RETORNO
PREVENTION & TREATMENT OF ADDICTION

Welcome! The following pages contain your application for Retorno in Givat Shemesh, Israel. Please use this checklist to make sure your application is complete:

- ☐ Signed affirmation (page 2)
- ☐ Background and Medical History (pages 3-4)
- ☐ Medical Form, filled out by doctor (page 5)
- ☐ Copy of EKG (as requested on page 6)
- ☐ Radiologist report of chest x-ray (as requested on page 6)
- ☐ Blood test results from within the past 3 months (as requested on page 6)
- ☐ Confidentiality Release Form (page 7)
- ☐ Insurance application (pages 8-10)

  Instructions for insurance application:
  - Section A – only the "main insured" column. No email required.
  - Section B – Harel private arrangement
  - Section C – only the "main insured" column, both Part A and Part B
  - Then signature section, "main insured" only (first line)
  - The other sections do not need to be filled out.

- ☐ Application fee of $250

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Application for Referral and Treatment

Date_____

Name_____ Passport#_____

Address_____

Home Phone_____

Cell Phone _____

I hereby affirm that I have approached RETORNO of my own free will. I would like to receive assessment, advice, and treatment. I am committed to complying with the rules of the institution.

I hereby affirm that all information provided is accurate and the most recent information available. I understand that the inclusion of incorrect or outdated information or omission of relevant information may disqualify me at any time during the application or treatment process.

Signature_____

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Background Profile
(to be filled out by patient or guardian)

Date_____ Social Security # _____
Patient Name_____ Date of Birth_____
Address_____ Country: _____
Home phone: _____ Cell phone: _____

Family Description_____
_____

Childhood_____
_____
_____

Adolescence_____
_____
_____

Description of present situation_____
_____
_____
_____

Is there a history of behavioral problems in school? Please describe._____
_____
_____

Educational Evaluation: Yes/No If yes, please enclose a copy of the full report.

Psychiatric/Psychological Evaluation: Please send full written report (depression, suicide attempts, violence, diagnoses).

List of medications (including dosage): _____
_____
_____
_____

Prior Therapy_____
_____
_____

Motivation for treatment_____
_____

Expectations_____
_____

Filled out by _____ Relationship to patient: _____
Signature_____

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Medical Statement
(to be filled out by Patient)

I, _____, Social Security #: _____, declare that I do not suffer any medical issues, other than what is listed below:

1. Orthopedic: yes/no details:_____
2. Psychiatric: yes/no details:_____
3. Digestive: yes/no details:_____
4. Respiratory: yes/no details:_____
5. Cardiology: yes/no details:_____
6. Vascular: yes/no details:_____
7. Dermatology: yes/no details:_____
8. Reproductive: yes/no details:_____
9. Epilepsy: yes/no details:_____
10. Other: yes/no details:_____

I affirm that I am/am not physically limited in any way. If yes then provide details:
_____

I affirm that I do/do not take any medications. If yes, list medications and dosage:
_____

I hereby state that all the above is true, and that if any of the above is not true or I have omitted any information, then Retorno has the right to refuse or terminate my treatment immediately and without prior notice, and that Retorno is not liable, legally, medically or otherwise, for any possible consequences due to omission or incorrect information.

Full name: _____
Signature: _____
Date: _____

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Medical Form
(to be filled out by physician)

Date_____

Name_____
Passport# _____
Date of birth _____

General Appearance_____
_____
_____

History of Medical Problems_____
_____
_____
_____

Hospitalizations_____
_____
_____
_____

Present Situation_____
_____
_____
_____
_____

Current Diagnosis_____
_____
_____
_____
_____

Medications_____
_____
_____
_____
_____

Is this patient fit to withstand the stresses of treatment? _____

Name of Examining Physician_____

Signature and Stamp_____

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Lab Tests

1. EKG
2. Chest X-ray (radiologist's report only)
3. Blood count, Hematocrit, Thrombocytes
4. Biochemistry:

Glucose
Urea
Creatinine
Bilirubin:
total
direct
Total protein:
Globulin
Albumin
Cholesterol
Triglycerides
Uric Acid
Chlorid
Sodium
Potassium
Amylase
Alk.Phosphatase
SGOT,SGPT,GGT
VDRL
HBs HepC Ag
HIV
Pregnancy - Urine HCG-β (for women)
DHEA
DHEA-s
Cortisol

Please note: Tests must be within the last 3 months. Missing tests will delay treatment!

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Confidentiality Release Form

Date_____

I_____, ID or Passport #_____, hereby release all medical and other personal information, and allow RETORNO to acquire any related information that may be required. This will be made available upon request and sent directly to RETORNO.

_____
Signature

Tour and Care
Insurance Application for Tourists in Israel

HAREL Insurance & Finance

Please fill out this form fully and accurately.

04/2019 Edition

I the undersigned (hereinafter, the "Insurance Applicant") ask of "Harel" Insurance Company Ltd. (hereinafter, the "Insurer") to insure me, based on all the content of this Application.
The policy documents will be sent to your mobile phone number available to the Harel Company. If you wish to receive these documents by e-mail, you should fill in your e-mail address with the personal details. Alternatively, if you want to receive these document by Israel Post, please note this ..... (the documents will be sent according to the most recent details that appear in our files at the time of sending).

Agent's name: מלאמוד ריקרדו

Agent's number: 51402

Insurance Period Requested	
From date	To date

Attn.
Harel Insurance Company Ltd.
Foreign Employees / Tourists Insurance Section
3 Abba Hillel Street, PO. Box 1951, Ramat-Gan 5211802, Fax: 03-7348083
email: fax7930@harel-ins.co.il

A Personal information of insurance applicants (up to the age of 75 years)

	Main Insured	Spouse	Child 1	Child 2	Child 3
Passport number					
First Name					
Last name					
Date of birth					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of entry to Israel					
Citizenship					
Purpose of visit					
Address					
Mobile phone					
E-mail for personal notifications and mailings ..... @					

B Provider selection

☐ Harel's private arrangement ☐ Clalit Health Services [HMO]

C Health Statement

The Health Statement below shall apply severally to each one of the following: the main Insured, the spouse and each one of the children insured. Please answer the questions below by marking (✔) in the column of the correct answer. If the answer to any of the questions is "Yes", you must attach an up-to-date report from the attending physician regarding the stated problem, test results, the manner of treatment and the current condition.

	Part A: Investigation of a medical symptom or illness that has not been completed:	Main Insured		Spouse		Child 1		Child 2		Child 3	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	During the last two years have you been referred for any of the following medical and/or diagnostic examinations that are not yet completed and regarding which no **final diagnosis has been made yet such as**: catheterization, mapping, echocardiography, CT, MRI, ultrasound (not as part of routine prenatal monitoring), biopsy, occult blood, colonoscopy, gastroscopy.										
	Part B: Have you been diagnosed with a disease, syndrome, disorder related to one or more of the issues listed below:										
1	The nervous system (neurology) and the brain: ☐ The nervous system ☐ Cerebrovascular accident (CVA) ☐ Multiple sclerosis ☐ Muscular dystrophy										
2	Renal failure										
3	The respiratory system: ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Cystic Fibrosis										
4	Malignant disease or tumor (cancer)										
5	Immune system diseases: ☐ AIDS and/or HIV carrier ☐ Lupus										

Please specify (only if you answered "yes" to one of the questions in the Statement): .....

.....

.....

For your information - the policy does not provide coverage for a pre-existing medical condition.

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D Riders for Extra Insurance Fees

Supplemental coverage	Main Insured	Spouse	Child 1	Child 2	Child 3
Medical air transportation					
Death or total loss of organs due to an (accident above age 18)					

E Insurance Applicant's Statement

1. a. The information included in this document is required for your joining the policies and for all other matters and issues pertaining to the policies and the handling thereof. The Company and other companies of the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) and/or anyone on their behalf will make use of it, including the processing, storage and use thereof, for any matter pertaining to the policies and for other legitimate purposes, including by providing the information to third parties acting in the name and on behalf of the Harel Group.
   b. I/we hereby declare that all the answers are correct and complete and are provided out of my/our own free will.
   c. The answers specified in the Health Statement and any other information to be submitted to the Company as well as the Company's customarily prevailing terms and conditions in this matter shall be essential terms, conditions of the insurance contract between you and the Company, and constitute an inseparable part thereof.
   d. The Company may decide to either accept or reject the Application. For your information, the insurance contract shall come into force only after the Company issues a written confirmation of admission of all the insurance applicants.
   e. This consent and statement, including the Health Statement above, shall also apply to the children whose names are listed in the Application and your signature/s on the documents is made also in their names as their guardian.
   Are you authorized to sign these documents on their behalf? ☐ Yes ☐ No.
   f. I hereby confirm that I received essential information regarding the insurance, which included, at the very least, a description of the main elements of the coverage, the insurance premium, the insurance period, the main insurance amounts and the main limitations of liability, and regarding my possibility of obtaining full details about them.

For your information:

2. Preexisting medical condition: an insurance event, substantially caused by the normal course of a preexisting medical condition, which occurred to the Insured during the period in which a restriction applies. A restriction because of a preexisting medical condition, concerning an insured whose age at the beginning of the insurance period is:
   1. Less than 65 years - Shall apply for a period not exceeding one year from the beginning of the insurance period.
   2. 65 years or more - Shall apply for a period not exceeding half a year from the beginning of the insurance period.
3. This medical insurance is subject to a qualification period of 48 hours.
4. I am aware that the insurance contract shall come into force only after the Company issues a written confirmation of admission regarding the Insurance Applicant. In any case, the insurance period shall begin from the date of confirmation by the Insurer, as said above.
5. Agreement to Use of Information and Receipt of Advertising Material
   Do you agree, beyond the requirements of the law or agreement, that the information included in this document, as well as additional information about you that is or will be possessed by other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) will be used by the Harel Group and/or anyone on their behalf, including for any matter related to the other products and services of the companies in the Harel Group (in the field of insurance, long-term savings and finances) and in their marketing, including allowing the said companies to inform you of products and services, and also for the purpose of handling other policies and/or insurance products, long-term savings and financing that you hold, processing and storing the information, and also for additional uses associated with the above-said uses and required in order to complete them, and for other related legitimate purposes, including by means of transferring the information to third parties acting on behalf of and in the name of the Harel Group.
   ☐ Yes ☐ No
6. **Waiver of medical confidentiality:** I/we the undersigned hereby give permission to an HMO (kupat holim) and/or its medical institutions and/or the IDF, and all the physicians and/or psychiatrists, the other medical institutions and hospitals, the National Security Council (MALAL) and/or the Ministry of Defense and/or any insurance company and/or to any other institution and entity, **insofar as required in order to inquire and settle claims according to the policy and/or for the purpose of the procedure for examining my acceptance to the requested insurance plan** to provide Harel including any information held by the Company and details with no exception and in the form required by those requesting it, about my/our health condition, about any illness I/we had in the past and/or that I/we are ill with now and/or will be ill with in the future and I/we release you from the duty of maintaining medical confidentiality and waiver this confidentiality towards the "requestor." This waiver binds me/us, my/our estate and my/our legal representatives and anyone that appears in my/our place. This waiver will also apply to my/our minor children.

Insurance Applicant's Signature

	Date	Name of Insured	ID No.	Signature
Main Insured				
Spouse				
Child over the age of 18 years				
Child over the age of 18 years				
Child over the age of 18 years				

Witnessed the signing (the insurance agent) ..... Date ..... ID ..... Full name ..... Signature

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F Agent's Declaration (required clause that the agent must sign)

Agent's Statement of Compliance with Instructions of the Insurance Commissioner's Circular on the Matter of Joining an Insurance Plan:
I confirm that in the process of selling the products specified in this Form of Joining, I complied with all the instructions of the Commissioner of Insurance in the Matter of Joining an Insurance Plan, and specifically, I inquired about the needs of the candidates, I proposed insurance and/or additional coverage, a rider or a service letter to the existing insurance policy that meet/s his/her/their needs and I gave him/her/them all the essential information required.

Date: ..... Name of agent: ..... Signature of agent: ✎ .....

G Payment by credit card - according to the arrangement of the Insured/Payer with the credit card company

Personal information of Insurance applicant		
First name	Last name	Passport No.

Personal information of Payer		
ID No.		Cardholder's name
CVV number (3 digits on the back of the card)	Valid until ..... /	Card number

You can pay in several installments depending on the period		
Number of days	1 to 90	91 to 181
Number of payments	1	1 ☐ 2 ☐

Postal code	City	House No. and Street

Email address: ..... @	Telephone

For your information, the means of payment will be used to pay the insurance fees for all those insured under the policy/ies. The amounts and dates of charges will be according to the Company's determination, according to the terms of payment of the insurance policy/ies and the changes made to them from time to time. The charge will be in New Israeli Shekels, according to the dollar exchange rate on the billing will be sent to the credit company.

Date:	Name of credit card holder:	Credit card holder's signature ✎ .....

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Additional information concerning privacy policy of the institutional entities in Harel Group is available on the Group website: www.harel-group.co.il.

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