Mitchell A. Fleisher, M.D., D.Ht., D.A.B.F.M.
Homeopathic Family Medicine & Nutritional Therapy
AlternativeMedCare.com

PATIENT REGISTRATION FORM

Last Name:	First Name:		MI:
Social Security #:	Date of Birth:	Sex:	M F
Address:			Apt #:
City:	P.O. Box:	State:	Zip:
Home Phone: ( )	Work Phone: ( )	Fax:	
Occupation:	Employer:	E-mail:	
Address:	City:	State:	Zip:

Marital Status (Circle one) Single Married Separated Divorced Widowed

Spouse's Name:	
Spouse's Employer:	Work Phone: ( )
Emergency Contact:	Emergency Contact Phone: ( )

Other Family Members

First Name	MI	Last Name	S.S. #	Date of Birth	Sex

How were you referred to us?

- Q Internet
- Q Our web site
- Q Magazine
- Q Yellow Pages
- Q Another Patient - Name:
- Q Another Doctor - Name:
- Q Other:

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

For each member of your family read down the list and put a check in the boxes which apply. Put one check for each relative having a certain disease, e.g., put 3 checks in Grandparents - Stroke, if 3 of your grandparents suffered strokes. Indicate age only if deceased.

	Father	Mother	Brothers	Sisters	Spouse	Children	Grandparents	Aunts/Uncles
Age (at death only)								
Cause of Death								
Cancer								
Tuberculosis								
Diabetes								
Heart Trouble								
High Blood Pressure								
Stroke								
Allergies or Asthma								
Anemia/Blood Disease								
Mental Illness								
Genetic Disease								
Alcoholism, Drug Abuse								
Kidney Disease								
Arthritis, Autoimmune								
Venereal Disease								
Malaria								

PERSONAL HISTORY

Put a check in the box next to any of the following that you now or have ever had:

○ Measles	○ Chronic Sinusitis	○ Serious infection	○ Hay fever	○ Serious injury	○ other
○ Mumps	○ Bronchitis	○ Malaria	○ Frequent Colds	○ Alcoholism or Drug Abuse	_____
○ Chicken pox	○ Pneumonia	○ Yellow jaundice	○ Neuritis or Neuralgia	○ Nervous breakdown or Psychosis	_____
○ Polio	○ Pancreatitis	○ Liver disease/Hepatitis	○ Sciatica	○ Hyperactivity and/or A.D.D.	_____
○ Diphtheria	○ Ulcers	○ Skin disorders	○ Low Back Pain	○ Heart trouble	_____
○ Small pox	○ Diverticulosis	○ Kidney disease or Stones	○ Anemia or Blood disease	○ Hypertension/High Blood Pressure	_____
○ Meningitis	○ Hernias	○ Venereal disease	○ Diabetes	○ Stroke	_____
○ Scarlet fever	○ Hemorrhoids	○ Tuberculosis	○ Hormonal disorders	○ Gall Bladder disease	_____
○ Rheumatic fever	○ Bone/Joint disease	○ Concussion/Head injury	○ Thyroid disease	○ Rabies	_____
○ Genetic disease	○ Cancer	○ Migraines/Headaches	○ Anxiety	○ Reaction to drugs, vaccines, transfusions	_____
○ Chronic Fatigue	○ Seizures/Epilepsy	○ Neurological disorders	○ Depression	To what?	

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalization below. Use the reverse side if needed. (Do not include normal pregnancies)

Year	Operation or Illness	Physician's Name	City and State

Please list the name and address of any other physicians who have treated you in the past year and the problem for which you were treated (Do not include visits for cold, flus or other minor acutes)

Physician's Name	Address	Problem

MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past. Please give the name and dosage of all current medicines.

Present	Past		Present	Past	
		Antibiotics			Diabetes medicines
		Pain medicine			Arthritis medicines
		Diuretics (water pills)			Diet pills
		Sedatives			Antacids or laxatives
		Blood pressure medicines			Birth control pills
					Hormones
		Heart medicines			Antimalarial drugs
		Thyroid medicines			Antituberculosis drugs
		Aspirin			Allergy desensitization
		Vitamins & Herbs			Other

DRUG ALLERGIES

Please list any and all medicines you are allergic to, e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.

TESTS AND IMMUNIZATIONS

Check those tests and immunizations which you have had. Enter the year when you last were given the tests or shots.

Year		Year		Year	
	Chest X-Ray		Sigmoidoscopy		DPT
	Kidney X-Ray		PAP smear		Tetanus
	G.I. Series		Nutritional Analysis		Flu shot
	Colon X-Ray		Polio series		Pneumonia shot
	Electrocardiogram		Measles, mumps, rubella		Other
	TB test		HIV vaccine		
	CT or MRI scan		Ultrasound		

HEALTH FACTORS

Please check those items below that apply.

Yes	No	Do you drink or use?		Yes	No	
		Coffee?	__ cups/day			Do you use an electric blanket?
		Tea?	__ cups/day			Do you have silver-mercury amalgams in your mouth?
		Sodas?	__ cans/day			Do you exercise regularly?
		Beer?	__ cans/day			How much?
		Wine?	__ glasses/day			Do you meditate regularly?
		Other alcohol?	__ glasses/day			Do you use “recreational” drugs, e.g. cocaine, LSD, marijuana, etc.?
		Cigarettes?	__ packs/day			Have you any known environmental sensitivities or past or present toxic chemical exposure?
		Cigars?	__ cigars/day			Please describe:
		Pipe?	__ bowls/day			
		Chew tobacco?				
		Snuff?				

Please describe your emotional nature and personality characteristics, especially the major issues in your life:

HEALTH QUESTIONNAIRE

If you have recently been bothered with these problems check **YES**.

Yes	No		Yes	No		Yes	No	
♀	♀	frequent or severe headache	♀	♀	recurring indigestion	♀	♀	aching muscles or joints
♀	♀	neck pains	♀	♀	frequent belching	♀	♀	swollen joints
♀	♀	neck lumps or swelling	♀	♀	nausea	♀	♀	back or shoulder pains
♀	♀	loss of balance	♀	♀	vomiting	♀	♀	weakness in arms or legs
♀	♀	dizzy spells	♀	♀	pain in abdomen	♀	♀	painful feet
♀	♀	blackouts/fainting	♀	♀	bloated abdomen	♀	♀	trembling
♀	♀	wear glasses	♀	♀	constipation	♀	♀	numbness
♀	♀	blurry vision	♀	♀	loose bowels	♀	♀	leg cramps
♀	♀	eyesight worsening	♀	♀	black stools	♀	♀	skin problems
♀	♀	see double	♀	♀	gray or whitish stools	♀	♀	scalp problems
♀	♀	see halos or lights	♀	♀	pain in rectum	♀	♀	itching or burning skin
♀	♀	eye pains or itching	♀	♀	itching rectum	♀	♀	bruise easily
♀	♀	watering eyes	♀	♀	blood in stools	♀	♀	nervousness or anxiety
♀	♀	hearing difficulties	♀	♀	frequent urination	♀	♀	nervous with strangers
♀	♀	earaches	♀	♀	involuntary escape of urine	♀	♀	nail biting
♀	♀	running ears	♀	♀	burning on urination	♀	♀	difficulty making decisions
♀	♀	noises in ears	♀	♀	brown, black or bloody urine	♀	♀	lack of concentration
♀	♀	dental problems	♀	♀	weak urine stream	♀	♀	absentminded/loss of memory
♀	♀	sore or bleeding gums	♀	♀	difficulty starting urine	♀	♀	lonely or depressed
♀	♀	sore tongue	♀	♀	constant urge to urinate	♀	♀	frequent crying
♀	♀	congested nose	♀		**(MEN ONLY)**	♀	♀	hopeless outlook
♀	♀	running nose	♀	♀	burning or discharge	♀	♀	difficulty relaxing
♀	♀	sneezing spells	♀	♀	lumps or swelling on testicles	♀	♀	worry a lot
♀	♀	head colds	♀	♀	painful testicles	♀	♀	frightening dreams or thoughts
♀	♀	nosebleeds	♀		**(WOMAN ONLY)**	♀	♀	feeling desperation
♀	♀	sore throat	♀	♀	a missed period	♀	♀	shy or sensitive
♀	♀	difficulty swallowing	♀	♀	menstrual problems	♀	♀	dislike criticism
♀	♀	hoarse voice	♀	♀	bleeding between periods	♀	♀	angered easily
♀	♀	wheezing or gasping	♀	♀	tension or pain before periods	♀	♀	annoyed by little things
♀	♀	frequent coughing	♀	♀	heavy bleeding	♀	♀	family problems
♀	♀	cough up phlegm	♀	♀	bearing down feeling	♀	♀	problems at work
♀	♀	cough up blood	♀	♀	vaginal discharge	♀	♀	sexual difficulties
♀	♀	chest colds	♀	♀	genital irritation	♀	♀	considered suicide
♀	♀	rapid or skipped heartbeats	♀	♀	pain on intercourse	♀	♀	sought psychiatric help
♀	♀	chest pains	♀	♀	swelling or lumps in breasts	♀	♀	loss or gain in weight
♀	♀	shortness of breath with normal activity	♀	♀	painful breasts	♀	♀	often feel warmer or colder than others
♀	♀	swollen feet or ankles			____ # of pregnancies	♀	♀	loss of appetite
					____ # of births	♀	♀	always hungry
					____ miscarriages	♀	♀	armpits or groin swelling
					____ premature births	♀	♀	unusual fatigue or weariness
					____ cesareans	♀	♀	difficulty sleeping
					____ abortions	♀	♀	fever or chills
						♀	♀	motion sickness
						♀	♀	excessive sweating
						♀	♀	night sweats
						♀	♀	hot flashes

Comments or Special Problems:

_____

_____

Mitchell A. Fleisher, M.D., D.Ht., D.A.B.F.M.
Homeopathic Family Medicine & Nutritional Therapy
Rockfish Center, Suite 1, Nellysford, VA 22958
(434) 361-1896

Contract for Homeopathic and Nutritional Medical Services

Dear Patient:

Homeopathy and Nutritional Medicine are distinct, specialized types of medical services apart from allopathic or conventional medical practice. Due to the unique office visit and the extraordinary amount of time and effort required by Dr. Fleisher to conduct the homeopathic and nutritional medical examination and interview, the charge may not be adequately reimbursed by health insurance.

Please note: We are currently restricted from billing for homeopathic and nutritional medical services to Medicare, Medicaid, Blue Cross/Blue Shield and other health insurers. Also, Medicare and Medicaid patients cannot personally file for reimbursement from Medicare and Medicaid.

You will be fully responsible for the payment of all fees at the time that homeopathic and nutritional medical services are rendered. An invoice with the appropriate coded billing information will be provided to you for submittal to your insurance company for your reimbursement.

You acknowledge the receipt of and agreement with all of our medical practice's payment requirements within our Homeopathic Practice Information document, including those regulations regarding confirmed consultations that are missed.

Please sign the following statement, which will serve as a billing contract for homeopathic and nutritional medical services.

"I understand that I am responsible for the full payment of fees for homeopathic and nutritional medical visits at the time service is rendered."

Signed:_____
Patient, Parent or Guardian

Print Name:_____

Date:_____

Mitchell A. Fleisher, M.D., D.Ht., D.A.B.F.M.
Homeopathic Family Medicine & Nutritional Therapy
Rockfish Center, Suite 1, P.O. Box 303,
Nellysford, Virginia 22958
(434) 361-1896

Patient Acknowledgement of Receipt/Review of the Notice of Privacy Practices

PATIENT NAME: _____

By signing this form, I am acknowledging my receipt and/or review of the posted Notice of Privacy Practices of Mitchell A. Fleisher, M.D., D.Ht., D.A.B.F.M., Homeopathic Family Medicine & Nutritional Therapy. I have been given the right to review the Notice of Privacy Practices prior to signing this form.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Legal Guardian (if applicable)

_____
Print Name of Patient

_____
Date

Please kindly complete and return with the Patient Registration Form.

HOMEOPATHIC PRACTICE INFORMATION

Mitchell A. Fleisher, M.D., D.Ht., D.A.B.F.M.
Center for Integrative & Regenerative Medicine
Rockfish Center, Suite 1, 1543 Beech Grove Rd., Roseland, Virginia 22967
(434) 361-1896

FEE SCHEDULE:

Initial 2.5 hour Homeopathic Medical consultation.....$995.00 Follow-up ½ hour consultations.....$140.00

Initial, ½ hour Integrative Medicine consultation...$295.00 Initial, 1 hour Integrative Medicine consultation...$425.00

PAYMENT IN FULL is due at the time services are rendered. An invoice with the appropriate coded billing information will be provided for submittal to your insurance company for your reimbursement.
A $200.00 deposit must be received prior to the initial consultation to reserve the new appointment.
Patients are responsible for calling *48* hrs. in advance to change or cancel new or follow-up appointments.
New patients who cancel without rescheduling the appt. will be charged an administrative fee of $50.00.
There may be additional charges for special laboratory examinations if testing is indicated in a given case.
Please know that there will be a charge for confirmed consultations which are missed!
($500.00 for 2.5-3 hr. consultation, and $100.00 for half-hour consultation)
In the event of inclement weather, when patients choose not to come to the office, then the scheduled, confirmed consultations will be provided via telephone; if this consultative service is declined, please know that there will be a charge for the missed, scheduled, confirmed appointment.

REGULAR OFFICE HOURS:

Constitutional Homeopathic cases are seen on Tuesdays through Thursdays from 2:00 p.m. to 4:30 p.m.

'After-hours care' phone consultations will be billed at $5.00 per minute after the first, free, three minutes. Brief, informational calls will not be charged. Due to our large volume of long-distance service, phone calls will be returned collect; the patient may then immediately return the doctor's call to decrease the phone charges.

For all questions, scheduling and acute problems, please call the homeopathic receptionist, between 10:00 a.m. and 5:00 p.m. on Tuesdays through Thursdays. The office is closed on Mondays and Fridays, and over the weekend.

Daytime office phone number: (434) 361-1896 Fax: (434) 361-1928
After-hours emergency phone number: (434) 361-2573

DIRECTIONS TO THE OFFICE PRACTICE:

Physical Address: Rockfish Center, Suite 1, 1543 Beech Grove Rd., Roseland VA 22967

Mailing Address: P.O. Box 860, Nellysford, VA 22958

From the North: From Charlottesville and all points north, follow Rt. 29 south to I-64 west to Exit 107 (Crozet, Rt. 250). Turn left off ramp and take 250 west to Rt. 151 south, turn left. Follow Rt. 151 south to Rt. 664, 14.2 miles. Turn right, and the Rockfish Center will be 1.35 miles ahead on the left. Allow 45 minutes minimum travel time from Charlottesville.

From the South and West: From Lynchburg, take Rt. 29 north to Rt.6 west, turn left. Follow to Rt. 151 south, turn left and continue to Rt. 664. Turn right, and the Rockfish Center will be 1.35 miles ahead on the left. From Roanoke and Blacksburg, take I-81 north to I-64 east to Exit 99 (Rt. 250). Take Rt. 250 east to Rt. 151 south and follow to the Rockfish Center as above. Allow 1 hour minimum travel time from Lynchburg. Allow 2 to $2^1/_2$ hours minimum travel time from Roanoke and Blacksburg respectively.

From the East: From Richmond, take I-64 west to Exit 107 and proceed as above. From points south of Richmond, take Rt. 60 west to Amherst then turn right at rotary onto Rt. 29 north continuing to Rt. 6 west, as if coming from Lynchburg, and proceed as above. Allow $1^1/_2$ hour minimum travel time from Richmond.

For overnight accommodations, call Wintergreen Resort reservations at 1-800-325-2200.