Dr. William Kleber, D.C., DABCI - Dr. Brett Wisniewski, D.C., DACBN, DABCI - Igor Zelinksi LAc
1211 Lake Ave, Berthoud, CO 80513 - P: 970-532-2755 F:970-532-9838

The following information provided is confidential and is for medical purposes only. It is important you fill it out to the best of your ability. Even if the question seems not to apply to your current condition please fill this form out completely as many things can be connected and will help us better serve you.

Name:____ **Today's Date:**_____________(mm/dd/yr)

DOB:________ (mm/dd/yr) **Current age**:____ **Height**:____ **Weight**:______ **Gender**: □ **male** □ **female**

Address:______________________________ **City:**____________ **State:**____ **Zip Code:**___________

Home Phone:_________________________ Permission to leave a 'medical' message? □ **Yes** □ **No**

Cell Phone:__________________________ Permission to leave a 'medical' message? □ **Yes** □ **No**

Email for medical/healthcare correspondence:____

Occupation:__________________________ **Employer:**___________________________________

Emergency Contact Name:______________________________ **Phone #:**______________________

Please Describe your current problem/complaint that brought you to our office: List them in order of importance. For example #1 is most important, and #5 is least important. *(if your complaint is of pain please also use the diagram on the following page)*

1.____

2.____

3.____

4.____

5.____

How long have you had the above condition/s? _________________ Is it getting worse? □ yes, □ no

Does it effect your (check appropriate box): □ work, □ sleep, □ other:_____________________________

Initial cause of complaint: ____

Major goals for your our first visit: Let us know what you would like to accomplish on your first visit.

1.____

2.____

3.____

4.____

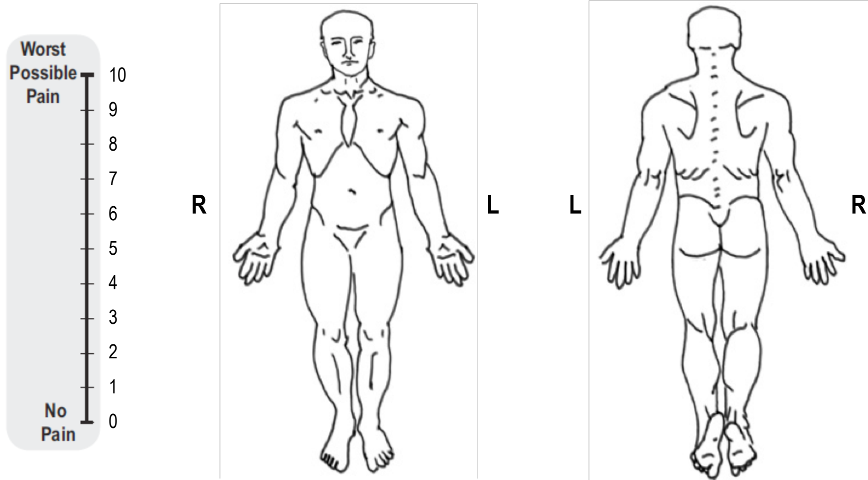
Have you been treated for this condition in the past/present? □ yes, □ no; If YES, by whom?

____

Have you been diagnosed for this condition? □ yes, □ no; Diagnosis:__________________________

Is there anything else the Doctor should know about *you* or your *condition*?________________________

Please circle a number corresponding with to your pain and use "X"'s and lines to locate your pain and describe any radiation of pain.



PAST HISTORY

Have you…	Yes	No	If yes, explain briefly WITH approximate date/year
... ever been hospitalized?	□	□	______________________________
... had any surgeries?	□	□	______________________________
... had any mental disorders?	□	□	______________________________
... had any broken bones?	□	□	______________________________
... had any strains or sprains?	□	□	______________________________

Have you ever been bitten by a *tick or spider* that you know of? □ **yes,** □ **no** If yes, did you have a reaction such as a rash, fever, joint pain, etc. □ **yes,** □ **no**

____

Have you ever have mono or Epstein barr virus? □ **yes,** □ **no**

Have you ever been diagnosed with MRSA? □ **yes,** □ **no**

Have you had any other infections? □ **yes,** □ **no** :______________________________

Do you have any allergies to foods, medications or environment? ______________________________

____

FAMILY HISTORY

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Cancer ______________________

□ High blood pressure ______________________

□ Anemia ______________________

□ Diabetes ______________________

□ High cholesterol ______________________

□ Arteriosclerosis ______________________

□ Emphysema ______________________

□ Multiple sclerosis ______________________

□ Epilepsy ______________________

□ Osteoporosis ______________________

□ Stroke ______________________

□ Bleed easily ______________________

□ Heart disease ______________________

□Thyroid disease ______________________

□ Dementia/Alzheimer's/Parkinson's ______________

□ OTHER: ______________________

____

____

HABITS and LIFESTYLE

Please *circle* any of the following you consume: Alcohol Coffee Tobacco Drugs Soft Drinks OTC meds. Pain Killers

Do you exercise regularly? If YES-what do you do? If NO what keeps you from exercise? ____________________________

DIET- Do you Follow any particular diet regimen or restrictions?:____

____

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?* ____

Date of last complete physical exam: ______________

Date of most recent lab/blood tests: _______________

***WOMEN—date of last PAP smear**:* _________________results:______________

Currently pregnant? YES NO UNSURE

Do you still have your monthly period? YES NO UNSURE

Do you have any children? YES NO **How many?**__________ **Healthy?**________________

Name/s of your children:____

Is there anything else the Doctor should know or you would like to elaborate on?:

____

____

____

____

Current **prescription medications** (e.g., Prozac, lipitor, etc), **non-prescription medications** (e.g., aspirin, Tylenol, ibuprofen) and/or **health supplements** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking. If you need more room please attached a sheet to this form.* ***Please also list any drug allergies**.*

NAME *of medication or supplement—drugs, vitamins, herbs, minerals*	**DOSE** *in milligrams or grams (or number of capsules, tablets)*	**FREQUENCY***:* **Times per day/ week/ month**	**DURATION***:* *Been* **taking for how long?**

REVIEW of SYSTEMS: Simply circle the most appropriate number for each attribute so we can better understand and discuss your current condition. Although this list is extensive it is important to fill out completely and as accurately as possible. If you mark "YES" to a question please provide additional info to the right or on the bottom of the page.

GENERAL HEALTH	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Fatigue, lack of energy, lack of stamina	□ 0	□ 1	□ 2	□ 3
Tired even after "good" sleep	□ 0	□ 1	□ 2	□ 3
Lack of desire to get out of bed	□ 0	□ 1	□ 2	□ 3
Undesired weight gain, difficulty losing weight	□ 0	□ 1	□ 2	□ 3
Undesired weight loss	□ 0	□ 1	□ 2	□ 3
Hard time falling asleep	□ 0	□ 1	□ 2	□ 3
Hard time staying asleep	□ 0	□ 1	□ 2	□ 3
Faint/dizzy/nauseous if a meal is skipped	□ 0	□ 1	□ 2	□ 3
Decreased appetite	□ 0	□ 1	□ 2	□ 3
Food or environmental allergies	□ 0	□ 1	□ 2	□ 3
Sensitive to perfumes, chemical smells, exhaust, etc.	□ 0	□ 1	□ 2	□ 3
Cold sores and blisters	□ 0	□ 1	□ 2	□ 3
Morning stiffness/muscle cramps	□ 0	□ 1	□ 2	□ 3
Pain at night/Night sweats	□ 0	□ 1	□ 2	□ 3
Past or present diagnosis of serious conditions such as : cancer, systemic infection, kidneys disease, heart disease or other	□ **NO**	□ **YES —>**		

HAIR, SKIN, and NAILS	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Oily or dry skin (please circle	□ 0	□ 1	□ 2	□ 3
Eczema	□ 0	□ 1	□ 2	□ 3
Psoriasis	□ 0	□ 1	□ 2	□ 3
White spots on finer nails	□ 0	□ 1	□ 2	□ 3
Small bumps on the back of the arms	□ 0	□ 1	□ 2	□ 3
Skin rash or fungal infection	□ 0	□ 1	□ 2	□ 3
Increased body or facial hair	□ 0	□ 1	□ 2	□ 3
Decrease in body or facial hair	□ 0	□ 1	□ 2	□ 3
Acne	□ 0	□ 1	□ 2	□ 3
Discoloration or depigmentation of skin	□ 0	□ 1	□ 2	□ 3
Other problems or concerns in this area	□ **NO**	□ **YES —>**		

HEAD and MIND	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Lack of desire to get out of bed	☐ 0	☐ 1	☐ 2	☐ 3
Headaches or Migraines (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Loss of consciousness or feeling faint, dizzy	☐ 0	☐ 1	☐ 2	☐ 3
Hard time remembering (long or short term)	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or "finding" words	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3
Dyslexia or word confusion	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES –>**		
Feelings of sadness or depression	☐ 0	☐ 1	☐ 2	☐ 3
Anxiety and stress	☐ 0	☐ 1	☐ 2	☐ 3
Inability to cope with stressful situations	☐ 0	☐ 1	☐ 2	☐ 3
Lack of interest or concern	☐ 0	☐ 1	☐ 2	☐ 3
Mental sluggishness	☐ 0	☐ 1	☐ 2	☐ 3
Use of alcohol, drugs, vitamins/minerals/ herbals to deal with stress	☐ 0	☐ 1	☐ 2	☐ 3
Recent or current thoughts of suicide	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or "finding" words	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES –>**		
Diagnoses of any mental disorder- depression, bipolar, schizophrenia or other	☐ **NO**	☐ **YES –>**		

CARDIOVASCULAR and PULMONARY	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain in the chest, left arm, and/or left side of neck	☐ 0	☐ 1	☐ 2	☐ 3
Shortness of breath upon relaxation or exertion	☐ 0	☐ 1	☐ 2	☐ 3
Swelling in upper or lower extremities	☐ 0	☐ 1	☐ 2	☐ 3
Irregular heart beat	☐ 0	☐ 1	☐ 2	☐ 3
Pounded heart beat heard when resting your head on a pillow	☐ 0	☐ 1	☐ 2	☐ 3
Rapid heart beat	☐ 0	☐ 1	☐ 2	☐ 3
Irregular breathing or discomfort	☐ 0	☐ 1	☐ 2	☐ 3
“Blushed” or red faced	☐ 0	☐ 1	☐ 2	☐ 3
Tightness of the chest	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES –>**		

EYES, EARS, NOSE, THROAT	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Watery, red, or itchy eyes	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under eyes	☐ 0	☐ 1	☐ 2	☐ 3
Loss of vision/Blurry vision	☐ 0	☐ 1	☐ 2	☐ 3
Hard to see at night	☐ 0	☐ 1	☐ 2	☐ 3
Pain in, near, or behind the eye	☐ 0	☐ 1	☐ 2	☐ 3
Earache or pain in the ears	☐ 0	☐ 1	☐ 2	☐ 3
Tinnitus/ Ringing in the ears	☐ 0	☐ 1	☐ 2	☐ 3
Reoccurring ear infections	☐ 0	☐ 1	☐ 2	☐ 3
Decrease or loss of hearing	☐ 0	☐ 1	☐ 2	☐ 3
Enlarged lymph nodes under the chin/jaw/ on the neck	☐ 0	☐ 1	☐ 2	☐ 3
Bleeding/ sore gums	☐ 0	☐ 1	☐ 2	☐ 3
Tongue has a white coating	☐ 0	☐ 1	☐ 2	☐ 3
Dry mouth, eyes, and/or nose	☐ 0	☐ 1	☐ 2	☐ 3
Halitosis/ bad breath	☐ 0	☐ 1	☐ 2	☐ 3
Sore throat	☐ 0	☐ 1	☐ 2	☐ 3
Excessive mucous formation	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

GENITO-URINARY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Pain in the mid to lower back	☐ 0	☐ 1	☐ 2	☐ 3
Kidney stones	☐ 0	☐ 1	☐ 2	☐ 3
Cloudy, bloody, or dark urine	☐ 0	☐ 1	☐ 2	☐ 3
Urinary tract infections	☐ 0	☐ 1	☐ 2	☐ 3
Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Painful urination	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Low sex drive/ libido	☐ 0	☐ 1	☐ 2	☐ 3
HIV test	☐ NOT	☐ YES —>	☐ Positive	☐ Negative
Sexually transmitted disease	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

GASTROINTESTINAL	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Constipation / Diarrhea (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Gas or bloating	☐ 0	☐ 1	☐ 2	☐ 3
Nausea / Vomiting (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Pains in the stomach or lower abdomen	☐ 0	☐ 1	☐ 2	☐ 3
Heartburn or "GERD"	☐ 0	☐ 1	☐ 2	☐ 3
Sense of fullness after meals	☐ 0	☐ 1	☐ 2	☐ 3
Tired after meals or feel better if you skip meals	☐ 0	☐ 1	☐ 2	☐ 3
Undigested food in stool	☐ 0	☐ 1	☐ 2	☐ 3
Food allergies	☐ 0	☐ 1	☐ 2	☐ 3
Mucous build up/ sinus congestion after meals	☐ 0	☐ 1	☐ 2	☐ 3
Greasy or fatty foods upset your stomach	☐ 0	☐ 1	☐ 2	☐ 3
Anal itching	☐ 0	☐ 1	☐ 2	☐ 3
Coated white tongue	☐ 0	☐ 1	☐ 2	☐ 3
Fungal or yeast infections	☐ 0	☐ 1	☐ 2	☐ 3
Symptoms get worse after eating sugar	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under the eyes	☐ 0	☐ 1	☐ 2	☐ 3
Hemorrhoids	☐ 0	☐ 1	☐ 2	☐ 3
Blood or mucous in the stool (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Crohn's disease or Celiac disease (please circle)	☐ **NO**	☐ **YES —>**		
History of alcohol abuse	☐ **NO**	☐ **YES —>**		
History of hepatitis	☐ **NO**	☐ **YES —>**		
Long term use of prescription/recreational drugs	☐ **NO**	☐ **YES —>**		
Loss of bowel control, incontinence	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

MALE ONLY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Difficulty or painful erections	☐ 0	☐ 1	☐ 2	☐ 3
Cloudy, bloody, or dark urine	☐ 0	☐ 1	☐ 2	☐ 3
Painful or difficulty with ejaculation	☐ 0	☐ 1	☐ 2	☐ 3
Waking to urinate at night	☐ 0	☐ 1	☐ 2	☐ 3
Decreased sexual function	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Family history of prostate cancer	☐ **NO**	☐ **YES —>**		
Painful/tender testis	☐ **NO**	☐ **YES —>**		
Undescended testis, testis in abdomen or pelvis	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

FEMALE ONLY	Never-Very rare	Occasional-Mild	Intermittent-Moderate	Frequent-Severe
Irregular or painful menses	☐ 0	☐ 1	☐ 2	☐ 3
Pain between cycles	☐ 0	☐ 1	☐ 2	☐ 3
Heavy clotting	☐ 0	☐ 1	☐ 2	☐ 3
Painful, swollen, fibrocystic breasts	☐ 0	☐ 1	☐ 2	☐ 3
Excessive bleeding	☐ 0	☐ 1	☐ 2	☐ 3
Painful intercouse	☐ 0	☐ 1	☐ 2	☐ 3
Hot flashes or fluctuations in temperature	☐ 0	☐ 1	☐ 2	☐ 3
Yeast infections/ vaginal itching	☐ 0	☐ 1	☐ 2	☐ 3
Mood fluctuations that follow your cycle	☐ 0	☐ 1	☐ 2	☐ 3
The use of birth control pill	☐ 0	☐ 1	☐ 2	☐ 3
Menopausal symptoms or concerns	☐ **NO**	☐ **YES —>**		
Infertility	☐ **NO**	☐ **YES —>**		
Poly cystic ovarian syndrome (PCOS)	☐ **NO**	☐ **YES —>**		
Family history of breast, uterine, or ovarian cancer?	☐ **NO**	☐ **YES —>**		
Annual female exam: breast, pap smear, etc.?	☐ **NO**	☐ **YES**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

Informed Consent and Mutual Understanding

TO THE PATIENT: Once this document has been reviewed with you verbally, please read it in its entirety prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

It is not necessary or encouraged to discontinue treatments with other physicians or healthcare providers. If you are on any current medication or nutritional supplementation- it is your responsibility to inform changes in your condition, symptoms, contact information, or treatments between visits.
You are encouraged to contact Dr. William Kleber,D.C., DABCI and/or Dr. Brett Wisniewski, D.C., DACBN, DABCI at anytime with health related questions as this is a team effort and every effort will be made to keep you focused on your ultimate goal of optimal health.
Dr. William Kleber,D.C., DABCI and Dr. Brett Wisniewski, D.C., DACBN, DABCI hold a Doctor of Chiropractic Degree and are currently licensed in the state of Colorado. Each procedure/lifestyle modification/treatment holds both risks and benefits. Your case will be thoroughly evaluated to avoid some of these negative reactions and customized to your unique health status; but no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s) nor are they implied.
For distance consultations: *Due to the nature of this consult a primary care provider is necessary and should have performed a physical exam on your current major complaint that you are seeking advice from Dr. William Kleber,D.C., DABCI and/or Dr. Brett Wisniewski, D.C., DACBN, DABCI for.* Because of the nature of phone visits and internet consultations there is the inability to perform physical examination during these visits thus you need to have a complete physical exam by a local primary care physician or other healthcare provider and you need to try to provide very complete information and an accurate description of any physical ailments. For skin rashes and other visible problems, digital photos sent by email are helpful and will aid in the assessment. You must also appreciate that a full evaluation may not be possible but that in most instances we can share sufficient information to proceed with safety and effectiveness.

Nutrition Informed Consent:
According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:
“Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.”
A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient’s diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support overall health and well-being. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking. Adverse reactions are rare, and may include, but are not limited to: bloating, nausea, vomiting, rash, fatigue, diarrhea, constipation, headaches and dizziness. If any of these or other symptoms appear, please discontinue immediately and talk to Dr. Kleber or Dr. Wisniewski, or in case of emergency, go to your local urgent care facility/Hospital. May times adjustments in

dosages and or timing is all that is needed to alleviate these symptoms. Keep in mind also; there is often an initial “Herxhiemer” reaction. This was first described by a German physician of the same name. He observed that as patients started to fulfill a need nutritionally, or emotionally, often a “detox” would start to happen as the body adjusts to metabolic pathways becoming functional again. This is usually temporary and may last a few days to several weeks.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.
Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.
Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

Distance Consultations
Due to the nature, distance consultations carry there own unique risks. It is required you consult with a local physician in conjunction with any care recommended which includes but is not limited to exercises, supplementation and dietary/lifestyle changes. A physical exam is strongly recommended to be performed prior to any consultation. Should any emergency arise, call 911 immediately.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read the above explanation of the chiropractic adjustment and related treatment. Dr. William Kleber,D.C., DABCI and/or Dr. Brett Wisniewski, D.C., DACBN has discussed this document with me as it pertains to my specific case and has answered all my questions to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (print) ____

Patient/Guardian Signature____

Date ____________________

Gateway Natural Medicine and Diagnostic Center Financial Agreement

Dr. William Kleber,D.C., DABCI and/or Dr. Brett Wisniewski, D.C., DACBN, DABCI value your time. Dr. William Kleber,D.C., DABCI and/or Dr. Brett Wisniewski, D.C., DACBN, DABCI strive to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that Dr. William Kleber,D.C., DABCI and/or Dr. Brett Wisniewski, D.C., DACBN, DABCI can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.
Please refer to the guidelines below to learn more about our Missed Appointment policy:

- It is your responsibility to provide us with a working telephone number to allow us to communicate important information, such as laboratory results, and provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important; please help us to maintain your records.

- **New patient appointments will be subject to 80% of the value of the visit. When a patient does not show up or does not cancel within 24 business hours the follow fees will be added to the patient's account:**
  80% of new patient appointment cost
  Credit card may be necessary to re-schedule your appointment or future appointments and charged at full cost if the appointment is cancelled/rescheduled.

-Established patients- allowed 1 missed appointment in 12-month period
We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible.
$25 fee for second offense
$50 fee for third offense
Credit card will be required to schedule all future appointments and charge full cost if appointments are cancelled / rescheduled.

- Accounts that accumulate three missed appointment fees may be dismissed from the practice.
- Any cancellation not made at least 24 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.

We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however there are times when Dr. William and Dr. Brett need to spend extra time with a patient that was not foreseen, as they may have done with you in the past or need to, with you, in the future.

Patient Name (print) ____

Patient/Guardian Signature____

Date ______________________

<u>Notice to Medicare/Medicaid Patients</u>

The following is the office policy for treatments performed at Gateway Natural Medicine and Diagnostic Center regarding Medicare Benefits. Please read carefully and sign only if you understand and agree to the terms.

<u>We will not bill Medicare insurance for you</u> if you have coverage with Medicare or with a secondary insurance policy; **payment for the visit is due at time of service**.

For patients of Drs. William Kleber and/or Brett Wisniewski:
<u>Medicare will not reimburse you if you submit a super bill for coverage since Drs. William Kleber and Brett Wisniewski are non-providers.</u> You CAN NOT submit codes and charges for coverage by Medicare/Medicaid if receiving services by Drs. William Kleber or Brett Wisniewski.

<u>Notice of Exclusion from Medicare/Medicaid Benefit (NEMB)</u>

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them directly.

Please see our fee schedule for a more complete list of services offered and associated prices.

Before you make a decision, you should read this entire notice carefully.

If you have any questions, please ask us so we can clarify. By signing below you are acknowledging that you have read, understand and agree to these terms.

Patient Name (print) ____

Patient/Guardian Signature____

Date ____________________