



east • west • wellness  
OF MARIN

**Patient Information**

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Skype: \_\_\_\_\_ Fax: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_ Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Are you seeing any other healthcare provider? \_\_\_\_\_

**Billing Information: You must provide a credit/debit card number below or provide one over the phone when your consult is scheduled.**

Credit Card Type: Visa / MasterCard / Discover (please circle one)

CC #: \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_

### **CONSENT TO TREAT**

I hereby authorize this office and its doctors to examine and administer care as the examining/treating doctor deems necessary. I understand and agree that I am personally responsible for payment of all these fees charged by this office for such care.

### **HIPPA – NOTICE OF PRIVACY POLICIES**

The notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or other healthcare operations. It also describes your rights to access and control your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health. Please be advised that our office may deem it necessary to discuss your PHI with other treatment facilities, laboratories, or payment centers, among other reasons, with or without your consent. A full explanation of our rights and responsibilities as a healthcare facility and your rights as a patient, under HIPPA requirements, is available upon request.

### **DISCLAIMER**

Please be advised that the nutritional and herbal programs that are administered by our office, and/or Dr Eve Bernstein are not intended as a primary therapy for any disease, but rather to provide nutritional and herbal support for normal body physiology and repair. Also be advised that any and all testing ordered by our office and/or Dr Eve Bernstein whether it be by saliva, hair analysis and/or blood work is not used to treat or diagnose any disease. These types of testing simply offer guidance on how to use whole food supplements and herbs to support and balance the body, while dealing with imbalances.

### **BILLING**

We **do not** bill insurance for nutritional services, nor do we provide CPT or diagnosis codes for you to do so, as the nutritional work performed by Dr Eve Bernstein is not designed to diagnose or treat a disease. We would appreciate it if you were prepared to pay your consultation fee at the time of service.

**Please sign to confirm that you have read and understand the above information.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you so much for taking the time to fill out this packet of information. We look so forward to working with and getting to know you. We are dedicated to finding the best individual path for each of our patients.

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