Greetings! Please let me know ASAP whether you were able to download the attachments contained within this document. Please reply to DrMGennaro@yahoo.com

I am looking forward to seeing you and your child at our first appointment. I have a small DVD player and some DVDs in my office. Feel free to bring your child's favorite DVD to the appointment.

Please fill out the attached history form and the informed consent form and bring them with you. MAKE SURE YOU BRING ANY DRUGS OR SUPPLEMENTS YOU ARE TAKING OR THINKING OF TAKING. If you have any lab tests and vaccination records and can get access to them, please bring them as well.

I often use products that are sold only through health professionals. You may pay for the office visit and supplements (if needed) by cash, check (made payable to Margaret Gennaro, M.D.) or credit card (MasterCard, Visa and Discover).

PLEASE DO NOT WEAR FRAGRANCES OR ANY PERSONAL ITEMS THAT ARE PERFUMED. We have staff and patients at the office who are chemically sensitive. Thank you.

My practice is in Mosby Tower, 10560 Main Street, Suite 301 (3rd Floor), Fairfax, VA 22030. Leave extra time at peak hours of travel. Directions by car are attached. If you need directions if you are lost or late, please call 703-865-5692.

CANCELLATION POLICY:
If you need to cancel, please give me 48 hours notice.
If I can not find a replacement for you, my policy is to charge a fee for the missed appointment.

Date_____ **MARGARET M. GENNARO, M.D.** **Children's Intake Form**

Patient's Name _____ **Email** _____
Last First Middle

Address _____
Street City State Zip

Home Phone ( ) _____ **Date of Birth** _____ **Social Security #** _____

If patient is a minor, provide parent's or guardian's name _____

Mother's Work Phone ( ) _____ **Mother's Cell Phone ( )** _____

Father's Work Phone ( ) _____ **Father's Cell Phone ( )** _____

Name of nearest relative not living with you _____

Address_____ **Phone ( )**_____
Street City State Zip

How did you hear about our office? _____

Responsible Party Information – Patient is responsible for bill, your insurance may reimburse you.

Patient's Name _____
(Or parent, if minor) Last First Middle

Address _____
Street City State Zip

Home Phone _____ **Work Phone** _____ **Email** _____

Date of Birth _____ **Social Security #** _____ **Relationship to Patient** _____

Employer Name / Address _____

Spouse's Name _____
Last First Middle

Employer Name / Address _____

Date of Birth_____ **Social Security #** _____ **Work Phone** _____

CONSENT

I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1- ½ % finance charge (18% APR) may be added to my account.

Patient Signature _____ **Date** _____

Parent or Responsible Party Signature _____ **Relationship** _____

INTAKE FORM FOR CHILDREN

Name of Child _____

Briefly state your main concerns about your child and approximately how long you noticed problems:

_____

_____

_____

Family History:

Biological mother's name_____ Age _____ Health problems_____
Biological father's name_____ Age _____ Health problems_____
Mother's name (if different)_____ Age _____ Health problems_____
Father's name (if different)_____ Age _____ Health problems_____

Please check off if there is any history in the extended family of these diseases and who suffers from it:

[ ] Developmental disabilities_____
[ ] Mental illness_____
[ ] Genetic diseases (i.e. Tay-Sachs, cystic fibrosis)_____
[ ] Diabetes or other metabolic disorders (i.e. thyroid)_____
[ ] Abnormalities of the heart_____
[ ] Abnormalities of the lungs_____
[ ] Drug abuse_____
[ ] Alcohol abuse_____
[ ] High blood pressure_____
[ ] Kidney disease_____
[ ] Deafness_____
[ ] Cancer_____
[ ] Arthritis_____
[ ] Asthma_____
[ ] Allergies_____
[ ] Intestinal problems (i.e. ulcerative colitis, Crohn's) _____

Siblings:

Full- Name_____ Age_____ Health problems_____
Name_____ Age_____ Health problems_____
Name_____ Age_____ Health problems_____
Name_____ Age_____ Health problems_____
Half- Name_____ Age_____ Health problems_____
Name_____ Age_____ Health problems_____

Who does the child reside with? _____

Type and quantity of pets _____

Has there been marriage between close relatives?

[ ] No [ ] Yes, _____

Are there any physical abnormalities in close relatives that your child resembles?

[ ] No [ ] Yes, _____

Pregnancy History:

Length of pregnancy _____weeks

Was pregnancy supervised by a doctor? [ ] No [ ] Yes, _____

Any drugs (Rx, OTC, or other) during pregnancy? [ ] No [ ] Yes, which:_____

Any tobacco use during pregnancy? [ ] No [ ] Yes, how much per day? _____

Any alcohol during pregnancy? [ ] No [ ] Yes, How much? _____

Were there any complications during pregnancy? [ ] No [ ] Yes, Be specific: _____

Were there any drugs used during labor? [ ] No [ ] Yes, what kind, if known_____

Labor was: [ ] Induced [ ] Spontaneous

What kind of anesthesia did mother require? [ ] Epidural [ ] General

How long was labor? _____

Were there any complications during labor or delivery? [ ] No [ ] Yes, be specific _____

_____

What kind of delivery? [ ] Vaginal [ ] Headfirst [ ] Breech

[ ] C-section , for what reason? _____

What were baby's Apgar scores, if known? _____ Birth Weight _____

Was there anything unusual about how your child looked after delivery? [ ] No [ ] Yes, be specific _____

Did your child cry spontaneously, move arms and legs immediately after birth? [ ] No [ ] Yes

If no, what resuscitation was given? _____

Developmental History:

Was child breast fed? [ ] No [ ] Yes, for how long? _____

Was child bottle fed? [ ] No [ ] Yes, what formula(s)? _____

Did your child have trouble sucking? [ ] No [ ] Yes

Did your child have colic or problems with any formula? [ ] No [ ] Yes, please be specific _____

Age when child sat? _____

Age when child stood holding on? _____

Age when child walked? _____

Did child crawl normally? [ ] No [ ] Yes

If no, how ? _____

Age when child spoke two-word sentences? _____

At what age could you tell if child was left or right handed?

[ ] Less than 1 year
[ ] 1 – 2 years old
[ ] over 3 years old

Vaccinations received and how many (if known) <u>If can, please bring in shot records</u>.

[ ] DPT _____ [ ] DT _____ [ ] DtaP (Acellular DPT) _____

[ ] MMR _____ [ ] Hepatitis B _____ [ ] HIB (Haemophilus Influenza type B) _____

[ ] Rotavirus _____ [ ] Chicken Pox _____ [ ] IPV (Inactivated polio) _____

[ ] OPV (Oral polio) _____ [ ] Other _____

Has your child had <u>any unusual</u> reactions to any vaccine? Be specific _____

_____

Do you have any developmental concerns about your child? _____

_____

Medical History

Any hospitilizations? [ ] No [ ] Yes, for what conditions and dates? _____
_____

Any surgeries? [ ] No [ ] Yes, for what conditions and dates? _____
_____

If your child has had anesthesia, have there been any complications?
[ ] No [ ] Yes, be specific _____

Does your child have any allergies?
[ ] No [ ] Yes, be specific _____

Has your child ever had a concussion or head injury?
[ ] No [ ] Yes, explain _____

Has your child ever been involved in a significant accident?
[ ] No [ ] Yes, explain _____

Has a physician ever noted that your child exhibits any structural or biochemical abnormalities? What? _____
_____

Has your physician ordered any medical evaluations or tests?
[ ] No [ ] Yes, what were results? (Please bring them in) _____
_____

Has your child had any of the following symptoms? Please check off category and circle the specific problem.

[ ] Difficulty gaining/losing weight or obsession with weight
[ ] Frequent headaches, stomachaches or other pains
[ ] Frequent diarrhea, constipation, nausea, gas, vomiting, heartburn or bloating
[ ] Chest pains, palpitations, irregular heart beat, heart murmur
[ ] Heat or cold intolerance
[ ] Excessive sweating
[ ] Frequent episodes of breathlessness
[ ] Fainting spells
[ ] Significant snoring
[ ] Frequent colds, ear or sinus infections, bouts of the flu
[ ] Asthma (bronchospasm, reactive airway disease), bronchitis
[ ] Hives, rashes
[ ] Dark circles under eyes / lines under eyes / frequent sneezing / frequent rubbing of nose
[ ] Trouble sleeping
[ ] Excessive ear wax
[ ] Impulsivity
[ ] Hyperactivity
[ ] Compulsive eating
[ ] Frequent urinary tract infections
[ ] Frequent yeast infections (vaginal, diaper or thrush = mouth)
[ ] Itching (skin, genitalia, anus)
[ ] Excessive thirst
[ ] Frequent episodes of dizziness
[ ] Frequent urination
[ ] Prolonged fatigue
[ ] Trouble waking up in the morning
[ ] Eczema or psoriasis
[ ] Coughing or shortness of breath during exercise
[ ] Tics such as grimacing or twitching
[ ] Bedwetting (after being toilet trained) day or night / soiling self
[ ] Excessive acne
[ ] Mood swings
[ ] Distractibility
[ ] For girls: abnormal vaginal discharge

Have you noticed any of the following? (please check category and circle specific problem)

[ ] Abnormal gait when walking, running, hopping, skipping or climbing stairs
[ ] Child sweats excessively after meals
[ ] Child reacts to any foods (sugar, chocolate, colorings, milk, eggs, wheat, corn, others)
[ ] Abnormal posture
[ ] Child tires more easily than other children
[ ] Child gets very irritable/aggressive/shaky if meals are delayed
[ ] Child feels better after meals
[ ] Uncoordinated at sports or particularly clumsy

[ ] Poor fine-motor control (difficulty coloring, writing, Picking up small objects

[ ] Child craves certain foods, which? _____ _____

[ ] Child's dominant hand is different from parents

[ ] Child eats non-food items (paste, dirt, crayons, laundry detergent, other)

[ ] Child writes with right hand and kicks with left foot or vice versa

Has child gotten any tattoos? [ ] No [ ] Yes, when and by whom? _____

Have you noted your child exhibits any of the following (please check off category and circle specific problem)

[ ] Head (abnormal shape, other)

[ ] Ears (hypersensitivity to noise, hearing loss, pulling on ears red ears, oddly shaped or placed, other)

[ ] Facial features (abnormal)

[ ] Hair (unusual coarse/dry or fine, hair whorl on same side as dominant hand, whorl in the middle of head, two hairs whorls, hair loss)

[ ] Fingers or toes (webbing between toes, unusually long or short fingers or toes, other)

[ ] Eyes (visual problems, squinting, itchy, other)

[ ] Nose (cold sores or fever blisters, teeth grinding, frequent throat clearing, abnormal tongue, other)

[ ] Skin (dark or light patches, other unusual markings)

[ ] Fingernails or toenails (brittle, white spots, ridged, discolored, misshapen, other)

[ ] Joints (double-jointed, pain in joints, other)

[ ] Genitalia (abnormally large or small, malformed)

[ ] Handedness (no hand preference, has switched hand preference or does not use one hand at all, other)

Activities (please check off category):

[ ] You or your spouse work jobs that expose you to lead or other pollutants (car repair, battery repair, smelting, stained glass work, home restorations, painting, pest control, farming or industrial jobs involving lead-cadmium)

[ ] You/spouse/child do extensive gardening or yard work

[ ] Your house is heated with gas/ you smell gas in your house/ your furnace has not been checked in over 2 years

[ ] You do not have a carbon monoxide detector and smoke detector

[ ] Your house has not been checked for radon gas (an odorless, tasteless, invisible gas)

[ ] Family hobbies include shooting, model building, car restoration, furniture refinishing or other activities involving solvents, glues, paints or other chemicals

[ ] Live in an older home (over 20 years), have peeling, chipped paint or have done any large scale renovations including sanding old paint on walls or sanding floors

[ ] Your house contains lead-based paints

[ ] You have traveled or lived in any foreign country? Which? _____ and if so, how hygienic were your living conditions? _____

[ ] If you traveled outside the U.S., did your child or any family member become ill? (i.e. diarrhea)

[ ] Your child takes any Rx or OTC drugs regularly now or recently. Please list:

_____ _____

_____ _____

[ ] Your child takes any ethnic or herbal remedies or any supplements, including vitamins. List

_____ _____

_____ _____

[ ] Your child swims or plays in a pond now or in the past. When? _____

Cognitive/Social History

[ ] You have concerns about your child's speech (too fast, too slow, difficult to understand, not appropriate for age, stuttering, lisp, other)

[ ] Your child speaks another language. If so, what age did your child begin speaking English? _____

[ ] More than one language is spoken at home. If so, what language? _____

[ ] Your child has academic problems or specific problems with reading, spelling, mathematics, or handwriting
[ ] Your child reverses letters such as "b" and "d"
[ ] Your child reverses words when reading aloud and pronounces 'dog' as 'God' or 'saw' as 'was'
[ ] Your child's handwriting is poor or as deteriorated recently
[ ] Your child academic abilities or physical skills have deteriorated from earlier levels
[ ] Your child has difficulty making or keeping friends

[ ] Your child has fantasies and daydreams- and if so, does he/she know the difference between fantasy and reality_____
[ ] Your child has obsessive or compulsive behavior, List _____
[ ] Your child is usually anxious, tired, sad, or angry _____
[ ] Your child hurts other children or animals regularly
[ ] Your child is physically aggressive to a degree that causes problems at school or at home
[ ] Your child is verbally aggressive to a degree that causes problems at school or at home
[ ] Your child is emotionally mature or immature for age
[ ] Your child has trouble relating to other people. If so, why? _____
[ ] Your child has trouble playing with children his/her own age. If so, why? _____
[ ] Your child is the target for bullies or bullies other children
[ ] Your child's teacher has mentioned any concerns about your child's academic or social development. If so, what?
_____
[ ] Your child shows signs of illicit drug or alcohol use ("stoned" behavior, hang-over-like appearance, watery nose, dilated pupils, constricted pupils)
[ ] Your child is sexually active
[ ] You have any suspicion of sexual abuse or your child has ever been abused. Please be specific _____
_____
[ ] You have any suspicion of physical abuse or your child has ever been abused. Please be specific _____
_____

The 24-hour Day

Bedtime:

What time does your child go to bed? _____

Is your child ready for bed?	[ ] No	[ ] Yes
	If no, what happens?	_____
Does your child have bedtime rituals (circling bed, lining up slippers, etc)?		
	[ ] No	[ ] Yes, _____
Where does your child sleep?	[ ] Alone	[ ] With parent(s) [ ] With sibling(s)
Is there a gas heater in your child's room?	[ ] No	[ ] Yes, Circle: old heater, poor ventilation in room
Does your child sleepwalk?	[ ] No	[ ] Yes, how often? _____
Describe how your child sleeps?	[ ] Soundly	[ ] Restlessly
Does your child wake up frequently in the middle of the night to urinate?		
	[ ] No	[ ] Yes, how long has this been happening and how frequently? _____
If over six, does your child still wet the bed?	[ ] No	[ ] Yes, how often? _____
If child wets the bed, was there a time when he/she was completely dry?	[ ] No	[ ] Yes, when did bedwetting restart? _____
Does your child frequently get up at night to drink?	[ ] No	[ ] Yes
Does your child frequently get up at night to eat?	[ ] No	[ ] Yes

Does your child have frequent nightmares or "night terrors"?

[ ] No [ ] Yes, how often?_____

Is your child difficult to waken when he/she is sleeping?

[ ] No [ ] Yes

Morning:

What time does your child awaken? _____

Does your child eat breakfast? [ ] No [ ] Yes

After breakfast, does your child feel? [ ] Good [ ] Behavior regression, irritable

[ ] Tired or sweaty [ ] Don't know

Does your child nap in the morning? [ ] No [ ] Yes, for how long?_____

Describe what your child's behavior, mood and energy level is like in the morning? _____

_____

Does your child eat a morning snack? [ ] No [ ] Yes, what? _____

Does it appear to affect your child's mood or energy level?

[ ] No [ ] Yes

If your child goes to school, [ ] Walk [ ] Car [ ] Bus

how does he/she get there? [ ] Bike [ ] Other

Do you notice your child has tantrums

in the morning? [ ] No [ ] Yes, what time? _____

Ask your child's teacher to assess your child's morning behavior/mood/energy level, particularly compared to that of other children. _____

_____

Afternoon: (prior to 3 p.m.)

Does your child eat lunch? [ ] No [ ] Yes

What time does your child eat lunch? _____

What does he/she eat and drink? _____

Does your child feel weak or irritable or shaky before lunch? [ ] No [ ] Yes [ ] Don't know

How does your child feel after lunch? [ ] Good [ ] Tired or sweaty

[ ] Don't know [ ] Other _____

Does your child nap during the afternoon? [ ] No [ ] Yes, for how long?

Describe what your child's mood, behavior and energy level is like in the afternoon, _____

_____

Does your child eat an afternoon snack? [ ] No [ ] Yes, what? _____

Does the snack appear to affect your child's mood or energy level?

[ ] No [ ] Yes, in what way? _____

Does your child have tantrums in the afternoon? [ ] No [ ] Yes, what time?_____

Ask your child's teacher to assess your child's afternoon behavior, mood and energy level particularly as compared with that of other children _____

_____

Late afternoon: (After 3 p.m.)

How does your child get home from school? [ ] Walk [ ] Car

[ ] Bus [ ] Bike

Describe what your child's mood, behavior and energy level is like when he/she gets home? _____

_____

Does your child snack upon getting home? [ ] No [ ] Yes, what? _____

_____

What does your child drink in the afternoon? Please check of category, circle specific and give approximate quantities.

[ ] Caffeinated soda (i.e. Coke, Pepsi, Mountain Dew, others) _____

[ ] Decaffeinated soda (7-up, Sprite, others) _____

[ ] Iced tea (sweetened or unsweetened) _____

[ ] Diet soda (diet Coke, diet Sprite, Crystal Light, others) _____

[ ] Juice (orange, apple, Capri-Sun, Kool-Aid, others) _____

[ ] Milk (whole, 2%, 1% or skim, soy, rice, almond, others) _____

[ ] Water _____

How many hours of TV does your child watch before dinner? _____

What other activities does your child participate in before dinner?

[ ] Homework [ ] Sports [ ] Computer or video games

[ ] Hobbies [ ] Other _____

Does your child do homework in the late afternoon? [ ] No [ ] Yes

If yes, how long does homework before dinner take?

[ ] Less than 30 minutes [ ] 30 – 60 minutes [ ] 1 – 2 hours [ ] over 2 hours

Do you need to help your child with homework?

[ ] Rarely [ ] Sometimes [ ] Many times [ ] All the time

What is your child's behavior immediately before dinner? _____

Does your child have tantrums in the late afternoon? [ ] No [ ] Yes, when? _____

Evening:

What does your child eat/drink for dinner? _____

_____

How good is his/her appetite? _____

How does your child feel after dinner? [ ] Good [ ] Fatigued or sweaty [ ] Don't know [ ] Other

What are your child's behavior, mood and energy level after dinner? _____

_____

Does your child have tantrums in the evening? [ ] No [ ] Yes, when? _____

How many hours of TV does your child watch in the evening? _____

What activities does your child participate in during the evening?

[ ] Homework [ ] Sports [ ] Computer or video games

[ ] Hobbies [ ] Other _____

Does your child do homework in the evening? [ ] No [ ] Yes

How long does homework take to complete?

[ ] Less than 30 minutes [ ] 30 – 60 minutes [ ] 1 – 2 hours [ ] over 2 hours

Does your child have a snack before bedtime? [ ] No [ ] Yes, what? _____

What does your child drink in the evening? Please check category, circle specific and give approximate quantities.

[ ] Caffeinated soda (i.e. Coke, Pepsi, Mountain Dew, others) _____

[ ] Decaffeinated soda (7-up, Sprite, others) _____

[ ] Iced tea (sweetened or unsweetened) _____

[ ] Diet soda (diet Coke, diet Sprite, Crystal Light, others) _____

[ ] Juice (orange, apple, Capri-Sun, Kool-Aid, others) _____

[ ] Milk (whole, 2%, 1% or skim, soy, rice almond, others) _____

[ ] Water _____

Parents feel (circle all that apply): frustrated, guilty, helpless, depressed, angry, tired, hopeless, at the end of my rope, other _____

_____

Person filling out this form _____

Please feel free to make any additional comments that might be helpful to me.

Childhood Symptom Questionnaire

Rate each of the following symptoms based upon the child's current health profile.

0 = never or almost never has the symptom 1 = Occasionally has symptom 2 = Frequently has symptom

Digestive Tract/Urinary:

____ Nausea ____ Passing Gas ____Vomiting ____ Diarrhea
____ Constipation ____ Poor appetite ____ Bloated ____ Refusal to eat
____ Belching ____ Fatigue, lethargy ____ Frequent urination ____Bed wetting
____ Itching of anus or genitals

TOTAL: _____

Ears:

____ Reddening of ears ____ Itchy ears ____ Earaches/Ear infections
____ Drainage from ears ____ Hearing loss ____ Drainage from ears

TOTAL: _____

Skin:

____ Easy bruising ____ Hives ____ Rash ____ Dry of flaky skin ____ Eczema

TOTAL: _____

Mind/Emotions:

____ Inattentiveness or poor concentration ____ Mood swings ____ Anxiety, nervousness, fear
____ Anger, irritability ____ Aggressiveness (hitting, kicking, biting, etc.)
____ Hyperactivity ____Sleeping problems ____ Headaches

TOTAL: _____

Nose/Eyes/Lungs:

____ Runny nose ____ Stuffy nose ____ Sneezing ____ Watery or itchy eyes
____ "Allergic Salute" (rubs, itches, wipes nose) ____ Dark circles under eyes ____ Bags under eyes
____ Coughing ____ Wheezing ____ Difficulty breathing

TOTAL: _____

GRAND TOTAL: _____

Margaret Gennaro, M.D.

New Patient Informed Consent

Some of the characteristic qualities of complementary medicine that are used in this practice include the following:

1. A person's lifestyle including his or her diet, exercise patterns, sleep habits and stresses are believed to be directly related to the development and maintenance of illness. Complementary medicine evaluates these factors and seeks to help the patient give up negative lifestyle patterns and establish more positive ones regardless of age or type of medical program.

2. Although prescription and over-the counter medications are used when the physician believes it is necessary, an attempt is first made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, enzymes, amino acids, essential fatty acids and herbs.

3. In addition to recommending that a patient take nutritional supplements by mouth, we frequently recommend that a patient receive a series of injections either intravenously or by intramuscular injection. Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems) and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken by mouth.

4. I look for imbalances in the body and for trends that may result in an illness if not addressed. I sometimes order tests that may be considered by mainstream medicine to be either unnecessary or of no value. These may include tests for nutritional status, such as blood levels of vitamins and minerals, hormone levels or blood tests for allergies.

5. I believe that environmental factors may play a major role in health and disease. Some of the diseases of unknown cause may be triggered or perpetuated by common environmental substances, many of which are manmade. Individuals may vary greatly in their susceptibility to various substances, so that one individual may be made deathly ill by an exposure to a substance while another is not at all affected. I attempt to identify offending substances and help patients to detoxify from past exposures that are affecting them.

6. I very much believe in persons being involved in their own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. I encourage consultations with consensus mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.

7. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.

The above represents some of the ways our practice may differ from other physicians' offices that you have visited. You should also be aware of the following points:

8. My practice is exclusively office based. I do not work in a hospital. Additionally, some patients come long distances to receive care at my office. Consequently, I STRONGLY RECOMMEND that in addition to our care you maintain a relationship with one or more physicians appropriate to your condition and situation. For example, most of you may want to have a relationship with a family physician or pediatrician in the case of children. Cardiac patients should have either a cardiologist or an internist or both. I am happy to cooperate with any physician who is willing to work with me.

9. I make no representations, claims or guarantees that you will be helped with your medical problems or conditions by undergoing treatment here. However, I will do my best to help you accomplish your health care and wellness goals.

10. In my office, I make available nutritional supplements and other recommended products. Many of these products are not available through retail outlets or the quality is superior to retail brands. These are provided for the convenience of our patients. You are in no way obligated to purchase these products from this office. You are free to purchase any recommended supplements or other products from any source that you chose.

11. Most health insurance plans today have clauses which limit coverage to "usual and customary fees for reasonable and necessary services." Because many of the treatments used in complementary medicine are not recognized by consensus mainstream medicine, I cannot guarantee the amount or availability of coverage for my services and treatments under your health care insurance policy. You are responsible for the payments of my invoices without regard to insurance

coverage. You are entitled to know the cost of all service and procedures in advance. Please ask if they are not told to you.

I have read, understand and agree to the foregoing. I understand that I have the right to review this Consent with a lawyer if I choose before accepting any medical services from Margaret Gennaro, M.D. I have executed this Consent freely and willingly understand its provisions. I recognize that Margaret Gennaro, M.D. will rely upon my signing of this document in accepting me as a patient.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian (if patient is minor): _____

Statement of Understanding

I do hereby acknowledge that by signing this Statement of Understanding that I understand that some and perhaps all of the medical, preventive, nutritional and diagnostic services provided by Margaret Gennaro, M.D. on or after the date of my signing this statement may be innovative, nontraditional or unconventional. (Definition: services that are not necessarily recognized by traditional medicine, some physicians, some 3rd party purveyors of the AMA, as acceptable testing/evaluation techniques and/or medical and nutritional recommendations or therapies.)*

I also understand that these unconventional services may be viewed by 3rd party insurance purveyors as non-covered services, in that they might be considered unreasonable or unnecessary under the Medicare program or any other medical insurance program.

I also realize that my insurance coverage may not pay for such uncovered services and that I will be personally responsible for payment to Margaret Gennaro, M.D. for all such non-covered services.

Should it be necessary for Margaret Gennaro, M.D. to take action for the purpose of recovering any sum of money owed for services rendered, I understand that I will pay all costs including responsible attorney fees, should that become necessary. I understand that all outstanding balances bear interest at the maximum rate allowable by law.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian (if patient is minor): _____

*Definition of innovative, non-traditional or unconventional: Services: preventive nutritional, homeopathic and naturopathic evaluation and therapies, acupuncture & traditional Chinese medicine; health risk assessment; immune stimulating therapy; magnetic and electromagnetic evaluation and therapy; specialized food and immune antibody assessments; body composition analysis; hyperbaric oxygen therapy; hair analysis; gastrogram; blood analysis for vitamins, minerals, amino acids and other specialized studies; oral and intravenous therapies, including chelating or metabolic techniques; counseling; massage and colon irrigation therapies and electro-stimulating therapies.

Please initial (acknowledgement of above): _____

DIRECTIONS TO MARGARET GENNARO, M.D.
The Mosby Tower
10560 Main Street, Suite 301, Fairfax, VA
703-865-5692

Coming from the Beltway (495) north and from D.C.:

Take 66 West to exit 60 which is Route 123 South (Chain Bridge Rd).
Once you get off the exit, you will come to a light. Go through the light and proceed 0.9 miles and make a right onto North Street (236 West).
Stay in the right lane as North Street immediately becomes Main Street.
In 0.1 miles, make a right into The Mosby Tower parking lot.
Take the elevator to the 3rd Floor. Make a right off of the elevator and walk down the corridor to Suite 301 which is the last door on your right.

Coming from Route 50 West of Office:

Take Route 236 Eastbound (Main Street).
Pass Judicial Drive on your right and make a left after Railroad Avenue into The Mosby Tower parking lot.
Take the elevator to the 3rd Floor. Make a right off of the elevator and walk down the corridor to Suite 301 which is the last door on your right.

Coming from Route 50 East of Office:

Take Route 50 Westbound and make a left onto Route 123 South (Follow directions above).

Coming from Richmond:

Take 95 North to 495 West (toward Tyson's Corner).
Take 66 West to Exit 60 (123 South, Chain Bridge Road).
(Follow directions above).