Instructions Before You Come

1. The initial visit for any new patient will be approximately 1 -1 ½ hours in length. It is important that you complete these forms as accurately as possible and return them so we can schedule your appointment.
2. Fill out all the enclosed documents in **Black ink only**. If possible, please do not fold these documents.
3. For Lyme Disease Visits: It is helpful to us if you include a brief written description of when you feel your illness began with the treatments you have had since then.
   Please include whether or not you have had a tick- bite, with or without a rash. Also, include if you have had any Antibiotic treatment for Lyme Disease thus far.
4. Any laboratory tests performed by this office prior to your initial visit will be reviewed at your consultation. Tests results will be discussed at your visit. You may be asked to have additional blood work drawn on the day of your visit.
5. Take note in the **Office Policies** that we ask that you refrain from Smoking, wearing Perfumes, heavy Musk or Cologne when coming to this office. This policy is strictly adhered to, secondary to the health concerns of the staff and the other patients.
6. Dr. Caprio and Dr. Mulliken give equal time to each patient; this may cause a delay in your scheduled appointment time. We appreciate your understanding in this matter.
7. Although we do not submit to medical insurance for payment of your office visit, we will **need a copy of your insurance card** and insurance information for blood work and other tests.

We have a long cancellation list of patients waiting to be seen. If you must cancel your appointment, please give us at least 48 hours notice, so that we can fill your empty appointment slot.

Thank you!

Sacred Heart Center for Health and Healing

Teresa A. Caprio, D.O. Scott P. Mulliken, N.D.

62 Portland Road, Suite#5 • Kennebunk, ME 04043 • 207-467-3345 • (fax) 207-467-3403

New Patient Information Form

(Please Print /Black Ink)

Patient Information

Name _____ Date of Birth _____

Mailing Address

Home Phone _____

Street _____ Work Phone _____

City _____ Cell Phone _____

State _____ Zip _____

Email Address _____

Primary Care Physician

_____ Your Last Visit_____

In Case of Emergency Contact

_____

Spouse Information (Parent, if minor)

Name _____

Mailing Address (if Different)

Street _____ Work Phone _____

City _____ Cell /Home Phone _____

State _____ Zip _____

Authorization to Disclose Healthcare Information.

Sacred Heart Center for Health and Healing regards the safeguarding of your confidential health care information as an important duty. The elements of this authorization to disclose Healthcare Information are required by state law for your protection and to ensure your informed consent to the disclosure of health care information necessary to support your relationship with your physician.

I, _____, authorize Sacred Heart Center for Health and Healing,
(Please print)

to disclose my health care information with health care practitioners and health care facilities who are involved in providing health care and with my family who are providing me with emotional support as I receive health care services. Also, I authorize Sacred Heart Center for Health and Healing to disclose my health care information to my health insurance carrier, utilization review organization, or benefit manager or any third party who may be responsible for the payment for services rendered to me.

My health care information, which is the subject of this document, includes information, written or not, about the preventative, diagnostic, or treatment services provided to me and that may be used to identity me. Depending upon the services I request from my physician, this information may include information about treatment for sexually-transmitted disease, mental health, or substance abuse. This authorization to disclose with remain in effect for all subsequent exchanges of health care information for the limited purposes outlined within this authorization, unless I revoke it in a written request.

I understand that I may refuse to disclose all or some health care information and that I may revoke this authorization at any time by providing my physician with a written, signed, and dated request. However, I understand that my refusal to disclose all or some health care information or to provide this authorization at this time or to revoke it later, may result in improper diagnosis or treatment, denial of coverage from a claim for health benefits or other insurance, or other adverse consequences.

Should you wish to have a copy of this authorization, please ask the office staff.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

WELCOME TO OUR PRACTICE

NAME **DOB** **AGE** **DATE**

Reason you are Here

_____

_____

_____

Medications You are Taking _____

_____

Supplements you are Taking_____

_____

_____

Allergies to Drugs:_____

_____

PAST MEDICAL HISTORY (CIRCLE WHAT YOU HAVE)

1. Stroke / Coronary Disease: Heart Attack/ Elevated BP and/or Elevated Cholesterol
2. Cancer (Type_____) Diabetes Type I or II/ Neuropathy /Liver Disease: Cirrhosis /Hepatitis / Fatty Liver / Ulcer
3. Osteoporosis / Osteoarthritis / Thyroid Disease /Auto Immune Disease / GERD
4. Asthma / Bronchitis/ Emphysema /Pneumonia (what year _____)
5. Lyme Disease/ Tick Borne Illness/ Depression/Anxiety/STD/ HIV/ Blood Transfusion (what year)

Surgeries / Hospitalizations

_____

Social HISTORY: Occupation_____ Married / Single / Divorced / Widowed

Use of Tobacco: Never / Previously, but quit. / Still Smoke / # Packs per Day_____

Use of Alcohol: Never / Rare / Daily # Drinks per (Day___) (Week____) (Month____)

Family History/ Mother: Alive or Deceased / List Major Illnesses _____

Father: Alive or Deceased / List Major Illnesses

_____

Please *Circle* the Symptoms That You Have: Name: _____

Date: _____

General Well Being

Malaise (Not feeling well)
Fatigue / Tiredness – (can be extreme) Exhaustion
Early Experience of Flu-like symptoms, especially when not in "Flu Season"
Symptoms seem to come and go or cycle in patterns
Decreased interest in Activities of Daily Living or for Children decreased interest in Play
Unexplained Fevers (High or Low Grade)
Chronic Re-curing Infections (Ears, Eyes, Kidney or Sinuses)
Rash – Does not have to be a "Bulls Eye"

Head & Neck

Headache / Pressure in Head
Twitching or Paralysis
Sensations of Numbness / Tingling Sensations of Face
Jaw Pain or Symptoms of TMD (Temporal Mandibular (*Joint)* Dysfunction)
Stiff Neck
Sore Throat / Swollen Glands in Face & Neck
Hoarseness / Difficulty Swallowing
Changes in sense of Smell or Taste / Sinus Trouble / Nosebleeds
Persistent Sinus Congestion or Infection

Eyes / Vision

Double or Blurry Vision
Drooping Eyelid / Eye Pain
Floaters or Spots in Field of Vision / Seeing "Flashing Lights"
Sensitivity to Light
Decreased Perception of Light or Color
Visual Changes (Corneal Lesions, Retinal Damage, Loss of Vision)
Recurrent Eye Infection or Inflammation

Ears/ Hearing

Decreased Hearing in one or both Ears
Ear Pain
Ringing or Buzzing in one or both Ears / *Tinnitus
Increased Sensitivity to Sound

Digestive System / Urogenital System

Diarrhea or Constipation
"Upset" Stomach (Nausea, Vomiting, Abdominal Pain, Increase in Acid Reflux)
Unexplained Weight Gain or Loss
Loss of Appetite
Pain on Urination / Urgency / Frequency / Hesitancy to Urinate
Pain in Testicles / Vaginal Pain

Cough
Difficulty with Breathing / Difficulty taking a Deep Breath / Air Hunger
Shortness of Breath / Chest Pain / Rib Pain or Soreness
Night Sweats / Chills
Heart Pain / Palpitations / Skipped or Extra Beats / Rapid Heart Rate
Diminished Exercise Intolerance / Swelling of Hands or Feet
*Heart Diagnosis of 2nd degree AV Block / Right Bundle Branch Block

Musculoskeletal System

Joint Pain / Swelling or Stiffness
Migrating Joint Pain (Moves from one Joint to Another)
Muscle Pain or Muscle Cramps
Burning Sensation of Feet / Pain in Feet upon Walking
Increased Joint and Muscle Pain after Exercise

Endocrine System

Excessive Thirst/ Hunger / Urination
Intolerance to Heat or Cold / Dry Hair / Hair Loss / Brittle Nails

Neurologic System

Weakness or Paralysis of Limbs
Tremor or Unexplained Shaking
Numbness or Tingling or Pins & Needles Sensation in Extremities
Poor Balance / Difficulty Walking / Dizziness
Lightheadedness / Fainting
Pronounced Motion Sickness
*May have a Diagnosis of Seizures
*White Matter Lesions seen on MRI

Mental Capabilities / Cognition

Forgetfulness / Memory Loss (Short or Long)
Poor School or Work Performance
Confusion / Difficulty with Thinking
Difficulty with Concentration / Reading or Spelling
Disorientation: Getting lost or going to the wrong place
Difficulty with Speech (Slowed, Slurred or Stammering)
Word Searching or Word Retrieval Problems
Difficulty with Writing / Dyslexia-Type Reversals
Forgetting how to perform a simple task
Difficulty with simple math equations

Psychiatric

Anxiety / Panic / Panic Attacks
Paranoia / Worries all the Time / Unusual Fears
Violent Behavior / Rage / Irritability
Rapid Mood Swings that may mimic Bipolar Disorder
*Diagnosis of OCD / ADD / ADHD / Autism-like Syndrome

Sacred Heart Center for Health & Healing

Office Policies

Check-in and Payment

Please check in at the front desk prior to each appointment. Make yourself at home in our reception area. Dr. Caprio or Dr. Mulliken will let you know when they are ready to see you.

At the end of your appointment, you will be checked out and given your Itemized Bill and your next appointment.

We accept Cash, Personal Check and Credit Cards. We also accept many Health Savings Accounts. You will receive your receipt at the time of check out. Please keep this for your records, as we do not keep CC Receipts.

We are unable to keep running balances in the office. If for some reason there is any prior balance, it will be due at your next scheduled visit.

Dr. Caprio and Dr. Mulliken **do not bill insurance,** but may be considered "Out of Network" Providers under your Insurance Policy. Many patients do receive re-imbursement for their visit.

Please note: Payment is due when services are rendered.
We do not bill medical insurance companies for payment.

Email Correspondence and Texting

In keeping with privacy laws Dr. Caprio and Dr. Mulliken have encrypted our email transmissions and made them as secure as possible. However, please understand that no transmission is 100% secure. If you choose to do so, we have provided a general email address for your questions.
Our email address is Sacredheartcenter@ymail.com

Questions will be reviewed by Dr. Caprio and Dr. Mulliken and a response sent to you from Melissa, with every attempt to have all questions answered within 24-48 hours. (Week-ends Excluded)

Any communications including emails that contain:

- ***"new subjects", "new treatments", "what do I do next?"***
- **discussions about information from other Doctors**
- ***emails that are very long in nature*** **or too complex will need to be addressed through either a brief Office Visit or Phone Consultation with the Doctor.**

*****Email answers will be limited and are not intended to replace regular office visits.**

***Since Email cannot be completely protected under privacy laws, **if you choose to email you are consenting to release** Dr. Mulliken and Dr. Caprio from any liability.

Please be aware that Dr. Caprio and Dr. Mulliken do not accept **"Texting"** as a form of communication for their Medical Practice.

If it is an *Urgent Matter*, please call 207-251-8068 If we cannot be reached, then we recommend going to your local Emergency Room or Urgent Care.

Fees are as follows:

First Visit: $275.00- $365 depending on Complexity

Follow – up visits are: $180.00/ per hour

Low Level Laser Treatment

1st Appointment is 1 Hour and includes LLLT: $225.00

LLLT/ Multiple Areas ½ Hour - 45 mins: $90 ea. visit.

Most protocols are Twice/ week for 3-4 weeks

Patients may request an abbreviated appointment at the time of scheduling. **This must be agreed upon with the Doctor.**

Note: There are no abbreviated appointments for Laser Treatments

Abbreviated Appointments will be billed at:

30 mins	**$90.00**
45 mins	**$135.00**
60 mins	**$180.00**
75 mins	**$225.00**
90 mins	**$275.00**

This Fee Schedule includes Phone Consultations.

The phone consultation fee will be charged at the end of the phone call. Credit Card or Health Spending Account Card will need to be given before the Phone Consult takes place.
Phone consultations are available to clarify Treatment Plans, as a convenience for those who live a significant distance from the office or during inclement weather.

Please print your initials *on the line next to the paragraph and then* Sign *at the bottom.*

_____All Lab tests will be discussed at your follow-up visit with your Doctor. **Please do not call the office to request the results of Laboratory Testing.** If there is a need for a change in your treatment plan due to a Lab result, the Doctor or office staff will contact you to discuss changes. Otherwise, testing will be reviewed at your follow-up visit.

_____We would like to request that unless you are having a significant problem or a medical emergency, that you do not call the office and ask to speak to the Doctor. Please leave a brief message for Melissa or you may send an email correspondence.

_____Time constraints only allow Dr. Mulliken and Dr. Caprio to return phone calls during office hours if it is an urgent medical matter that cannot wait.

_____In respect for other patients who may be sensitive to solvents, we ask that you refrain from wearing any essential oil, musk, cologne, perfume or scented lotion when coming to this office

_____It is our desire to have all of our patients quit smoking now and forever, but if you continue to smoke, **we ask that you abstain for at least *2 hours* before your visit.**

I have read and understand the Office Policies of Sacred Heart Center, and I agree to be bound by its terms. I also understand such terms may be amended from time to time by the practice.

_____

Signature of Patient or Guardian (if under age 18)

Print Name_____ Date _____