

Rhinebeck Health Center
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Center for Progressive Medicine
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518-435-0082
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FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. **ALL PATIENTS MUST COMPLETE OUR "PATIENT DATA FORM" BEFORE BEING SEEN AT THE RHINEBECK HEALTH CENTER. FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.** Any other arrangements must be made in writing prior to the time of service.

PLEASE NOTE THAT WE DO NOT FILE FOR INSURANCE. We give you two copies of your fee slip at the end of your visit. One is for you to submit to your insurance company, and the other is for your records. As we provide this at the time of your visit, if you require a copy in the future, there will be a charge of \$1.00 per copy. The fee slip we give you includes standard information which is required when filing your insurance claim. If your insurance company requires additional information, we will bill them prior to sending the requested information. Charges for additional information include: copy of your medical records - \$.75 per page, short insurance form - \$25.00, long insurance form - \$50.00, medical letter of necessity - \$35.00 and narrative reports - \$150.00 - \$300.00. Unfortunately, some insurance companies feel that this is not an allowable charge, and if that is the case, any fees will be your responsibility.

We are doing everything we can to keep our fees down, however the increases in insurance correspondence and requests have caused an added burden to our office expense. To be fair to all of our patients, we are billing only those patients whose insurance companies request more than the standard information, and not raising our overall charges to cover this service. We cannot send out this information until the fee is paid, either by you or your insurance company. Your insurance policy is a contract between you and your insurance company. **WE ARE NOT A PARTY TO THAT CONTRACT.** The bill is your responsibility, whether your insurance company pays or not. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

Unless cancelled at least 72 hours in advance, our policy is to charge for missed appointments at normal office rates. If cancelled on a Friday after 1:00PM or over the weekend, you will also be charged at normal office rates.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy above. I understand and agree to this Financial Policy.

Signature of Patient/Responsible Party

Date

Kenneth A. Bock, MD
Michael Compain, MD

Rhinebeck Health Center
108 Montgomery Street
Rhinebeck, NY 12572
914-876-7082

Steven J. Bock, MD

**METABOLIC CLEARING THERAPY
TESTING SCALE**

Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have it, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

DIGESTIVE TRACT	_____	Nausea or vomiting	TOTAL -----
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching or passing gas	
	_____	Heartburn	
EARS	_____	Itchy ears	TOTAL -----
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	
EMOTIONS	_____	Mood swings	TOTAL -----
	_____	Anxiety, fear or nervousness	
	_____	Anger, irritability or aggressiveness	
	_____	Depression	
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	TOTAL -----
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	

EYES	_____	Watery or itchy eyes	TOTAL -----
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near or far sightedness)	
HEAD	_____	Headaches	TOTAL -----
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	
HEART	_____	Irregular or skipped heartbeat	TOTAL -----
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	
JOINTS/ MUSCLES	_____	Pain or aches in joints	TOTAL -----
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	
LUNGS	_____	Chest congestion	TOTAL -----
	_____	Asthma, bronchitis	
	_____	Shortness of Breath	
	_____	Difficulty breathing	
MIND	_____	Poor memory	TOTAL -----
	_____	Confusion, poor concentration	
	_____	Poor concentration	
	_____	Poor physical condition	
	_____	Difficulty in enacting decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
MOUTH/ THROAT	_____	Chronic coughing	TOTAL -----
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	
NOSE	_____	Stuffy nose	TOTAL -----
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	

SKIN	_____	Acne	TOTAL -----
	_____	Hives, rashes, or dry skin	
	_____	Hair Loss	
	_____	Flushing or hot flashes	
	_____	Excessive sweating	
WEIGHT	_____	Binge eating/drinking	TOTAL -----
	_____	Craving certain foods	
	_____	Excessive weigh	
OTHER	_____	Frequent illness	TOTAL -----
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	
GRAND TOTAL			

METABOLIC ASSESSMENT FORM

NAME: _____

AGE: _____

SEX: _____

PART 1

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number "0-3" on all questions below.
0 as the least/never to 3 as the most/always

Category 1

- Feeling that bowels do not empty completely 0 1 2 3
- Lower abdominal pain relief by passing stool or gas 0 1 2 3
- Alternating constipation / diarrhea 0 1 2 3
- Constipation 0 1 2 3
- Hard, dry or small stool 0 1 2 3
- Coated tongue or "fuzzy" debris on tongue 0 1 2 3
- Pass large amount of foul smelling gas 0 1 2 3
- More than 3 bowel movements daily 0 1 2 3
- Do you use laxatives frequently 0 1 2 3

Category II

- Excessive belching, burping or bloating 0 1 2 3
- Gas immediately following a meal 0 1 2 3
- Offensive breath 0 1 2 3
- Difficult bowel movements 0 1 2 3
- Sense of fullness during and after meals 0 1 2 3
- Difficulty digesting fruits and vegetables; undigested foods found in stools 0 1 2 3

Category III

- Stomach pain, burning or aching 1-4 hrs after eating 0 1 2 3
- Do you frequently use antacids 0 1 2 3
- Feeling hungry an hour or two after eating 0 1 2 3
- Heartburn when lying down or bending forward 0 1 2 3
- Temporary relief from antacids, foods, milk, carbonated beverages 0 1 2 3
- Digestive problems subside with rest and relaxation 0 1 2 3
- Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3

Category IV

- Roughage and fiber cause constipation 0 1 2 3
- Indigestion and fullness lasts 2-4 hrs. after eating 0 1 2 3
- Pain, tenderness, soreness on left side, under rib cage bloated 0 1 2 3
- Excessive passage of gas 0 1 2 3
- Stool undigested, foul odor, mucous-like, greasy or poorly formed 0 1 2 3

METABOLIC ASSESSMENT FORM con't.

Category IV cont.

Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attack or stones	0	1	2	3
Have you had your gallbladder removed	YES		NO	

Category VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded and when meals are missed, eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII

Fatigue after meals	0	1	2	3
Crave sweets during day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

METABOLIC ASSESSMENT FORM con't.

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders of lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Male Only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you a menopausal	0	1	2	3
Alternating menstrual cycle lengths	0	1	2	3
Extended menstrual cycle, greater than 32 days	0	1	2	3
Shortened menses, less than every 24 days	0	1	2	3
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal	_____			
Do you ever have uterine bleeding since menopause	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breast	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcohol beverages consumed per week? _____

How many times do you eat out per week? _____

How many times per week do you eat fish? _____

How many caffeinated beverages do you do you consume per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you schedule for work outs? _____

List three worst foods you eat during the average week: _____, _____, _____

List three of the healthiest foods you eat during the average week: _____, _____, _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Circle any of the following medications that you are currently taking:

- | | | | | |
|-----------------|---------------------|--------------------|---------------------|----------------------|
| Antacids | Antifungals | Anxiety medication | High Blood Pressure | Hydrocortisone Cream |
| Antibiotics | Antihistamines | Aspirin/Tylenol | High Cholesterol | Oral Contraceptives |
| Antidepressants | Anti-inflammatories | Diuretics | Hormone Replacement | Thyroid Hormones |

OTHER:

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a month), (2) for MODERATE symptoms (occur several times a week), and (3) for SEVERE symptoms (you are aware of it almost constantly).

GROUP ONE

1	Acid Foods Upset	8	Gag Easily	15	Appetite Reduced
2	Get "Chilled" Frequently	9	Unable to Relax, Startles	16	Cold Sweats Often
3	"Lump" in Throat	10	Extremities Cold, Clammy	17	Fever Easily Raised
4	Dry Mouth-Eyes-Nose	11	Strong Light Irritates	18	Neuralgia-Like Pains
5	Pulse Speeds up after Meals	12	Urine Amount Reduced	19	Staring Blinks Little
6	Keyed Up – Fail to Calm	13	Heart Pounds After Retiring	20	Sour Stomach Frequent
7	Cuts Heal Slowly	14	"Nervous" Stomach		

GROUP TWO

21	Joint Stiffness After Rising	29	Digestion Rapid	37	"Slow Starter"
22	Muscle Leg & Toe Cramps at Night	30	Vomiting Frequent	38	Get "Chilled" Frequently
23	"Butterfly" Stomach, Cramps	31	Hoarseness Frequent	39	Perspire Easily
24	Eyes or Nose Watery	32	Breathing Irregular	40	Circulation Poor, Sensitive to Cold
25	Eyes Blink Often	33	Pulse Slow; Feels "irregular"	41	Subject to Colds, Asthma, Bronchitis
26	Eyelids Swollen or Puffy	34	Gagging Reflex Slow		
27	Indigestion Soon After Meals	35	Difficulty Swallowing		
28	Always Seems Hungry; Feels "Lightheaded" Often	36	Constipation, Diarrhea Alternating		

GROUP THREE

42	Eat When Nervous	47	Fatigue, Eating Relieves	52	Awaken After Few Hours Sleep- Hard to get Back to Sleep
43	Excessive Appetite	48	"Lightheaded" if Meals Missed	53	Crave Candy or Coffee in Afternoons
44	Hungry Between Meals	49	Heart Palpates if Meals Missed	54	Moods of Depression- "Blues or Melancholy"
45	Irritable Before Meals	50	Afternoon Headaches	55	Abnormal Craving for Sweets or Snacks
46	Get "Shaky" if Hungry	51	Overeating Sweets Upsets		

GROUP FOUR

56	Hands & Feet go to Sleep Easily, Numbness	62	Get "Drowsy" Often	68	Bruise Easily "Black & Blue"
57	Sigh Frequently, "Air Hunger"	63	Swollen Ankles Worse at Night	69	Tendency to Anemia
58	Aware of "Breathing Heavily"	64	Muscle Cramps, Worse during Exercise; Get "Charlie Horses"	70	"Nose Bleeds" Frequent
59	High Altitude Discomfort	65	Shortness of Breath on Exertion	71	"Noises in Head" or "Ringing in Ears"
60	Opens Windows in Closed Rooms	66	Dull Pain in Chest or Radiating into Left Arm, Worse on Exertion	72	Tension Under the Breastbone or Feeling of "Tightness"; Worse on Exertion
61	Susceptible to Colds & Fevers	67	Afternoon "Yawner"		

SYMPTOM SURVEY FORM – PAGE 2

GROUP FIVE

73	Dizziness	81	Bowel Movements Painful or Difficult	89	Stools Alternate from Soft to Watery
74	Dry Skin	82	Worrier, Feel Insecure	90	History of Gallbladder Attacks or Gallstones
75	Burning Feet	83	Feeling Queasy, Headache	91	Sneezing Attacks
76	Blurred Vision	84	Greasy Foods Upset	92	Dreaming, Nightmare Type, Bad Dreams
77	Itching Skin & Feet	85	Stools Light -Colored	93	Bad Breath (Halitosis)
78	Excessive Falling Hair	86	Skin Peels on Foot Soles	94	Milk Products Cause Distress
79	Frequent Skin Rashes	87	Pain Between Shoulder Blades	95	Sensitive to Hot Weather
80	Bitter, Metallic Taste in Mouth in Mornings	88	Use Laxatives	96	Burning or Itching Arms
				97	Crave Sweets

GROUP SIX

98	Loss of Taste for Meat	101	Coated Tongue	104	Mucous Colities or "Irritable Bowel"
99	Lower Bowel Gas, Several Hours after Eating	102	Pass Large Amounts of Foul Smelling Gas	105	Gas Shortly after Eating
100	Burning Stomach Sensations, Eating Relieves	103	Indigestion ½ - 1 Hour After Eating May be up to 3-4 Hours	106	Stomach "Bloating after Eating

GROUP SEVEN

	(A)		(B)		(C)	
107	Insomnia	122	Increase in Weight	137	Failing Memory	
108	Nervousness	123	Decrease in Appetite	138	Low Blood Pressure	
109	Can't Gain Weight	124	Fatigue Easily	139	Increased Sex Drive	
110	Intolerance to Heat	125	ringing in Ears	140	Decrease Sugar Tolerance	
111	Highly Emotional	126	Sleeping During Day	141	Headaches, "Splitting" or "Rendering" Type	
112	Flush Easily	127	Sensitive to Cold			
113	Night Sweats	128	Dry or Scaly Skin		(D)	
114	Thin, Moist Skin	129	Constipation	142	Abnormal Thirst	
115	Inward Trembling	130	Mental Sluggishness	143	Bloating of Abdomen	
116	Heart Palpates	131	Hair Coarse, Falls Out	144	Weight Gain Around Hips	
117	Increased Appetite w/o Weight Gain	132	Headaches Upon Rising	145	Sex Drive Reduced or Lacking	
118	Pulse Fast at Rest	133	Slow Pulse Below 65	146	Tendency of Ulcers or Colitis	
119	Eyelids & Face Twitch	134	Frequency of Urination	147	Women: Menstrual Disorders	
120	Irritable & Restless	135	Impaired Hearing	148	Young Girls: Lack of Menstrual Function	
121	Can't Work Under Pressure	136	Reduced Initiative	149		

SYMPTOM SURVEY FORM – PAGE 3

GROUP SEVEN cont

	(E)			(F)			
150		Dizziness	157		Weakness, Dizziness	165	Poor Circulation
151		Headaches	158		Chronic Fatigue	166	Swollen Ankles
152		Hot Flashes	159		Low Blood Pressure	167	Crave Salt
153		Increased Blood Pressure	160		Nails Weak, Ridged	168	Brown Spots or Bronzing Skin
154		Hair Growth on Face or Body (FEMALE)	161		Tendencies to Hives	169	Allergies-Tendencies to Asthma
155		Sugar in Urine (Not Diabetes)	162		Arthritic Tendencies	170	Weakness After Colds, Influenza
156		Masculine Tendencies (FEMALE)	163		Perspiration Increase	171	Exhaustion – Muscular & Nervous
			164		Bowel Disorders	172	Respiratory Disorders

		FEMALE ONLY					MALE ONLY
173		Very Easily Fatigued	181		Hysterectomy / Ovaries Removed	186	Prostate Trouble
174		Premenstrual Tension	182		Menopausal Hot Flashes	187	Urination Difficult
175		Painful Menses	183		Menses Scanty or Missed	188	Night Urination Frequent
176		Depressed Feelings Before Menstruation	184		Acne, Worse at Menses	189	Depression
177		Menstruation Excessive & Prolonged	185		Depression of Long Standing	190	Pain on Inside of Legs or Heels
178		Painful Breast				191	Feeling of Incomplete Bowel Evacuation
179		Menstruate to Frequently				192	Lack of Energy
180		Vaginal Discharge				193	Migrating Aches & Pains
						194	Tire to Easily
						195	Avoids Activity
						196	Leg Nervousness at Night
						197	Diminished Sex Drive

IMPORTANT

TO THE PATIENT: Please list below the five (5) main Physical Complaints you have in Order of their Importance

1	
2	
3	
4	
5	

CHIEF COMPLAINT AND PRESENT ILLNESS

Chief complaint (main symptom) _____

Describe in detail _____

When did it begin and how has it progressed _____

What treatment have you had and by whom _____

When and where did you have you last complete physical _____

What were the results _____

List current medical problems	List past medical problems
_____	_____
_____	_____
_____	_____

Have you ever had:

_____ lapse of consciousness

_____ convulsions

_____ shock

_____ stroke

_____ high blood pressure

_____ heart attack

_____ diabetes

_____ arthritis

_____ emphysema

_____ pneumonia

_____ history of allergy

Hospitalizations:

when where reason

GASTROINTESTINAL/DIGESTIVE

Check what applies to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> heartburn | <input type="checkbox"/> queasy stomach | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> indigestion | <input type="checkbox"/> freq. Nausea | <input type="checkbox"/> belch freq. |
| <input type="checkbox"/> freq. Vomiting | <input type="checkbox"/> bloody stools | <input type="checkbox"/> ulcer |
| <input type="checkbox"/> flatulence | <input type="checkbox"/> bloating | <input type="checkbox"/> anal itching |
| <input type="checkbox"/> cramping | <input type="checkbox"/> stomachaches | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> picky eater | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> constipated |
| <input type="checkbox"/> stool/foul odor | <input type="checkbox"/> gallbladder trble. | <input type="checkbox"/> anal pain |
| <input type="checkbox"/> mucous colitis | <input type="checkbox"/> on special diet | <input type="checkbox"/> burning stomach eating relieves |
| <input type="checkbox"/> mucous in stool | <input type="checkbox"/> good appetite | <input type="checkbox"/> gas shortly after eating |

URINARY AND GENITALIA

Check what applies to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> freq. urination | <input type="checkbox"/> painful urination | <input type="checkbox"/> burning |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> itching | <input type="checkbox"/> cystitis |
| <input type="checkbox"/> kidney stones | <input type="checkbox"/> bladder disease | <input type="checkbox"/> weak stream |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> being treated for inf. | <input type="checkbox"/> pass blood |
| <input type="checkbox"/> prostate trbl. | <input type="checkbox"/> lumps, pain, swell, in testicles | <input type="checkbox"/> sores |
| <input type="checkbox"/> have yeast inf. | <input type="checkbox"/> difficulty starting urination | <input type="checkbox"/> genital herpes |
| <input type="checkbox"/> spouse being trtd | <input type="checkbox"/> had or have cancer | <input type="checkbox"/> being treated for trich. |
| <input type="checkbox"/> for trichomonas | | <input type="checkbox"/> satisfactory sexual relations |
| <input type="checkbox"/> being treated for yeast | | |

EYES

Check or list every symptom you have if your eyes trouble you:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> itching | <input type="checkbox"/> styes | <input type="checkbox"/> blurred vision |
| <input type="checkbox"/> irritated | <input type="checkbox"/> crusty lids | <input type="checkbox"/> bloodshot |
| <input type="checkbox"/> watering | <input type="checkbox"/> granulated lids | <input type="checkbox"/> mucous in eyes |
| <input type="checkbox"/> dryness | <input type="checkbox"/> twitching lids | <input type="checkbox"/> dark circles |
| <input type="checkbox"/> burning | <input type="checkbox"/> swelling both lids | <input type="checkbox"/> sensitive to light |
| <input type="checkbox"/> pain | <input type="checkbox"/> puffy under eyes | <input type="checkbox"/> sensitive to dark |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> glaucoma | <input type="checkbox"/> wear glasses |
| <input type="checkbox"/> see halos | <input type="checkbox"/> wear contacts | <input type="checkbox"/> double vision |

Are your eye symptoms present all year round? Yes _____ No _____

What is your worst season? _____

EARS

Please check or list every symptom that applies to your ears:

- | | |
|--|---|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> "floating sensation" |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> ever lanced |
| <input type="checkbox"/> itching inside | <input type="checkbox"/> sense of imbalance |
| <input type="checkbox"/> crusting inside | <input type="checkbox"/> frequent infections |
| <input type="checkbox"/> serous otitis | <input type="checkbox"/> ears stuffed up |
| <input type="checkbox"/> hearing aid | <input type="checkbox"/> nerve deafness |
| <input type="checkbox"/> drainage | <input type="checkbox"/> tubes in ears |
| <input type="checkbox"/> pressure | <input type="checkbox"/> ringing/roaring |
| <input type="checkbox"/> pain | <input type="checkbox"/> other |

NOSE

Check every symptom that applies to your nose (to a greater than normal degree)

- | | | |
|--|---|--|
| <input type="checkbox"/> itches | <input type="checkbox"/> bleeds | <input type="checkbox"/> sinus infections |
| <input type="checkbox"/> blocks | <input type="checkbox"/> crusts | <input type="checkbox"/> post nasal drip |
| <input type="checkbox"/> burns | <input type="checkbox"/> require nose drops/spray | <input type="checkbox"/> mucous yellow |
| <input type="checkbox"/> sneeze | <input type="checkbox"/> runs | <input type="checkbox"/> mucous blood streaked |
| <input type="checkbox"/> no sense of smell | <input type="checkbox"/> other | <input type="checkbox"/> polyps |

Are these symptoms present all during the year? Yes _____ No _____

Which is your worst season? _____

Symptoms are worse:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> upon arising | <input type="checkbox"/> after meals | <input type="checkbox"/> after medication |
| <input type="checkbox"/> at night | <input type="checkbox"/> upon lying down | <input type="checkbox"/> cold |
| <input type="checkbox"/> hot | <input type="checkbox"/> humid | <input type="checkbox"/> dry |

MOUTH AND THROAT

Please check every symptom that applies to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> snore | <input type="checkbox"/> sleep mouth open | <input type="checkbox"/> difficulty swallowing |
| <input type="checkbox"/> hoarse | <input type="checkbox"/> canker sores | <input type="checkbox"/> lips crack/corners |
| <input type="checkbox"/> bad breath | <input type="checkbox"/> tongue swollen | <input type="checkbox"/> throat itches |
| <input type="checkbox"/> bad taste | <input type="checkbox"/> throat clearing | <input type="checkbox"/> neck glands swell |
| <input type="checkbox"/> lips swell | <input type="checkbox"/> wear dentures | <input type="checkbox"/> grind teeth in sleep |
| <input type="checkbox"/> chapped lips | <input type="checkbox"/> post nasal drip | <input type="checkbox"/> fever blisters |
| <input type="checkbox"/> sore throats | <input type="checkbox"/> hoarseness | <input type="checkbox"/> sore/ raw tongue |
| <input type="checkbox"/> throat closed | <input type="checkbox"/> other | |

CARDIAC AND RESPIRATORY

Please check or list any chest symptoms you have now, or have had in the past:

- | | | |
|-------------------|-----------------------|----------------------------|
| _____ wheeze | _____ frequent coughs | _____ frequent infections |
| _____ asthma | _____ cough mucous | _____ pneumonia ____ times |
| _____ bronchitis | _____ cough dry | _____ cough up blood |
| _____ tingling | _____ frequent colds | _____ ankle swelling |
| _____ murmurs | _____ tight chest | _____ short of breath |
| _____ angina | _____ chest pains | _____ night sweats |
| _____ rapid heart | _____ skipped beats | _____ other |

Which is your main symptom: _____

When is this symptom worse:

- | | | |
|---------------|------------------|--------------------|
| _____ morning | _____ afternoon | _____ evening |
| _____ spring | _____ summer | _____ fall |
| _____ winter | _____ year round | _____ before lunch |
| _____ other | | |

Which medications relieve you best? How soon? For how long?

_____	_____	_____
_____	_____	_____
_____	_____	_____

How far can you walk vigorously before becoming short of breath?

HERPES HISTORY

Are you subject to: Fever blisters (cold sores) _____

Genital herpes _____

Shingles _____

On what part of your body do they occur: _____

When did the attacks first begin: _____

How frequently do they occur: _____

How long do the attacks usually last: _____

Do the attacks follow any pattern of recurrence: _____

Are lesions brought on by exposure to: Sunlight _____

Fever _____

Local irritation _____

SKIN

Check or list any past or current skin symptoms:

_____ eczema

_____ shingles

_____ fungus nails

_____ cracking

_____ edema

_____ peeling

_____ blanching

_____ oiliness

_____ itching

_____ bruising

_____ hives

_____ fungus

_____ rash

_____ brittle nails

_____ scalp problems

_____ boils

PSYCHOLOGICAL HISTORY

- | | |
|--|--|
| <input type="checkbox"/> often unhappy | <input type="checkbox"/> frequently keyed up & jittery |
| <input type="checkbox"/> blackouts | <input type="checkbox"/> startled by sudden noises |
| <input type="checkbox"/> incessant talker | <input type="checkbox"/> difficulty falling asleep |
| <input type="checkbox"/> use tranquilizers | <input type="checkbox"/> considered a nervous person |
| <input type="checkbox"/> feel "lost in time" | <input type="checkbox"/> extremely shy or sensitive |
| <input type="checkbox"/> am a workaholic | <input type="checkbox"/> misunderstood by others |
| <input type="checkbox"/> numbness | <input type="checkbox"/> easily flare in anger |
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> am being controlled by other forces |
| <input type="checkbox"/> considered clumsy | <input type="checkbox"/> hospitalized for nerves |
| <input type="checkbox"/> sleep walking | <input type="checkbox"/> go to pieces easily |
| <input type="checkbox"/> unable to concentrate | <input type="checkbox"/> have difficulty staying awake |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> often unable to perform work |
| <input type="checkbox"/> have had visions | <input type="checkbox"/> been addicted to a drug |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> feeling of hostility |
| <input type="checkbox"/> fainting spells | <input type="checkbox"/> unable to coordinate muscles |
| <input type="checkbox"/> amnesia | <input type="checkbox"/> short attention span |
| <input type="checkbox"/> nervous breakdown | <input type="checkbox"/> have heard voices |
| <input type="checkbox"/> shaky | <input type="checkbox"/> have seriously considered suicide |
| <input type="checkbox"/> feel withdrawn | <input type="checkbox"/> have overused drugs |
| <input type="checkbox"/> frustration | <input type="checkbox"/> have overused alcohol |
| <input type="checkbox"/> aggressive | <input type="checkbox"/> irritable |
| <input type="checkbox"/> restless legs | |

FOR CHILDREN ONLY

- | | |
|--|---|
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> often whiny and bad tempered |
| <input type="checkbox"/> reading problem | <input type="checkbox"/> has a finicky appetite |
| <input type="checkbox"/> writing problem | <input type="checkbox"/> clumsy/uncoordinated |
| <input type="checkbox"/> has few friends | <input type="checkbox"/> sluggish in the morning |
| <input type="checkbox"/> is slow to learn | <input type="checkbox"/> markedly shy and timid |
| <input type="checkbox"/> has trouble sleeping | <input type="checkbox"/> spells of intense temper |
| <input type="checkbox"/> unable to gain weight | <input type="checkbox"/> other |

NUTRITIONAL HISTORY

Food	Daily	Weekly	Monthly
Alcohol type			
Soda			
Ice Cream			
Candy			
Beef			
Bacon/sausage			
Butter (pat)			
Margarine (pat)			
Cold breakfast cereal			
Chicken			
Fish			
Raw fruit			
Bran			
Soy/Tofu			
Rice			
Potatoes			
Tomatoes			
Green vegies			
Eggs (1)			
Yogurt (8oz)			
Cheese (2oz)			
Pastries/cookies			
Catsup			
Honey (tblsp.)			
Sugar (tsp)			
Coffee			
Tea regular			
Herbal			
Instant breakfast cereal			
Raw vegies			
Salad			
Bread			
Milk			
Yellow vegies			
Citrus			

List all the foods you have ever avoided because they bother you:

FOOD HISTORY

Do you frequently have:

- | | |
|--|---|
| <input type="checkbox"/> excessive hunger | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> overindulge foods | <input type="checkbox"/> crave beverages |
| <input type="checkbox"/> eat daytime snacks | <input type="checkbox"/> bothered by food odors |
| <input type="checkbox"/> skip meals | <input type="checkbox"/> crash diets |
| <input type="checkbox"/> rotation diet | <input type="checkbox"/> use convenience food |
| <input type="checkbox"/> use exotic food | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> excessive thirst | <input type="checkbox"/> eat “junk” food |
| <input type="checkbox"/> crave certain foods | <input type="checkbox"/> elimination diet |
| <input type="checkbox"/> avoid certain foods | <input type="checkbox"/> cook from “scratch” |
| <input type="checkbox"/> have bedtime snacks | <input type="checkbox"/> eat regular meals |

As an infant or child, did you ever have:

- | | |
|--|--|
| <input type="checkbox"/> bothered by foods | <input type="checkbox"/> legaches |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> fussiness |
| <input type="checkbox"/> bottle fed | <input type="checkbox"/> wet the bed |
| <input type="checkbox"/> eczema | <input type="checkbox"/> failure to thrive |
| <input type="checkbox"/> constipation | <input type="checkbox"/> constant hunger |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> skin rash |
| <input type="checkbox"/> headaches | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> hyperactivity | <input type="checkbox"/> stomachaches |
| <input type="checkbox"/> behavior problem | <input type="checkbox"/> night sweats |

_____ short attention span

_____ learning problem

_____ bothered by beverages

_____ dyslexia

_____ picky eater

_____ depressed

_____ colic

_____ withdrawn

_____ hives

_____ other

_____ gasiness

Is there a family history of allergies or food intolerance? _____

Are most of your meals: at home _____, at restaurants _____, gourmet _____,

Do you mostly eat foods that are: fresh _____, canned _____, frozen _____, packaged _____.

What is your favorite or most enjoyed food and beverage? _____

CHEMICAL AND INHALANT HISTORY

Please check your occupational exposures:

_____ office worker

_____ work around chemicals

_____ salesperson

_____ work around cosmetics

_____ professional worker

_____ work around dust

_____ factory worker

_____ work around fumes

_____ construction

_____ work with animals

_____ farm worker

_____ work indoors

_____ hospital worker

_____ work outdoors

_____ house worker

_____ work in extreme heat

_____ teacher

_____ work in extreme cold

_____ painter

_____ other

Check if exposed to, double check if you have symptoms from:

- | | | |
|--|---|--|
| <input type="checkbox"/> dust | <input type="checkbox"/> rugs | <input type="checkbox"/> perfumes |
| <input type="checkbox"/> grain dust | <input type="checkbox"/> old carpet | <input type="checkbox"/> newsprint |
| <input type="checkbox"/> chemicals | <input type="checkbox"/> new carpet | <input type="checkbox"/> art supplies |
| <input type="checkbox"/> fireplace | <input type="checkbox"/> cotton | <input type="checkbox"/> fresh newspapers |
| <input type="checkbox"/> mildew | <input type="checkbox"/> kapok | <input type="checkbox"/> old magazines |
| <input type="checkbox"/> molds | <input type="checkbox"/> sisal | <input type="checkbox"/> photocopy paper |
| <input type="checkbox"/> potted plants | <input type="checkbox"/> hemp | <input type="checkbox"/> paints |
| <input type="checkbox"/> slab home | <input type="checkbox"/> glue | <input type="checkbox"/> varnishes |
| <input type="checkbox"/> raised home | <input type="checkbox"/> tar | <input type="checkbox"/> lacquers |
| <input type="checkbox"/> new home | <input type="checkbox"/> smoke | <input type="checkbox"/> turpentine |
| <input type="checkbox"/> old home | <input type="checkbox"/> tobacco smoke | <input type="checkbox"/> furniture polish |
| <input type="checkbox"/> marshy area | <input type="checkbox"/> solvents | <input type="checkbox"/> floor wax |
| <input type="checkbox"/> wooded area | <input type="checkbox"/> cosmetics | <input type="checkbox"/> detergents |
| <input type="checkbox"/> feathers | <input type="checkbox"/> eye makeup | <input type="checkbox"/> disinfectants |
| <input type="checkbox"/> dog inside | <input type="checkbox"/> nail polish | <input type="checkbox"/> incense |
| <input type="checkbox"/> cat inside | <input type="checkbox"/> hairsprays | <input type="checkbox"/> moth balls |
| <input type="checkbox"/> bird inside | <input type="checkbox"/> soaps | <input type="checkbox"/> alcohol |
| <input type="checkbox"/> pet inside | <input type="checkbox"/> deodorants | <input type="checkbox"/> fertilizers |
| <input type="checkbox"/> insecticides | <input type="checkbox"/> dyes | <input type="checkbox"/> floor furnace |
| <input type="checkbox"/> herbicides | <input type="checkbox"/> gasoline fumes | <input type="checkbox"/> space heaters |
| <input type="checkbox"/> plastics | <input type="checkbox"/> exhaust fumes | <input type="checkbox"/> gas stove/heat |
| <input type="checkbox"/> rubber | <input type="checkbox"/> diesel fuel | <input type="checkbox"/> central heat/cool |
| <input type="checkbox"/> drapes | | |

Check if you have symptoms:

- | | | | |
|---|---|--|---------------------------------|
| <input type="checkbox"/> housecleaning | <input type="checkbox"/> from dyes | <input type="checkbox"/> when too hot | <input type="checkbox"/> spring |
| <input type="checkbox"/> when too cold | <input type="checkbox"/> worse at night | <input type="checkbox"/> worse in daytime | <input type="checkbox"/> summer |
| <input type="checkbox"/> in humid/windy weather | <input type="checkbox"/> around odors | <input type="checkbox"/> in moldy areas | <input type="checkbox"/> fall |
| <input type="checkbox"/> when cutting grass | <input type="checkbox"/> when raking leaves | <input type="checkbox"/> when physically exerted | <input type="checkbox"/> winter |

List family hobbies (model planes, etc.) _____

List family work exposures (e.g. parent, spouse) _____

DRUG HISTORY

Are there any drugs you take on a regular basis? _____

List any allergenic drug or injection with symptoms:

Drug	Symptoms	Drug	Symptom
------	----------	------	---------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

Have you ever reacted to: Dental anesthetics __, Tetanus antitoxin __, Tetanus toxoid __, Iodides __, X-ray contrast media __, Penicillin __.

List any drugs which have relieved you and which cause no reaction:

Do you require: normal __, low __, high __, doses of drugs as a rule?

Does your condition require frequent use of antibiotics?

Which?

List you maximum weight: ____, minimum weight ____, desired weight ____.

Do you exercise regularly ____, What type ____ How often ____.

Do you consider yourself to be under (low, moderate, high) levels of stress?

WOMEN ONLY

_____ number of pregnancies

_____ premature births

_____ number of births

_____ caesarians

_____ miscarriages

_____ abortions

_____ menopause

_____ taking hormones/hot flashes

Breasts

_____ breast soreness before periods

_____ breast soreness not related to periods

_____ breast soreness during periods

_____ had breast biopsy

_____ breast cysts or lumps

_____ had mastectomy

Menses

_____ age at onset

_____ use douches

_____ tense before

_____ am now pregnant

_____ use I.U.D. foam

_____ had D&C

_____ use foam

_____ scant flow

_____ backaches

_____ heavy flow

_____ had miscarriage

_____ have cramps

_____ pelvic infections

_____ use lubricants

_____ dizzy during

_____ fibroids

_____ weight increase

_____ pain w/intercourse

_____ tense during

_____ depressed before/during

_____ had partial or

_____ regular/irregular periods

_____ total hysterectomy

_____ use diaphragm

_____ ovulation pain

_____ dizzy before

Kenneth A. Bock, MD Steven J. Bock, MD Michael Compain, MD

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Albany, NY 12203
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Fax: (518) 435-0086

Web site: www.rhinebeckhealth.com E-mail: rhc@rhinebeckhealth.com

PATIENT DATA FORM

Last Name: _____

First Name: _____ M.I. _____ Home Phone (____) _____

Address: _____ Work Phone (____) _____
(Street)

City: _____ State: _____ Date of Birth: _____

Zip Code: _____ Sex: (M/F) _____ Soc. Sec.#: _____

Number of dependents _____ (Please complete separate dependent form for each patient)

Referred by: _____

Employer: _____ Occupation: _____

Employer Address: _____

Employer Phone: (____) _____

Pharmacy Name: _____ Pharmacy Phone: (____) _____

Drug Allergies? Please list _____

Emergency Contact and Phone: _____

Insurance Information:

Medicare: _____

Other: _____

Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Group Name or Number: _____

Insurance ID#: _____

Name of insured if other than Patient: _____

INFORMED CONSENT FOR INTEGRATIVE MEDICINE SERVICES AT THE RHINEBECK HEALTH CENTER (RHC) AND/OR THE CENTER FOR PROGRESSIVE MEDICINE (CPM)

I seek the medical and healthcare services of Steven Bock, M.D., Kenneth Bock, M.D. or Michael Compain, M.D., their employees and staff. I understand that this medical practice uses some diagnostic and treatment methods that are variously known as complementary, alternative, integrative, environmental, holistic, or nutritionally oriented. Some of these methods are not viewed as typically accepted by some medical practitioners.

OUR PREMISE:

- A person's lifestyle including his or her diet, exercise pattern, sleep habits, stresses and interpersonal relationships are believed to be directly related to the development and maintenance of illness. Complementary medicine evaluates these factors and seeks to help the patient give up negative lifestyle patterns and establish more positive ones regardless of age or type of medical problem. As part of our treatment plan, we might recommend that you seek some other types of treatment from other health professionals such as a therapist. These practitioners may not be affiliated with our group, and as such, we do not supervise them, nor are we responsible for them.

SUPPLEMENTATION:

- Although prescription and over the counter medications are used when the physician believes it is necessary, an attempt is first made, when appropriate, to use nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs.
- In addition to recommending that the patient take nutritional supplements by mouth, we frequently recommend that a patient receive a series of injections either intravenously or by intramuscular or subcutaneous injection. There are several reasons why we might make this recommendation. Primarily we want to ensure that the particular substance gets into the body (which may not happen when the supplement is taken orally and/or the patients have absorption problems). Secondly, we want to achieve high concentrations of the substance in the bloodstream, which may be difficult if the substance is taken by mouth.

LABWORK:

- Because we look for imbalances in the body and for trends that may result in illness if not addressed, we sometimes order tests that may be considered by mainstream medicine to be "*unnecessary or of no value.*" These tests may include tests for nutritional status, such as blood levels, or functional vitamin or mineral tests, hormonal levels or tests for allergies, including blood and skin testing. For example, we frequently recommend testing via the method provocation/neutralization, a technique used by many environmental physicians. This test involves a series of injected or under-the-tongue challenges with substances suspected of causing allergic reactions or intolerance.

ENVIRONMENT:

- We believe that environmental factors may play a major role in health and disease. Some of the diseases of unknown causes may be triggered or perpetuated by common environmental substances, many of which are manmade. Individuals may vary greatly in their susceptibility to various substances, while others are not affected. We attempt to identify offending substances and help patients detoxify from past exposures that are affecting them.

PATIENT/YOUR PARTICIPATION:

- We very much believe in the patient being involved in his/her own healthcare and encourage questions, exploration and participation in decisions surrounding diagnosis and treatment procedures. We encourage discussion with mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues. We encourage you to bring your medical records from other health practitioners, as it is important that the care you are receiving from multiple practitioners is compatible. We have the necessary release forms in our office to help you obtain for us your prior medical records. Please continue on the medications prescribed by your other physicians and be sure to inform our physicians of the medications you are taking. ***You should advise your pharmacist of any supplements you are taking along with any medications.***
- Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Exercise, both aerobic and stretching, is encouraged for most patients, under the supervision of your primary care physician.

MEDICATION:

- We sometimes use medications that are approved by the FDA to treat a different condition than the one specified by the FDA. This is referred to as “off-label use” of FDA approved medications.

The above represents some of the ways that our practice may differ from other physician’s offices that you have visited. You should also be aware of the following points:

1. *Drs. Steven and Kenneth Bock are board certified in family medicine, and Dr. Michael Compain is board certified in Internal Medicine. Our practice is an office-based practice, and Dr. Steven Bock, Dr. Kenneth Bock and Dr. Michael Compain’s focus is nutritional, integrative and complementary medicine. We do not admit patients to the hospital, nor do we consult with patients in the hospital. Additionally, some patients travel long distances to receive care at our office. These patients are required to have a primary care physician near their home. In the case of adults, this can be an internist, family physician, gynecologist, cardiologist, etc., and in the case of children, a pediatrician or a family physician.*
2. We will do our best to help you achieve your healthcare and wellness goals. However, we are making no representations, claims or guarantees that your medical problems or conditions will be helped by undergoing treatment here.
3. **EMERGENCY POLICY:** *Please be advised that RHC/CPM does not provide inpatient care. A doctor is on call for questions and problems that arise on an emergency basis; however, patients of RHC/CPM are advised to be under the care of a primary care physician who is available to them to provide emergent and urgent care. If you encounter an emergency medical situation and you are not able to obtain care from your primary care physician, please contact 911 or report to a hospital emergency department as appropriate. In the event that the care provider(s) providing you with emergency care has questions about your care and treatment at RHC/CPM, the on-call physician at RHC/CPM may be contacted by calling our emergency line at (845) 876-7082 in Rhinebeck, or (518) 435-0082 in Albany.*

4. On site and/or in our internet store, we make available nutritional supplements and other products. We believe the prices are competitive with outside sources. (Please let us know if you find this not to be the case.) Mail order services are also available from our office. **YOU ARE IN NO WAY OBLIGATED TO PURCHASE THESE PRODUCTS FROM RHINEBECK HEALTH NUTRIENTS (RHN). YOU ARE FREE TO PURCHASE THESE PRODUCTS FROM ANY SOURCE THAT YOU MAY CHOOSE.** We are obliged to disclose to you that the products sold at RHN are sold on a for profit basis.

5. You are responsible for payment of our invoices without regard to insurance coverage. You are entitled to know the cost of all services and procedures in advance. *Neither the practice or any of the physicians in the practice are members of any HMO or managed care panel, except for Dr. Compain who sees MVP and Medicare patients. Patients with MVP that are seen by Dr. Compain are covered for services that MVP deems usual and customary. If Dr. Compain provides a patient with services that are deemed alternative, complementary, and/or integrative medicine, by MVP, these services may not be covered by MVP, and will be the patient's responsibility. Services for Medicare patients are covered to the extent that Medicare deems them coverable. We make no guarantee that services provided for Medicare patients will be covered by Medicare. Accordingly, you should check with your insurance carrier about any potential limitations or restrictions on your health insurance benefits were you to be seen by this practice. For MVP and Medicare patients, please be aware that on Dr. Compain's off days, if you have an emergency, you should be seen in the emergency room, if you wish to submit the bill to your appropriate insurance carrier, i.e. MVP or Medicare. If you choose to see Dr. Kenneth Bock or Dr. Steven Bock on a day which Dr. Compain is not in the office you will be responsible for payment and you agree not to submit the bill to your MVP or Medicare carrier. The Drs. Bock do not participate in MVP and are opted out of the Medicare program.*

I understand that I have been given the right to review this consent with a lawyer if I choose any medical services offered by the practice. I have executed this consent freely and willingly and understand its provisions. I recognize that Kenneth Bock, M.D., Steven Bock, M.D. and/or Michael Compain, M.D. will rely upon execution of this document in accepting me as a patient. I acknowledge receipt of a copy of this consent.

Patient Name

Date

Parent Name

Witness Signature

Parent Signature

Physician Signature