Welcome to the Center for Disease Prevention and Reversal

We are located at:
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TONI BARK, MD, MEDICAL DIRECTOR
CLASSICAL HOMEOPATHY, NUTRITIONAL MEDICINE
PSYCHONEUROIMMUNOLOGY, HYPNOTHERAPY, SCENAR

Dr. Bark has studied extensively with internationally renowned Homeopaths such as Massimo Mangialavori, Vasillies Ghegas, Rajan Sarkaran, Divya Chabra, Paul Herscu and Louis Klein. She initially studied homeopathy at The New England School of Homeopathy in Massachusetts and at The National Center for Homeopathy in Virginia. She also had post residency training in Hypnotherapy with Dr. Ericca Fromm and with the American Society for Clinical Hypnosis.

Dr. Bark completed her Pediatric Residency training at the University of Illinois, Chicago in 1991 and trained at New York University in Pediatrics from 1986 through 1987, and Rehabilitation Medicine from 1987 through 1988. Immediately post-residency, Dr. Bark worked as attending staff in the Neo-Natal Intensive Care Unit at Michael Reese Hospital. She then took the position as Director of the Pediatric Emergency Room at Michael Reese Hospital until 1993 when she began her studies in Holistic Medicine. She received her medical degree from Rush Medical School Chicago in 1986 and a Bachelor of Science degree in Psychology from The University of Illinois in 1980. She has maintained a private practice in Homeopathy for more than twenty-four years and was the Medical Director for the Integrative Medicine Department of Advocate Health Care Systems at Good Shepherd Hospital's Health and Fitness Center, from June of 2000 until July of 2003. Dr. Bark added to her training with a Master's degree in medical emergency preparedness and management as well as an accreditation in environmental and energy design. She trained and performed research in autonomic biofeedback as well as in ketogenic nutrition. She incorporates both modalities with her practice in classical homeopathy

Dr. Bark schedules initial visits for a minimum of one hour for children and two hours for adults. As she explores each individual's unique health concerns, it is helpful to have a dream journal and food journal prepared for your visit with her. Dr. Bark's practice of Classical Homeopathy involves understanding the patient's view of the world and their beliefs. The individual must be willing to explore the role of dreams, attitudes, fears and hopes in the relationship to health and overall life satisfaction. Dr. Bark also utilizes state of the art laboratories for early detection and intervention in reversing disease processes.
Dr. Bark's practice is not designed to manage medical emergencies.

To expedite your treatment, please sign and complete the following pages before your first appointment with Dr. Bark. Thanks for your cooperation.

NEW PATIENT INFORMATION

NAME _____

PHONE (Home)_____ (Work)_____

(Cell)_____ (Fax)_____

EMAIL _____

Note: Please indicate preferred method of contact by putting a star* after the preferred number or email address

ADDRESS_____

CITY_____STATE_____ZIP_____

AGE_____ BIRTH DATE_____SEX_____ SSN_____

OCCUPATION_____

MARITAL STATUS: SINGLE_____ MARRIED_____DIVORCED_____ WIDOWED_____

LIVING: ALONE_____ WITH MATE_____ WITH FRIENDS_____WITH PARENTS_____

CHILDREN: AGES LIVING AT HOME_____, OUTSIDE OF HOME_____

PETS IN THE HOME? (list type)_____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?_____
RELATIONSHIP_____

(H)_____ (W)_____(Cell)_____

ATTENDING PHYSICIAN INFORMATION_____

WHAT IS YOUR MAIN HEALTH COMPLAINT?

WHAT ARE YOU HOPING TO GAIN FROM TODAY'S VISIT?

LIST ANY MEDICATIONS AND SUPPLEMENTS YOU USE (PRESCRIPTION OR OVER THE COUNTER)

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, WHAT? _____

LIST PHARMACY AND PHONE NUMBER _____

HOW DID YOU HEAR ABOUT US? _____

INFORMED CONSENT FOR SERVICES

I understand that only the physicians are practicing medicine and prescribing any type of pharmaceuticals. I recognize that all non-physician providers are facilitating my health and well-being within the scope of their training and do not diagnose illness, with the exception of licensed psychotherapists evaluating and diagnosing psychological conditions as needed and allowed.

I understand that non-physician services are not a substitute for medical examination nor are non-psychotherapist services a substitute for a psychological exam. I understand that it may be recommended that I see Dr. Bark or a provider outside of the practice should special examinations be required or advised. I further understand that I am a unique individual with unique needs and responses and therefore, no guarantee of specific results can be made. I also acknowledge and claim that I am the key to my healing process and join in partnership with my health care provider in respectfully addressing my needs. I take responsibility for keeping Dr. Bark informed as to my state of health and I know that I am encouraged to discuss any questions or concerns with her.

_____ _____

Signature of Patient or Parent/Guardian Date

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Bark to release any conveyance or information gathered in the course of my examination or treatment by its providers involved in my care to my health insurance carrier:

Signature of Client (parent or guardian if minor)_____

Insurance carrier_____

I understand that I am free to rescind this authorization at any time and that any changes to this authorization must be made in writing and delivered to Dr. Bark.

Dr .Bark would like permission to discuss your case details with other doctors and to relay those details for the purpose of educational classes, publications and lectures regarding Homeopathy and Nutrition.
Dr. Bark assures that your name will remain anonymous and that your rights to doctor-patient confidentiality is respected. Dr. Bark has my permission to impart details of my case and treatment to other professionals and to students for the purpose of education or for publication in educational materials. I understand that my identity will remain confidential.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have been informed about a ***Notice of Privacy Practices*** that contains a more complete description of the uses and disclosures of my health information. I understand that I have the following rights and privileges:

*The right to review the notice prior to signing this consent
*The right to object to the use of my health information for directory purposes, and
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____
Patient / guardian signature Date

I give Dr. Toni Bark permission to share information with

Dr. _____

Patient/ Guardian Signature_____

Date _____

PAYMENT POLICIES

PAYMENT SCHEDULE: Payments should be made at the time of the visit.
We accept Visa, MasterCard, American Express or personal checks. Your credit card account will be billed and a statement will be sent to you for any products that are ordered over the phone and for any chargeable phone consultations.

Patients who are unable to complete payment on the service date are required to file post-dated checks totaling the balance due. These checks will be held by the office and deposited according to the specific arrangement. If it is more convenient for the amounts to be charged to a credit card, this can be specified and the checks will be mailed back to you with the credit card receipt. Any arrangements that have not been honored after 30 days, will acquire interest charged at an annual percentage rate of 20%.

MISSED APPOINTMENTS: A fee is issued for appointments not cancelled at least 48 hours before the appointment time. This fee is based on the amount of time that we were unable to reschedule due to the late notice and will **not be less than** $100.00 for follow-up appointments and $200.00 for initial visits. If you need to cancel or change your appointment, please let us know a.s.a.p. so we can schedule another patient in your time slot. Our cancellation policy will apply for missed or last minute cancellations.

INSURANCE REIMBURSEMENT: Many of our services are reimbursable. Please understand that while we have much success with insurance coverage, we cannot guarantee insurance reimbursement. Many insurance plans are not designed to recognize the types of services that we offer. Much depends on your specific policy. You can ask our office personnel for help, and if further information is desired, we will instruct you to call your insurance company with specific questions to obtain the information.

* The fee for an office visit and or consultation is for Dr. Bark's time. This amount will not be refunded after services have been rendered.

PLEASE SIGN BELOW TO CONFIRM YOUR UNDERSTANDING AND ACCEPTANCE OF THE POLICIES OUTLINED ABOVE AND TO AUTHORIZE THE CENTER TO BILL YOUR CREDIT CARD ACCOUNT FOR SERVICES.

_____ _____

Client Signature Date

_____ _____ _____

Cardholder Signature (if client is not the cardholder) Credit Card Number Exp.

Toni Bark, MD
FEE SCHEDULE

Initial Visit	Up to 45 minutes ……	$400.00
	Up to 60 minutes…….	$450.00
	Up to 90 minutes……..	$550.00
	Two hours…….……	$650.00
Follow Up Visit	15 minutes……..	$200.00
	30 minutes……..	$300.00
	45 minutes……..	$400.00
	60 minutes……..	$450.00

Note: We offer a 5% discount if payment for appointments are made by cash.

A phone consultation is an evaluation or a follow-up consultation over the phone.
It is done when symptoms need attention right away.
It can also be used for long distance clients or for purposes of convenience.

Phone Time: Billed as regular Patient/Doctor time.

CONVERSATIONS WITH DR. BARK: The first scheduled phone call to Dr. Bark, taking five minutes or less, between office visits is free. Additional phone time to discuss health problems that arise and cannot wait until the next visit will be charged according to the follow-up visit fee schedule.

EMERGENCY CHARGES: Double the normal charges. Only emergency calls requesting a return call will be returned on evenings, weekends and public holidays. All other calls will be returned on the next business day.

I HAVE READ AND UNDERSTAND THE FEE SCHEDULE

Sign your name here: _____

IMPORTANT!
Also, we ask that you do not wear any cologne or aftershave lotion to the office because some patients are hypersensitive to smells and chemicals. Thank you...