Welcome to
The Office of Dr. Michael Wald

Blood Logic, Inc., dba Blood Detective
Location: 29 King Street, Chappaqua, NY 10541, 2nd Floor
914-552-1442

DC/Doctor of Nutrition/CertifiedDietician-Nutritionist/Certified Nutritional Specialist/
Masters of Nutrition/Sports Nutritionist*

HERE IS YOUR NEW PATIENT PACKET – KINDLY COMPLETE IT

A message from Dr. Michael Wald

Thank you for reaching out to me to forward your health goals. My mission is to help you get better as quickly and as naturally as possible. If you are like many of my patients you are frustrated and have likely visited one or more health care providers and experienced limited results. My promise to you is that I will work hard on your behalf to put together a natural healing plan that makes sense. Together we will create a healing strategy that is do-able and focused exclusively upon your needs. Thank you for the opportunity of allowing me to help take care of a most precious gift ...your health!

What should you expect by working with Dr. Wald? Your expectations matter!

What are your expectations? This paperwork will give you a chance to tell me because we need to be on the same page! Then, I can create for you a "laser-focused" plan of action targeted to your health goals. If you are "sick of being sick", and willing to do the work necessary to build your health, then I am willing to put in the work to create a plan-of- action that is personalized for your needs.

What is a BloodDetective?

Ok, I know I have a funny nickname, but you have to admit that it's catchy right? lol. The term BloodDetective began when a grateful patient thanked me for helping her when some many other practitioners failed her. She said, "Dr. Wald, you are a 'BloodDetective'! Thank you!" The name stuck and has become my branding - meaning that I will relentlessly search for "natural answers" for my patients no matter how difficult healing journey has been. **ACCEPTABLE FORMS OF PAYMENT include, cash, Venmo, Zelle, personal or business check, bank check and money orders. Credit cards are NOT accepted.**

How to complete this paperwork

1. Complete this paperwork as thoroughly as you can, but leave questions blank if you are unsure of the answer(s).
2. If you cannot complete your paperwork for any reason prior to your first appointment please let me know and arrange to come to the office 30-minutes prior to your scheduled appointment to complete it. Also, if you must arrive late to your appointment your appointment time will be shortened accordingly and - you may be asked to wait until other on-time appointments are completed. The fee for shortened appointments resulting from lateness are the same as the regular fees for your visit types; new patient, second appointment and regular appointments.
3. Do NOT fast for your first appointment and CONTINUE to take all prescription medication. You CAN drink water prior to your appointment.

4. Cancellation Notice is Required – I run a fully-booked health care office. If an appointment slot is left open due to a cancellation of less then 48-hours notice you will be charged the full fee for your missed appointment. I do realize that their are valid reasons to cancel an appointment with less than 48-hours notice, but regardless of the reason(s) it does not change my empty appointment slot. By scheduling as a New Patient with with me you are agreeing to my policy and also agree not to contact your credit card company in an attempt to reverse Dr. Wald's/Blood Logic, Inc. credit card charges.

Dr Wald's promise to you...

My overall goal at your first visit is to assess your health needs by conducting a thorough health intake. Testing may be performed with your approval. You are free to accept or refuse any testing recommendations. If you have previously performed lab tests of any kind handy please bring them in to your first appointment.

Dr. Wald is qualified to help you

*If your health concerns have a nutritional basis or cause, or if they have resulted in nutritional issues, then I highly qualified to help you. I have many qualifications in the area of nutrition, and 30-years of experience, including a masters degree in human nutrition, I am a certified dietitian-nutritionist and certified nutritional specialist, I hold two board certifications in nutrition plus I hold other educational certificates/degrees/diplomas. I earned my medical diploma (MD) to be the best holistic practitioner that I could be, and decided not to complete a residency and am thus not a licensed MD. Please consult my website and/or this paperwork for further details regarding my educational credentials. My credentials may change at anytime without prior notice or having your consent. My credentials however do not guarantee that I will provide you with a medical and/or health diagnosis.

Your First Visit

Your **INITIAL CONSULTATION** is a full hour and costs *$430.00*; or if you have a **cancer diagnosis**, the initial visit costs *$690.00* and is 75-minutes in duration. During this visit we will clarify your responses to my paperwork so that we can come up with a plan-of-action to tackle your health issue(s). We may perform testing and will review any testing that you may have brought with you. I generally provide some health advice during the first visit, but I may not and most of my detailed and personalized health care advice is presented to you at your second follow-up visit and during continued regularly scheduled consultations.

The cost of your **FOLLOW UP VISIT** is *$375.00* (1-hr). If you are in need of further/"REGULAR" consultations the cost of each is *$175.00* and they are 30-min in duration.

Payment Options Include - ***Checks and cash are preferred. You can pay with Zelle, Venmo, Credit cards are NOT accepted.***

What about insurance coverage?

I MAY GIVE YOU CLAIM FORMS: I will provide you with a completed insurance claim form with diagnoses for you to submit directly to your insurance company for potential reimbursement in some cases.

NATIONAL LABS MAY BE FULLY COVERED: If we submit blood work to a national blood lab these tests are typically covered, but may not cover services. Some insurance companies consider some level of reimbursement if they consider the services rendered as "medically necessary"; this is based upon their own criteria.

OUT-OF-NETWORK INSURANCE MIGHT COVER: If your insurance covers out-of-network practitioners then your may receive up to 85% coverage reimbursed to you, but I cannot guarantee any insurance coverage.

If I believe that tests are better off being performed by your primary or other doctor(s) then I will provide you with a list of recommended tests to present to your doctor on my letterhead. For chiropractic services I accept Medicare, but I do not participate (I am a non-participating provider) for all matters nutritional that do not relate to neuro-musculo-skeletal problems (like chiropractic) under my dietician-nutritionist license. PLEASE SIGN THIS FORM DIRECTLY BELOW.

_____

Patient's Acknowledgment /**Signature** for all materials included in Dr. Wald's New Patient Packet. If your signature and/or date is absent in any area within this document then this signature directly above shall apply to all pages of this New Patient Document

_____

Today's Date:

_____

PRINT First and Last Name

DEMOGRAPHICS

Name: _____ Age: _____ Birth Date: __/___/___ Sex: F ☐ M ☐ Other ☐

Address: _____ City/State/Zip: _____

Phone (H): _____ Work: _____ Cell: _____

Occupation: _____

Email (write neatly): _____ Fax: _____

Social Security #: _____

How did you hear about Dr. Wald? _____

Family Status: Single Divorced Married Widow(er) Significant Other (check one)

Emergency Contact Name: _____ Phone: _____

PRIMARY CARE PROVIDER

Doctors Name: _____ Phone: _____

Address: _____

HEALTH HISTORY

Please list your major problems and/or symptoms and the approximatel date that they began. If none, please write your reason(s) for seeking this consultation. PLEASE RANK IN ORDER OF IMPORTANCE TO YOU.

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

HEALTH CONCERNS

Please check off each of the concerns below that you have currently or previously suffered within the *last 6 months*:

- ___Alcoholism
- ___Allergies
- ___Anemia
- ___Arthritis (type)
- ___Asthma
- ___Bleeding/Bruising
- ___Cancer
- ___Crohn's Disease/Colitis
- ___Depression
- ___Ulcers
- ___Diabetes (type)
- ___Digestive Disease
- ___Drug Problems
- ___Eating Disorder
- ___Heart Disease
- ___Herpes
- ___HIV
- ___Hypoglycemia
- ___Hepatitis
- ___High Cholesterol
- ___High Blood Pressure
- ___Irritable Bowel Syndrome
- ___Kidney disease
- ___Lupus
- ___Lyme Disease
- ___Mental Illness
- ___Migraine/Headache
- ___Multiple Sclerosis
- ___Pneumonia
- ___Polio
- ___Rheumatic Fever
- ___Stroke/TIA
- ___Seizures
- ___Tuberculosis
- ___Thyrid Disease (___Hypo)/(___Hyper)
- ___Veneral Disease

Other:

_____

_____

_____

Hospitalizations and Surgeries (include dates):

_____

_____

What else would you like Dr. Wald to know about your health concerns, goals and expectations?

_____
_____
_____
_____
_____
_____

LIST YOUR <u>MEDICATIONS</u> INCLUDING DOSAGES AND APPROXIMATELY WHEN YOU STARTED TAKING THEM:

1. _____daily dose: _____ 2. _____daily dose: _____

3. _____daily dose: _____ 4. _____daily dose: _____

5. _____daily dose: _____ 6. _____daily dose: _____

ADDITIONAL: _____

LIST YOUR <u>NUTRITIONAL SUPPLEMENTS</u> INCLUDING DOSAGES AND APPROXIMATELY WHEN YOU STARTED TAKING THEM:

1. _____daily dose: _____ 2. _____daily dose: _____

3. _____daily dose: _____ 4. _____daily dose: _____

5. _____daily dose: _____ 6. _____daily dose: _____

ADDITIONAL: _____

<u>LIFESTYLE</u>

SLEEP

Do you have any sleep difficulties? ___Falling asleep ___Staying asleep

___Waking up feeling rested? ____# of hrs of sleep per night on average

EXERCISE

Do you currently participate in a resistance training program? If yes describe:

_____

How long have you been folloiwng a regular resistance training program? ___1x/wk ___2x/wk___3x/wk___more

What is the difficulty of your participation, on average, on a 1-5 scale 5=hardest workout you have every had? ___1 ___2___3___4___5

DIET

Do you follow any particular way of eating/diet? If yes, describe:

How long have you been eating the way you are currently and do you fell that it is helping your health concerns?

Do you typically eat breakfast? Yes No **What is your current weight? _____**

Do you typically eat lunch? Yes No **What is your height?_____**

Do you typically eat dinner: ☐ Yes ☐ No

H0LISTIC HEALTH CARE MAY NOT BE ACCEPTED BY MAINSTREAM MEDICINE

General Informed Consent/Custom Supplement Acknowledgment Form & Agreement & Permission Slip.

You are acknowledging by beginning care with Dr. Wald that nutritional and/or holistic care may at times be recognized as the standard of care. However, certified dietician-nutritionists and certified nutritional specialists are recognized professions by the New York State Office of the Professions. You have sought the health care services of Dr. Michael Wald and/or Blood Logic, Inc. for your personal healthcare or for your child or children who are minors. You acknowledge and understand that Dr. Wald may recommend to you certain diagnostic and treatment methods that are known as complementary, alternative, or holistic, and they may not be covered by your insurance plan, or generally accepted by mainstream healthcare as the standard-of-care for your health condition(s). The terms complementary, alternative, and holistic refer to therapies that may include, but are not limited to, dietary and nutritional supplement advice, and various diagnostic/testing procedures and chiropractic care. Furthermore, the information gained from laboratory and other tests may be interpreted differently from mainstream medical doctors . Approaches for improving your general health and nutrition from Dr. Wald may be based upon the tests/evaluations and philosophies of complementary healthcare and may or may not be consistent with mainstream medical tests/evaluations and philosophies. Foods, vitamins, minerals, enzymes, herbs, and other nutritional approaches may be recommended by Dr. Wald as a stand-alone therapy or as adjunctive (to be used in addition) to medical therapies. Not all vitamin-drug (medication) reactions, both positive and negative, can be predicted, or may not be agreed upon, or may not be known or may result during the course of Dr. Wald's treatment recommendations. You hereby acknowledge that you are assuming the full risk of any negative and/or adverse and/or harmful drug-nutrition interactions that may occur during your course of treatment.

Our office and its employees make no representations, claims, or guarantees regarding the efficacy of our treatment recommendations. The treatments we recommend are based upon a combination of our clinical experience and knowledge of scientific and medical literature. With this information, individualized treatments may be offered and applied as either adjunctive (complementary) or primary treatments for various symptoms and disease states.

By signing this informed consent you agree to hold harmless Dr. Michael Wald and/or Blood Logic, Inc., dba Blood Detective and its employees from all professional and personal liability. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. If a legal case is brought against Dr. Wald and/or Blood Logic, Inc., or anyone affiliated with Dr. Wald, you agree that Dr. Wald shall be judged by the standards and principles of complementary, alternative, and/or holistic medicine and not the standards and principles of consensus conventional medicine alone and that you will assume 100% the cost of all legal fee's that are accrued by Dr. Wald, Blood Logic, Inc. or from any of Dr. Wald's affiliations. You have the right to have this consent reviewed by your lawyer before accepting any medical and/or nutritional (continued next page) services from this office. If you are investigating our office you are hereby requested to reveal your intentions prior to your first visit or meeting with Dr. Wald either in person or by phone, email or any other form of communication. If any portion/part of this agreement is deemed unenforceable all other portions/aspects of this agreement shall remain in force.

_____ Your Signature & Date Here _____

YOU DO NOT HAVE TO USE DR. WALD'S NUTRITIONAL SUPPLEMENTS

Our office makes available nutritional supplements and other health products. You are in no way obligated to purchase these products from our office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish. Dr. Wald profits from the sale of supplements and other products that he makes available to his patients. Many of our services (nutritional consultations) are often not considered to be necessary by insurance companies based upon their own internal criteria and thus may not be covered.

SIGNATURE ON FILE & RELEASE OF YOUR HEALTH CARE INFORMATION.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. Your signature verifies that you have not been told to discontinue treatments with any other medical specialists or other health care providers. Your signature is being given prior to your accepting any services, advice, and/or recommendations whatsoever from Dr. Michael Wald, and your payment for services will serve as your unconditional acknowledgment of satisfaction regarding all the services provided.

YOUR PROMISE TO FOLLOW UP WITH DR. WALD ABOUT ALL APPOINTMENTS/COMMUNICATIONS

This acknowledgment will serve as proof of Dr. Wald's financial policy, and your acknowledgment, of no-refunds of monies paid to this office in the form of cash, credit card, and personal check or by any other means will be granted. It is the responsibility of the patient to follow-up with our office for results of all testing and laboratory procedures. It should not be assumed on the part of the patient that if they are not contacted by Dr. Wald, or its employees, or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/ medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

Please schedule your follow-up appointment with Dr. Wald after each and every consultation or visit to the office. You are acknowledging that your insurance company may not cover some or all tests, consults or other services offered by Dr. Wald. The patient assumes full responsibility for the costs of non-covered tests and consultations. If allowed by law, our office will not provide insurance collection services, but will commonly make reasonable attempts to provide letters of medical necessity and answer correspondences from your insurance company regarding your treatments. By entering your signature below, or beginning health care services with Dr. Wald, you are acknowledging that you understand all terms, verbiage (language) and concepts herein and that you can read the font sized used throughout the entirety of this document (New Patient Paperwork). I understand this consent agreement and have executed it freely and willingly. If any portion of this new patient paperwork is considered unreasonable or non-enforceable in a court of law, all other aspects of this agreement shall remain in force. You are further acknowledging and authorizing Dr. Wald and/or his employees, to use your credit card on file as payment for any services and/or products that are purchased from Dr. Wald, including but not limited to, missed and completed consultations. You are providing permission to Dr. Wald for him to use your credit card on file, and apply your signature or first and last name in print to charge for such services.

_____ _____

Signature Here Today's Date

NUTRITIONAL AND HOLISTIC THERAPIES & NUTRITIONAL SUPPLEMENTS MAY NOT BE CONSIDERED MAINSTREAM TREATMENTS BY THE STANDARDS OF CARE IN MEDICINE

"Investigational" or "Experimental": Investigational or experimental refers to procedures or supplies that is/are not recognized by your insurance company and/or the FDA (Food and Drug Administration) and/or the AMA (American Medical Association) or other certifying boards and/or governing bodies or organizations (all of the aforementioned considered as "PLAN"), as standard medical care for the condition, disease, illness or injury being treated. A service, procedure or supply includes, but is not limited to the diagnostic service, treatment, facility, equipment, drug or device. A service is considered investigational (experimental) if any of the following criteria are met (although other criteria for the consideration of whether or not a services is considered experimental may exist):

If any portion of this notice is deemed unenforceable the remainder will remain fully enforceable and in effect. Nutritional supplements may cause side effects including, but not limited to, nausea, heartburn, diarrhea, dizziness, gas, bloating, death, bleeding, brusing, chocking among others. Please report to Dr. Wald any symptoms that you experience. DO continue to take all prescribed medications/supplements. Take the supplements above exactly as directed. Replace each of your supplements until advised otherwise. Nutrient-drug interactions data/information/knowledge is/are always evolving and you may experience adverse symptoms because of how certain nutritional supplements affect the use of your medication(s) that you may be taking. You are hereby releasing Dr. Wald of any and all responsibility for adverse drug-nutrient interactions that you may experience.

DR. WALD SELLS NUTRITIONAL SUPPLEMENTS, BUT YOU DO NOT HAVE TO USE THEM

Dr. Wald's supplement prices may change at anytime with out notice and may differer from his website and his supplement lists (PDF writable, word documents or in other forms). The higher cost found for Dr. Wald's supplements on any of his office and/or online materials will be the true cost that you would expect to pay. Your acknowledgment and agreement in the form of your signature is not required for your total and complete acknowledgment of all stipulations herein, but if your signature is provided a scanned, photocopy and or other image of your original signature will be considered as equivalent and valid as your original signature; Dr. Wald may not keep your original signature on these documents and may only keep a scanned copy or another electronic form of your signature and of these forms. We may choose not keep original signature documents.

_____ _____

Your Signature Here Today's Date

WAIVER AND RELEASE OF LIABILITY / DR. MICHAEL WALD, BLOOD LOGIC, INC. / 29 KING STREET, 2ND FLOOR, CHAPPAQUA, NY 10514

In consideration of the risk of injury while participating in Dr. Michael Wald's services, including, but not limited to, chiropractic, nutritional services, normal air hyperbaric therapy, sauna, weight training and exercise, the acceptance of and/or oral intake/ consumption of various vitamins, minerals, amino acids, herbal supplements, glandular tissues and other and all forms of nutritional supplements/nutraceuticals and/or (the "Activity"), as consideration for the right to participate in the “Activity”, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the “Activity”, and do hereby release and forever discharge Dr. Michael Wald, located at 29 King Street, 2nd floor, New York 10514, heir affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED “ACTIVITY” AND AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS “ACTIVITY”, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, INCLUDING BUT NOT LIMITED TO BROKE N BONES, BROKEN SKIN, BLEEDING, DIZZINESS, VERTIGO, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITION OF THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY

I agree to indemnify and hold harmless Dr. Michael Wald and/or ("The Colleagues") against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Dr. Michael Wald incurs any of these types of expenses, I agree to reimburse Dr. Michael Wald .I acknowledge that Dr. Michael Wald and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Dr. Michael Wald , "Wife" and/or "The Colleagues”. I ACKNOWLEDGE THAT THIS ACTIVITY MAY INVOLVE A TEST OF A PERSON’S PHYSICAL AND MENTAL LIMITS AND MAY CARRY WITH IT THE POTENTIAL FOR DEATH, SERIOUS INJURY, AND PROPERTY LOSS. The risks may include, but are not limited to, those caused by terrain,

ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND **DISCHARGE Dr. Michael Wald AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST Dr. Michael Wald FOR PERSONAL INJURY OR PROPERTY DAMAGE.**

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Dr. Michael Wald," and/or "The Colleagues", its agents, and employees.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

This agreement was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both the Participant, and Dr. Michael Wald "the Collegues" agree that this Agreement is clear and unambiguous as to its terms, and that no other evidence will be used or admitted to alter or explain the terms of this Agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

In the event of an emergency, please contact the following person(s) in the order presented: I, the undersigned participant, affirm that I am of the age of 18 years or older, and that I am freely signing this agreement. I certify that I have read this agreement, that I fully understand its content and that this release cannot be modified orally. I am aware that this is a release of liability and a contract and that I am signing it of my own free will. I further acknowledge that an electronic and/or scanned copy of your signature and information provided will serve as valid as an original signature and information.

Participant's Name:

Participant's Address:

Participants Signature: Date:

PARENT/GUARDIAN WAIVER FOR MINORS – this MAY NOT APPLY to you.

In the event that the participant is under the age of consent (18 years of age), then this release must be signed by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual

Parent/Guardian Name: _____

Relationship to Minor: _____

Signature: Date:

PRINT YOUR FIRST AND LAST NAME HERE

DATE

YOUR SIGNATURE HERE