patient, state relation

Witness_____Date_____

Spouse/Family Information Disclosure

Life Extension Center 425 Main Street, 2nd Floor Ridgefield, Connecticut 06877 Phone (203) 431-6165 Fax (203) 431-6167	**The Center for Integrative Medicine** at the Myrna Brind Center at Thomas Jefferson Hospital Phone (215) 955-8711

I,_____

_____/_____/_____

(Print Name) (Date of Birth)

Request the following restrictions to the use or disclosure of my protected information.

Life Extension Center may discuss my medical condition/information with the following people:

Please circle YES or NO and print in the appropriate person's name.

Spouse:	YES	NO	Name:_____
Parents:	YES	NO	Name:_____
	YES	NO	Name:_____
Children:	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____
Significant Other:	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____

Patient Signature:_____ Date:_____

Notice of Privacy Practices

The Life Extension Center, LLC

Effective Date: August 1, 2008

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians, or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to

agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Georgia law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

20. Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Georgia law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: **Department of Health and Human Services, Office of Civil Rights**

You will not be penalized for filing a complaint.

Complaints submitted to the DHHS Office for Civil Rights should be directed to:

Office for Civil Rights/U.S. Department of Health & Human Services
61 Forsyth Street, SW. - Suite 3B70/Atlanta, GA 30323
(404) 562-7886; (404) 331-2867 (TDD)
(404) 562-7881 FAX

The Physicians and Staff of the Life Extension Center Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") covers physicians and all other health care providers, health insurance companies and their claims processing staffs.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices on their first visit to us. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name:_____
(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:

_____