SIVIERI WELLNESS CENTER

Mark Sivieri M.D. PA
10005 Old Columbia Road, Suite P170
Columbia, MD 21046

T: (410)-312-5280
F: (877)-844-1423

SivieriWellness.com

Denton
510 South Fifth Avenue
Denton, MD 21629

Bethesda
5411 W. Cedar Lane, Suite 202A
Bethesda, MD 20814

Annapolis
205 Ridgely Avenue
Annapolis, MD 21401

Welcome to Sivieri Wellness Center. We are a Family Practice with locations in Annapolis, Bethesda, Columbia, and Denton, Maryland. We specialize in preventative medicine and alternative therapies. Our expertise in both traditional and alternative medicine is a complementary approach to health care, and allows us to offer patients the best of both worlds.

Our alternative therapies include, but are not limited to

- A host of intravenous therapies for immune support, detoxification
- Acupuncture
- Brain chemistry balancing
- Detoxification
- Energy healing
- Hormone balancing
- Integrative cancer therapy
- Nutraceutical recommendations
- Oxidative therapies (including hyperbaric oxygen therapy)
- Sleep medicine
- Thermography
- Weight loss

Because we have multiple office locations, we have one central scheduling and supplement ordering office: **please direct your calls and faxes to our Columbia office.**

It is also imperative to remember that **we do not accept health insurance or Medicare.** However, we do offer a 10% discount on supplements to patients with Medicare.

Welcome to our practice!

Take Care,

Mark Sivieri, MD

WELCOME

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

A PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

B INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

C PHONE NUMBERS

Home (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

D FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES
☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

E MEDICAL HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:
- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:
- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

F SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____
Reviewed By — Date

SIVIERI WELLNESS CENTER

Preferred Methods of Communication

We are asking all of our patients to fill out this form. Please read the following information and sign this form.

I wish to be contacted in the following manner (check all that apply).

Home

- ☐ OK to leave messages on home telephone with detailed information
- ☐ OK to leave messages on cell phone with detailed information
- ☐ Leave message with call-back number only

Work

- ☐ OK to leave messages on work phone with detailed information
- ☐ Leave message with call-back number only

Written Communication

- ☐ OK to mail my home address
- ☐ OK to mail my work/office address
- ☐ OK to fax to this number: _____
- ☐ Sign up for e-newsletter, with monthly specials and updates

Email address: _____

We are asking all of our patients to keep their signature on file with us.

_____ _____

Signature Please print name

_____ _____

Date Date of birth

SIVIERI WELLNESS CENTER

Permission to Disclose Medical Information

Date:_____

I, _____, give the following person/persons permission to discuss any/all of my medical information regarding my condition/care with my physician.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____
Patient Signature

_____
Employee Signature

SIVIERI WELLNESS CENTER

Read Carefully

Please acknowledge receipt and understanding of the following information by signing below.

Notice as to Nature of Services:
I understand that care I receive at Sivieri Wellness Center may be nontraditional or unconventional. Such services are commonly referred to as a complementary or alternative medicine ("CAM"), holistic, or innovative services. This can include nutritional and herbal consultation, chelation, vitamin IV and other therapies. Many of these services may not be recognized as standard medical practice, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that prescribed to me.

Notice of Privacy Practices:
I understand by signing this form, I consent to the use and disclosure of protected health information about my treatment, payment, and healthcare operations. I have the right to revoke this consent in writing, except where Sivieri Wellness Center has already made disclosures in trust on my prior consent. I understand that I have the right to request restrictions on how my protected health information may be used or disclosed for treatment, payment, or health care operations. I understand that Sivieri Wellness Center is not required to agree to my restrictions, but if they do, they are bound by their agreement with me.

Payment and Medical Records Release Authorization:
I request that payment of authorized medicare/Insurance carrier benefits be made on my behalf to Sivieri Wellness Center for any services furnished to me by any practitioners at the center. I authorize Sivieri Wellness Center to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company upon their specific request. I also authorize any physician or health care provider I have seen to release my medical records to Sivieri Wellness Center. Such authorization if effective for a period of one year, and extends to records regarding my minor child, if applicable.

Treatment Authorization:
I authorize medical and health treatment of _____myself _____ my minor child by Mark Sivieri, M.D. and other practitioners at Sivieri Wellness Center.

No Guarantees:
I am aware that no practice of medicine is an exact science and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive at Sivieri Wellness Center.

Duration/Revocation of Authorization:
The authorizations may be revoked by me in writing at any time. Such revocation will not afffect my financial responsibility to pay for services rendered. I also certify that I am here to receive medical care and for no other purpose.

_____
Date

_____ _____
Patient/Guardian Signature Patient/Guardian Name Printed

SIVIERI WELLNESS CENTER

Our Financial Policy

Please understand that payment of your bill is considered part of your treatment. THe following is a statement of our **financial policy** which we require you to read and sign prior to any treatment. All patients must complete our Patient Information and insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND MONEY ORDERS

Regarding Insurance:
We do not accept assignment nor file claims to ANY insurance company, including Medicare. Medicare beneficiaries are required to read and sign a separate private contract prior to being seen by the doctor. You are responsible for charges incurred for all treatment rendered, and agree that you are also responsible for payments for services your insurance company may have determined to be non-covered or excluded, or to be unreasonable or not medically necessary. You have an obligation to pay for these services, including laboratory or other clinical services, **at the time of visit**. (The only exception tot his is that Medicare beneficiaries will not have to pay for any laboratory services, since we will bill Medicare on your behalf). You will also be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for this office to take action to secure payment for an outstanding balance owed.

Usual and Customary Rates:
Recognizing that our office provides a unique service, we are committed to providing the best treatment for our patients while still charging what is usual and customary for your area. You are responsible for payment regardless of any insurance company's arbitrary determination oif usual and customary rates.

Missed Appointments:
Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of $30. Please help us serve you better by keeping scheduled appointments.

Fees for Forms and Documents:
We reserve the right to charge a fee in the amount of $10-$20 per occurrence for any forms or document requests. Examples of such requests include school or camp physicals, disability forms, FMLA forms, copy of complete medical records, notes to employers, requests for documentation or letters from insurance companies.

Interest:
We reserve the right to charge interest in the amount of 1.5%, as provided by state law, on balances not paid within 30 days.

_____
Date

_____
Patient/Guardian