Brian J. Henninger, N.D.
1305 Post Rd, Suite 301
Fairfield, CT 06824
203-255-4325

All information you provide in this questionnaire will be kept strictly confidential
How did you hear about Dr. Henninger? Is there someone we can thank for referring you?

_____

Name of Patient: _____ Date of Birth: _____

Address: _____ City, State, and Zip: _____

SS#: _____ Male/Female E-mail Address: _____

Phone: Day: _____ Employer: _____

Phone: Evening: _____ Occupation: _____

Phone: Cell: _____

Required – ALL INSURANCE INFO MUST BE FILLED OUT IN ORDER TO SUBMIT TO INS COMPANY.

Insurance: _____ Ins No.: _____ Group#: _____ Copay amt: _____

Insured Name: _____ Insured DOB: _____ Insured SS# _____

Primary Care Physician: Name: _____ Address: _____

Phone: _____ _____

Please list health concerns which you would like Dr. Henninger to address:

1. _____ 2. _____ 3. _____

Where and when did you last receive health care? For what?

_____

Health History: Surgeries _____ Injuries and accidents _____

Other hospitalizations _____

Are you allergic to any drugs? _____ If yes, what? _____

To any foods? _____ If yes, what? _____

Any other allergies? _____

Have you ever been exposed to hepatitis? _____

Have you ever been exposed to the AIDS virus (HIV) or do you have any concerns about AIDS you would like to discuss with the doctor? _____

This office reserves the right to charge for missed appointments with less than 48 hours notice. This office also reserves the right to assess a finance charge of 1.5% per month on all past due balances.
We care about you and your health.

I desire greater health. I have read and understand the above policies.

Insurance: Dr. Brian Henninger's Office will attempt to collect all applicable fees from your insurance company. You are responsible for securing a referral, if required, before the first visit. Supplements and many laboratory fees are not covered by common insurance companies. These fees plus any other fees which may be denied by your insurance company will be your responsibility.
I have read and understand my obligation to pay all charges not covered by my insurance.

_____ X. _____
Date **Signature**

Brian J. Henninger, N.D.
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Fairfield, CT 06824
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FINANCIAL POLICY – Please read carefully and sign below.

Dear Patient:
Thank you for choosing our office for your medical care. In the present climate of healthcare reform, our office is making every effort to keep medical costs down for our patients. For us to successfully do this, we ask for the cooperation of our patients. Please carefully read our Financial Policy. Our main concern is to provide you with the best possible care in a convenient, informative, and helpful manner.

MUST INITIAL 1 THROUGH 6 BELOW:

_____1.) Payment for office visits are due at the time service is rendered unless:
- i. Your health plan covers these services
- ii. Special arrangements are made in advance

_____2.) PATIENTS are responsible for referrals from their primary care doctor before each visit if required by insurance (call member service number on your card).

_____3.) Not all services are a covered benefit in all contracts. We can assist you in asking your insurance company if they will cover your treatment. If we do not participate with your insurance, you will be responsible for the difference your insurance company does not pay.

_____4.) Charges are the responsibility of the patient or the responsible party. Your insurance policy is a contract between you and your insurance company.

_____5.) If the insurance company does not pay your balance in full within 45 days, we ask that you contact the carrier to help expedite payment. If the insurance company does not pay the full amount within 60 days, we ask that you make payment on any balance due. We will accept cash, check and credit cards (MC/Visa) for payment. Returned checks will be subject to a fee of $20.00.

_____6.) Balances older than 60 days are subject to an interest charge of 1.5% per month if we so choose. In the event it becomes necessary to proceed with collection action, you will be responsible for any reasonable attorney fees and collection costs.

If you have any concerns about our payment policies, please do not hesitate to ask our office. We understand that temporary financial consideration may affect timely payment of your balance, and we encourage you to communicate any such problems so that we can assist you in the management of your account.

We are grateful for the opportunity to serve you and appreciate your trust in us.
We care about you and your health.

I desire greater health. I have read and understand the above policies.

_____

Date Signature

CANCELLATION POLICY

Dr.Henninger, Naturopathic Physician, values you as a patient and your scheduled appointment.

Our office requires a **48 hour notice** if you are not able to keep your appointment .We understand that Dr.Henninger's time is valuable, and when appointments are missed, it is time taken away from others in need of care .If you are unable to keep your scheduled appointment, please call our office at 203-255-4325 to reschedule at least 48 hours in advance.

Our office reserves the right to charge a **$25.00 fee** for any appointment not cancelled prior to 48 hours.

(I have read and fully understand the cancellation policy.)

Patient signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that the office of Brian J. Henninger, N.D. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

(203) 255-4325

I also understand that I am entitled to receive updates upon request if the office of Brian J. Henninger, N.D. amends or changes its Notice of Privacy Practices in a material way.

_____ _____

Signature Relationship to Patient, if signed by someone other than patient.

_____

Date

THIS SECTION IS TO BE COMPLETED BY THE OFFICE OF BRIAN J. HENNINGER, N.D. IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

____ Patient declined to sign this Written Acknowledgment.

____ Other (specify): _____

_____ _____

Name and title of employee Date

Patient Name:_____Date:_____

Please fill in the chart below with your/your child's **CURRENT** supplements, medications, and other therapies.

Supplement/Med	Dose	Frequency	Date Started	Comments

Other CURRENT Therapy (e.g. Craniosacral, Sauna, etc)	Frequency	Date Started	Comments

Please complete the chart below with any supplements, medications, or other therapies you/ your child has tried in the **PAST** (list recent ones first).

Supplement, medication, or other therapy	Date Stopped	Reason for stopping