ADVANCEDMEDICINE of New York, PLLC
Living Smarter Living Longer

Medicine Intake Form, Dr. Zina Kroner

Personal Information:

Name:_____
How do you prefer to be called?_____
Birth Date: _____ Age: _____Gender: _____
Address:_____
_____
_____
Phone: (Home) _____ (Work)_____
(cell) _____ (Fax) _____
Email: _____
What is your preferred mode of communication?_____
Occupation:_____
Employer:_____
Emergency Contact (name, #, & relationship)_____
_____

How did you hear about Advanced Medicine of New York? _____
What are your health goals? _____
_____

Medical Coverage:

Insurance Company: _____ Phone: _____
Policy or Group Number:_____

Primary Medical Doctor:

Name: _____ Phone: _____

Health Concerns

List your main health concerns in order of importance / severity?	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medical History:

Describe your general state of health: Excellent Good Fair Poor

Your energy levels are: (low) 0 1 2 3 4 5 6 7 8 9 10 (high)

Your stress level is: 0 1 2 3 4 5 6 7 8 9 10

Avg. # of hrs you sleep: 2 3 4 5 6 7 8 9 10 11 >

ADVANCEDMEDICINE of New York, PLLC
Living Smarter Living Longer

Indicate any serious conditions, illnesses, injuries, surgeries, or hospitalizations along with approximate dates:

Reason_____Dates_____

Reason_____Dates_____

Reason_____Dates_____

Reason_____Dates_____

Please list all current medications- include prescription and over-the-counter

Medication_____Dose_____Date Started_____

Tell us what medication(s) you recently discontinued:_____

Please list all current Supplements you are taking

Supplement_____Dose and brand_____Date Started_____

Do You Exercise?_Y/N_____ How Often?_____ What activity?_____

If you use any of the substances listed below, please mark a check next to it and indicated the

frequency and quantity of use	
	Aspirin: Tylenol, Motrin, alleve, etc.
	Alcohol
	Caffeine
	Diet pills
	Hormone therapy
	Laxatives
	Chinese herbs
	Marijuana
	Tobacco
	other recreational drugs

How many times a year are you being treated with antibiotics?
_____
Which antibiotic are you frequently prescribed?_____
Were you ever treated with an antifungal medication?_____When?_____

Do you have any allergies, sensitivities, or intolerances? Please explain.		
	Medications	
	Drugs	
	Cats	
	Dogs	
	Molds	
	Dust	
	Smoke	
	Latex	
	Nuts	
	Milk products	
	Eggs	
	Wheat	
	Gluten	
	Sugar	
	Chocolate	
	Additives	
	Alcohol	
	Pollen	
	Other	

Dietary Intake:

ADVANCEDMEDICINE of New York, PLLC
Living Smarter Living Longer

Do you have any dietary restrictions? (allergic, religious, vegetarian, vegan, etc…)
_____
Are you on a special diet such as gluten free, high protein, specific carbohydrate, candida, etc…?
_____
_
Describe the dietary intake of a typical day
Breakfast_____
Lunch _____
Dinner _____
Snacks _____
Beverages_____

Have you ever had an eating disorder such as bulimia or anorexia? Please explain.
_____
_____

Dietary preferences, habits Please note frequently eaten foods:

⑥ Vegetarian ⑥ Raw foods diet ⑥ Low fat diet ⑥ High protein / low carb diet ⑥ Dairy products/ milk/ ❑ Cheese ❑ Yogurt ❑ Ice cream ❑ Pizza	⑥ Sour ⑥ Cold drinks ⑥ Hot drinks ⑥ Extreme thirst ⑥ Thirst without desire to drink ❑ Tea ❑ Juice ❑ Water	⑥ Ice chewing ⑥ Chicken ⑥ Fish / seafood ⑥ Red meat ⑥ Artificial sweeteners	⑥ Fast food / burgers / fries *What is your favorite taste?* ⑥ Spicy / hot (pungent) ⑥ Sweet ⑥ Salty
Other			

Weight

Present Weight and Height: _____Weight one year ago: _____

Maximum weight and when: _____Minimum weight as adult & when: _____

Review of Systems (Place check mark to those that apply)

General symptoms

	Fatigue		Fever / chills		Bleed / bruise easily
	Sweat without exertion		Dizziness		Low immunity
	Night sweats		Do you prefer being warm or cold? (circle one)		Are your hands or feet cold, hot, clammy, sweaty? (circle one)

Digestion

	Extreme appetite		Cravings		Tired after eating
	No appetite		Dieting often		Bloating/stomach fullness
	Gas/belching		Acid regurgitation		Heart burn/ chest fullness
	Irritability or low energy between meals		Nausea		Vomiting

Gastrointestinal

	Diarrhea		Bloody stool		Irritable bowel syndrome
	Constipation		Mucous in stool		Colitis
	Hemorrhoids		Laxative use		Intestinal pain / cramping
	Anal itching / burning		Anal fissures		Incomplete evacuation
	Gout		Gallstones		
	How often do you have bowel movements? ___ x day;_____		Bowel movements: Soft, Hard, Wet, Dry, Float, Sink, Smell bad		What color is your stool? (circle) Black, Very dark, Brown, Green

Head

	Dry eyes		Spots / flowery vision		Bleeding gums
	Difficulty swallowing		Swollen glands		Headaches
	Earaches		Poor vision		Eye strain

	Blurred vision		Cataracts		Macular degeneration
	Night blindness		TMJ Problems		Sores on tongue or mouth
	Dry mouth		Excess saliva		Sinus problems
	Post-nasal drip		Sore throat, frequent or severe		Tinnitus / ringing in ears
	Deafness		Nosebleed frequent or severe		Wear glasses
	Any fillings, bridge work dentures, braces (please circle one)		Do you have any phlegm or mucus in your nose, throat or lungs? No Yes		What color of phlegm do you have? Clear, White, Yellow, Green (circle one)

Cardiovascular / respiratory

	Heart palpitations		Chest pain		Difficulty breathing
	High cholesterol		Varicose veins		Blood clots
	Swollen ankles		Heart valve abnormality		Shortness of breath
	Cold hands / feet		Dry cough		Wheezing
	Chest tightness		Difficult inhalation		Difficult exhalation
	Productive cough		History of abnormal stress test		other

Skin / hair

	Eczema		Dry skin		Rashes / hives / acne
	Hair loss		Brittle nails		Ridged nails

Musculoskeletal

	Tendonitis		Spinal pain		Joint pain/ Arthritis
	Limited range of motion		Swelling		Muscle cramps

	Osteoporosis/ oesteopenia		Vertebral disc degeneration		other

Genito-Urinary

	Dribbling when laughing or sneezing		Incomplete urination / retention		Decreased libido
	Burning urination		Blood in urine		Frequent urination
	Kidney stones		Bedwetting		Wake frequently to urinate

Neurological and psychological

	Insomnia		Anxiety		Irritability
	Poor memory		Depression		Easily stressed
	Tremors		Seasonal mood disorder		Tics
	Recent divorce/ death of loved one (circle)		Currently in psychotherapy		
	Pins and Needles In hands or feet		Coordination an issue		Double vision/ blurring of vision (circle)
	Shuffling gait		Migraines		Vertigo
	Loss of consciousness		Carpal tunnel		Profound weakness on one side of body

Men Only

	Impotency/libido (circle)		Prostate problems		Erectile dysfunction

Women Only

	Age menses began _____		Age menses ended _____		hormone replacement therapy
	Date of last ob/gyn exam? ___/___		Hysterectomy? partial full		Live births
	Abortion(s)		Miscarriage		Fibroids
	Birth control pills		Ovarian cysts		Vaginal odor
	Candida / yeast		Vaginal discharge		Human Papilloma Virus positive
	Vaginal sores		Herpes		Fibrocystic breast

	STD history (Chlamydia, PID, etc)		Breast cancer		Acne associated with period
	Pain at ovulation		Cramps / low back pain		Bleeding outside of regular menstrual cycle
	Constipation or diarrhea associated with period		Emotional irritability or depression associated w/ period		Low Libido
	No period / skipped cycles		Irregular cycle		Period lasts _____ days

Health Care Maintenance:

Test	Date	Result
Digital Rectal Exam		
Colonoscopy		
Endoscopy		
PSA test		
Mammogram		
Pap		
Breast Exam		
Bone Density		
Cholesterol levels		

Family History:

Family member	Age / or age deceased	Health condition (s)
Mother		
Father		
Sister		
Sister		
Brother		
Brother		

Environmental Toxin Exposure

ADVANCEDMEDICINE
of New York, PLLC
Living Smarter Living Longer

Did you live or work near a refinery or polluted area or were exposed to heavy metals, fumes or other toxic materials? _____

Have you ever had health problems when exposed to mold?_____

Do (did) you have silver fillings in your teeth?_____

How often do you eat fish? _____ What type?_____

Do you try to eat organic produce?_____

Are artificial sugars a daily part of your life? _____

Your Visit with Dr. Zina Kroner at Advanced Medicine of New York:

- **Arriving**

Please arrive 10 minutes before your scheduled consultation. We do not overbook and everyone is seen during their allotted time slot. If there is a wait, it is an exception. We respect your time immensely. If you need to cancel, please call as soon as you find out you are unable to make your appointment.

- **Dress**

Please dress comfortably. Do not wear any creams or perfumes to the office and please take off any nail polish.

- **What to Bring**

Please bring in any bloodwork that you had done in the last five years. Radiologic studies such as mammographies, CT scans, etc, would be helpful as well. Bring a list of all the medications and supplements that you are on, including dosages. Have handy the phone number of your primary care physician and your pharmacy so that we can have that on file as needed. Feel free to bring a family member or a friend as that may make the visit even more enjoyable for you. Please refrain from bringing your adorable pets (yes, it has happened before).

- **What to Expect**

On your first visit, you will have a 1 ½ hour consultation and physical examination with Dr. Kroner. Dr. Kroner does not have nurse practitioners or Physician assistants doing her physical exams for her. Dr. Kroner will take an in-depth look at your medical history and current concerns. She will also order blood work and other diagnostic tests that she deems necessary in order to help figure out the fundamental etiology behind the medical concerns. The exact medical rationale behind every test ordered will be explained to you so that you completely understand the diagnostic approach. A step by step plan will be outlined on the first and second visit once the pros and cons of all the available medical and nutritional options are reviewed. Dr. Kroner will keep you abreast of the medical and nutritional treatments available for your medical conditions. You will receive a binder that has all your medical information in it. This book will be added to after every visit. You will leave the office more in control of your medical issues than before you entered.

- **Tests**

You will have your blood drawn at the center itself by our trained phlebotomist or nurse. A significant portion of the blood will be sent out to a lab that your insurance company participates in, such as Enzo, LabCorp or Quest. Some blood work may be processed in the center. Dr. Kroner will also refer you as necessary to state of the art radiologic facilities where you will efficiently be seen, as needed.

- **Billing**

Advanced Medicine of New York, PLLC is a fee for service center which means that you get ample time with the physician, you are seen on time, and develop a personal and lasting relationship with the office. You will get premier medical care as we take your health seriously and respect your time. To clarify, Dr. Zina Kroner does not accept or participate with any insurance or HMO of any kind. We are happy to provide you with a "super-bill" at the end of each visit. It will contain a list of services rendered and appropriate diagnostic codes that your insurance company will recognize. Once you pay for the services rendered, we will be happy to electronically submit the insurance paperwork on your behalf. This saves you a lot of hassle. Reimbursement is dependent upon each patient's individual insurance carrier.

The only exception is Medicaid and Medicare. Because Dr. Kroner opted out of Medicaid and Medicare, the bills cannot be submitted for reimbursement.

- **Your Primary Care Doctor**

Please note that our center has chosen not to be affiliated with a hospital. This way we can better tend to your medical concerns during working hours. Due to this, we encourage all our patients to have a relationship with a primary care physician whose team is available to tend to all emergencies that you may have. We gladly will talk to your primary care physician about your treatment plan at our center. We will be happy to provide you with a referral to a board certified physician for your emergency needs. On a select basis, Dr. Kroner can be your primary care provider. Dr. Kroner will be happy to discuss this with you.

- **Phone Calls/ Emails**

We are always happy to receive your phone calls and emails. We want to hear about your medical updates and concerns. This system of open and frequent dialogue is necessary for you to succeed in health. If a message is left with the front desk during the doctor's working day, the doctor will call back that same day. Please be sure to provide alternate numbers where you can be reached. If you call when the office is closed, your phone call will be returned on the day that the doctor is scheduled to work. If your concern is involved, please be sure to schedule an appointment. Emails are for non-urgent administrative or medical inquiries. Thank you for understanding.

Authorization to Disclose Healthcare Information

Dear Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate uses of PHI in accordance with governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of

improper disclosure of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

If you want to, you can choose to give us a name of a person that you give permission for our office to discuss your protected health information with, including condition and treatment plan, test results, prescriptions, and x-rays:

Name	**Relationship to you**	**Telephone number**

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to know my healthcare information.

PATIENT CONSENT FORM to "Privacy Rule"

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records.

We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.You have the right to review our privacy notice, to

request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Acknowledgement Regarding Reimbursement by Medical Insurance Carrier:
By signing below, understand that I have been fully advised that some or all of the costs associated with my meetings with Dr. Zina Kroner may not be eligible for insurance reimbursement from my insurance company as some tests and/or procedures may be deemed to be "non-covered" services.

By signing below, you consent to the fact that you understand and agree to all of the statements outlined on pages 1-3. You also understand that you may feel free to discuss the specifics of the above any time with Dr. Kroner and her staff.

Name:_____ Signature:_____Date:_____

Sincerely,

Dr. Zina Kroner and Staff

Medicare Opt Out Contract:

This agreement is between Dr.Zina Kroner ("Physician"), whose principal place of business is 1035 Park Ave New York NY 10028 and patient _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on May 1 2010 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Physician agrees to provide the following medical services to Patient: Medical consultation, physical examination, blood draw, sending blood to a lab, and/or intramuscular or intravenous injection (the "Services"): In exchange for the Services, the Patient agrees to make payments to Physician. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.

- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.

Executed on [date] _____by [Patient name] _____
Patient Signature_____

and [Physician name] Dr. Zina Kroner_____ Physician Signature_____