Welcome!

How did you hear out about the FRESH Integrative Health Program?_______________________________________

(ex: friend, physician referral, Google, Yelp, ZocDoc, walking by, health fair, newspaper ad, postcard, flyer, etc.)

If referred by an individual, may we acknowledge the referral? Y / N ______________________________________

Name: _____________________________________ Nickname: ______________________ DOB: _____________

SSN: ____________________ Marital Status: _______ Company: _____________________________________

Address: _________________________Apt #_____ City: ___________________ State: ______ Zip: ____________

Phone Number: Home ____________________ Cellular_____________________ Work____________________

Do you prefer us to call your HOME / CELL / WORK phone (circle one)?

Email:____ ___________________________________(Email address is used to send appointment reminders)

Emergency Contact: _____________________________________ Relationship: __________________________

Emergency Contact Phone Number: ____

Primary Care Physician Name: __________________________________Phone: __________________________

Are you in need of a Primary Care Physician? ( ) YES ( ) NO

Is your insurance through your employer? ( ) YES ( ) NO

If yes, who is your employer?____

Policy Holder's Name:_______________________________________Relationship:_________________________

Policy Holder's SSN: ___________________ DOB: ___________________ Phone Number: __________________

Address (if different than above):____

City: ___________________ State: ______ Zip: ____________

FRESH Integrative Health and Wellness
Health History and Intake Form

Is there a specific practitioner whom you specifically want to see?

If a physician referred you, would you like the practitioners at Physio Logic to communicate information to this physician?
- ☐ No
- ☐ Yes, please contact: Phone:

Address:

Physio Logic/FRESH collects payment at the time of service. What will be your usual source of payment?
- ☐ Cash
- ☐ Check
- ☐ VISA/Mastercard

We require a credit card number OR a deposit when you schedule your appointment.

Treatment	Interested	Tried	Helpful?	Treatment	Interested	Tried	Helpful?	Treatment	Interested	Tried	Helpful?	Treatment	interested	Tried	Helpful?
Acupuncture				Physical Therapy				Meditation				Herbs			
Chiropractic				Nutritional Counseling				Rolfing				Stress Reduction			
Homeopathy				Naturopathic Medicine				Pilates				Massage Therapy			
Positive Psychology				Mind-Body Medicine				Yoga				Aroma-Therapy			

Complaints in priority order

Please describe the current condition or complaints for which you are seeking treatment at the center in priority order. Please include the date when the illness began.

This condition interferes with
- ☐ Work
- ☐ Sleep
- ☐ Exercise

This condition is getting
- ☐ Worse
- ☐ Better
- ☐ Staying the same

What do you believe is the cause?

How is this condition being treated?

Other Conditions

Please list other health concerns

Goals and Expectations

Please tell us your goals and expectations for our clinic

Surgical / Injury / Hospitalization History *(please attach list if you need more space)*

Please list prior surgeries, injuries, and hospitalizations, including dates

Date: Incident:

Date: Incident:

Date: Incident:

Have you ever had a blood transfusion?
- ☐ Yes
- ☐ No

If yes, when?

Review of Symptoms / Conditions			
Head	**Neck**	**General**	**Mental/Emotional**
☐ Headaches	☐ Goiter	☐ Chronic Fatigue or Tiredness	☐ Anxiety, nervousness
☐ Migraines	☐ Neck Lumps	☐ Frequent Colds	☐ Poor Memory
☐ Jas TMJ problems	☐ Neck Pain or Stiffness	☐ Infections, chronic	☐ Depression
☐ Hair Loss	☐ Whiplash Injury	☐ Slow Healing	☐ Concentration / focus, difficult
☐ Ear Pain	**Chest**	☐ Heat or Cold Intolerance	☐ Mood Swings
☐ Ear Infections	☐ Chest Pain / Pressure	☐ Increasing Hunger	☐ Tensions, stress
☐ Ears, itchy	☐ Palpitations / Heart Fluttering	☐ Increasing Thirst	**Urinary**
☐ Hearing Problems	☐ Difficult Breathing	☐ Excessive Sweating	☐ Frequent Infections
☐ Ringing / Tinnitus	☐ Pain with Breathing	☐ Night Sweating	☐ Inability to Hold Urine
☐ Wax, excessive	☐ Chronic Cough	☐ Fainting / Light Headedness	☐ Inability to Completely Empty Bladder
☐ Blurry Vision	Shortness of Breath ☐ at night ☐ lying down ☐ with exercise / exertion	☐ Dizziness / Vertigo	☐ Increased Urinary Frequency
☐ Color Blindness		☐ Numbness or Tingling	☐ Urinary Frequency at Night
☐ Diminished Night Vision		☐ Tremor	☐ Urgency with Urination
☐ Double Vision		☐ Back Pain	☐ Low Force of Urine
☐ Dry, red, gritty eyes	☐ Spitting up food	☐ Muscle Spasms / Cramps	☐ Pain with Urination
☐ Eyes, itchy	☐ Wheezing	☐ Muscle Weakness / Tiredness	☐ Bed Wetting
☐ Eye Pain	**Extremities**	**Digestion / Elimination**	**Female**
☐ Glasses / Contacts	☐ Joint Pain or Stiffness	☐ Abdominal /Stomach Pain	☐ Bleeding between cycles
☐ Spots in Eyes / floaters	☐ Joint Heat and Redness	☐ Alt. Diarrhea / Constipation	☐ PMS
☐ Tearing, excessive	☐ Joint Swelling	☐ Belching / Burping	☐ Endometriosis
☐ Hay Fever	☐ Swelling in Ankles	☐ Blood in Stool	☐ Difficulty Getting Pregnant
☐ Nose Bleeds, frequent	☐ Leg Pain	☐ Change in Stool	☐ Painful Intercourse
☐ Red Nose and/or Face	☐ Cold Hands and Feet	☐ Difficult Bowel Movement	☐ Sexual Difficulties
☐ Runny Nose	**Skin**	☐ Change in Appetite / Thirst	☐ Breast Lumps
☐ Sinus Problems	☐ Acne	☐ Constipation	☐ Breast Pain
☐ Stuffiness, congestion	☐ Rashes	☐ Diarrhea	☐ Nipple Discharge
☐ Bad Breath	☐ Flushing / Hot Flashes	☐ Fatigue after eating	☐ Vaginal Discharge
☐ Dental Cavities / Fillings #____	☐ Eczema	☐ Flatulence / Gassiness	☐ Vaginal Itching
☐ Root Canals # ____	☐ Hives	☐ Heartburn / Acid Reflux	☐ Vaginal Dryness
☐ Dentures	☐ Boils	☐ Hemorrhoids	☐ Genital Warts
☐ Frequent Sore Throat	☐ Itching	☐ Nausea	☐ Genital Herpes
☐ Frequently Clear Throat	☐ Color Change	☐ Pain in Rectum / Anus	☐ Hot Flashes
☐ Gum Disease	☐ Lumps	☐ Itching in Rectum / Anus	**Male**
☐ Hoarseness	☐ Psoriasis	☐ Painful Stool	☐ Penile Discharge
☐ Mouth Sores	☐ Moles	☐ Swallowing Difficulty	☐ Penile Sores
☐ Cold Sores / Oral Herpes	☐ Sun Sensitivity	☐ Vomiting	☐ Pain with Sexual Intercourse
☐ Mouth, dryness	☐ Tight Skin		☐ Difficulty getting / maintaining erection
☐ Sore Tongue, lips	☐ Easy Bleeding / Bruising		☐ Sexual Difficulties
☐ Teeth Grinding	☐ Varicose Veins		☐ Testicular Lump
☐ Swollen Glands	☐ Rosacea		☐ Testicular Pain
☐ Tonsils / Adenoids Removal			

Reproductive History

Female

Date of last menstrual period:	Date of last female annual exam:	Have you ever had HPV? ☐ Yes ☐ No	Normal Pap? ☐ Yes ☐ No

Sexual Orientation	☐ Heterosexual	☐ Homosexual	☐ Bi	☐ Other	Sexually Active? ☐ Yes ☐ No	Birth Control Type:

Number of Pregnancies	Number of Live Births	Number of Cesarian Deliveries	Number of Miscarriages	Number of Abortions

Age period began:	Length of period (bleeding):	Length of monthly cycle:	Are your cycles regular?

Menstrual Pain / Cramps	☐ none	☐ mild	☐ significant	☐ severe
Menstrual Flow	☐ light	☐ moderate	☐ heavy	☐ extremely heavy

Are you pregnant?	☐ Yes ☐ No	Are you breast feeding?	☐ Yes ☐ No	Have you ever breast fed?	☐ Yes ☐ No	For how long?

Were you ever on oral contraceptives?	☐ Yes ☐ No	If yes, how long?	Hormone Replacement Therapy	☐ Past ☐ Current	For how long?

Uterine Fibroids:	☐ Yes ☐ No	Fibrocystic breasts:	☐ Past ☐ Current	Polycystic Ovaries:	☐ Past ☐ Current
Are you menopausal?	☐ Yes, date of last period: What age? ☐ No	Have you had a hysterectomy?	☐ Yes ☐ No	Have you had an oophorectomy?	☐ Yes ☐ No

Do you do Self Breast Examination (SBE)?	☐ Yes ☐ No	Date of last mammogram:	Normal?	☐ Yes ☐ No

Male

Sexual Orientation	☐ Heterosexual	☐ Homosexual	☐ Bi	☐ Other	Sexually active? ☐ Yes ☐ No	Birth control type:

Ejaculation concerns?	☐ Yes ☐ No	Fertility concerns?	☐ Yes ☐ No	Impotence?	☐ Yes ☐ No	Hernia concerns?	☐ Yes ☐ No

Prostate concerns?	☐ Yes, explain: ☐ No

Medical History: Family & Self	Key: Se=Self Fa=Father Mo=Mother Sis=Sister Bro=Brother Chd=Child Gp=Grandparent														
Your Birthplace:	Race & Ethnicity Background						Mother:				Father:				
Alcoholism	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Kidney Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Allergies	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Kidney Stone**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Anemia/Blood Disorders	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Liver Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Arthritis, Rheumatoid	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Lung Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Arthritis, Osteo	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Lyme Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Asthma	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Mental Illness**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Autoimmune Disease	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Mouth, Throat Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Cancer Type:	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Muscular Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Chicken Pox	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Neurological Disease**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Depression or Anxiety	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Osteopenia**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Diabetes	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Osteoporosis**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Drug Addiction	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Pain, chronic**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Eating Disorder	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Skeletal Disorder**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Epilepsy/Seizures	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Skin Disorder**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Gallbladder Disorder	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Stroke**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Glaucoma / Cataracts	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Syphilis**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Gout	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Thyroid Disorder**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Hay Fever/Hives	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Tuberculosis**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Heart Disease	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Urinary Disorder**	Se	Fa	Mo	Sis	Bro	Chd	Gp
High Blood Pressure	Se	Fa	Mo	Sis	Bro	Chd	Gp	**Vascular Disorder**	Se	Fa	Mo	Sis	Bro	Chd	Gp
Infertility	Se	Fa	Mo	Sis	Bro	Chd	Gp								

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FRxESH Review

Weight current:
Weight 6 months ago:
Weight 1 year ago:

Would you want your weight to be different?

I consider my weight to be

- ☐ Not a factor in my present illness
- ☐ Somewhat a factor
- ☐ A Significant factor

Height:
At what point in your life did you feel best?

Food

Do you eat 3 meals a day?

- ☐ Yes
- ☐ No

Please describe your typical food intake:

Breakfast:

Lunch:

Dinner:

Snacks:

How many glasses of plain water do you drink per day?
Is it filtered?

- ☐ Yes
- ☐ No

How many cans of soda/juice do you drink per day?
Diet soda/juice?

- ☐ Yes
- ☐ No

What type?

How many cups of coffee do you drink per day?

What type of coffee do you drink?

How many cups of coffee or tea do you drink per day?

What percentage of you weekly food intake is organic?

What percentage of you weekly meals are home-prepared?

How many meals do you eat out per week on average?

Do you cook?

- ☐ Yes
- ☐ No

If yes, how often?

My diet can best be described as:

- ☐ Omnivore (meats, poultry, fish, eggs, dairy, fruits, grains, vegetables)
- ☐ Semi-vegetarian (I exclude some animal products specifically:
)
- ☐ Ovo-lacto-vegetarian (I exclude animal flesh, but include dairy and eggs)
- ☐ Vegan (I exclude all animal products)
- ☐ Other (please explain)

Anything else you would like to say about your diet?

Do you have any food allergies/intolerances?

- ☐ Yes
- ☐ No

If yes, please describe:

Do you experience food cravings? Which kind of food?

Recent improvements to your diet include:

What are the factors in your life that interfere with eating better?

Regarding the way you eat, which statement most closely describes you?

- ☐ I am not considering any nutritional changes at this time
- ☐ I am considering nutritional changes, but am not ready to take action.
- ☐ I am early into the process of making nutritional changes.
- ☐ I am well into the process of making nutritional changes.
- ☐ I am maintaining prior changes that I've implemented.

My interest and motivation to make and sustain change is:

- ☐ None
- ☐ Slight
- ☐ Moderate
- ☐ Strong

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- ☐ Very Strong

My confidence in my ability to make and sustain changes is:

- ☐ None
- ☐ Slight
- ☐ Moderate
- ☐ Strong
- ☐ Very Strong

What is your favorite meal now?

What was your favorite meal as a child?

Are you comfortable with your relationship with food?

- ☐ Yes
- ☐ No

If yes, please explain:

Do you take supplements?

- ☐ Yes
- ☐ No

If yes, what do you take?

Relaxation

Do you spend time outside?

- ☐ Yes
- ☐ No

Do you take vacations?

- ☐ Yes
- ☐ No

Do you follow a spiritual practice?

- ☐ Yes
- ☐ No

Type of practice/religion:

How important is spirituality in you daily life?

- ☐ Not Important
- ☐ Somewhat Important
- ☐ Important
- ☐ Very Important

Do you use tobacco?

- ☐ Yes
- ☐ No

What type?

How much per day?

For how many years?

Ever try to quit?

- ☐ Yes
- ☐ No

Do you use recreational drugs?

- ☐ Yes
- ☐ No

How often?

Ever been treated for drug dependence?

- ☐ Yes
- ☐ No

Have you been exposed to toxic/potentially toxic chemicals?

- ☐ Yes
- ☐ No

Please list:

Ever been diagnosed with a psychiatric disorder?

- ☐ Yes
- ☐ No

Did you undergo treatment?

- ☐ Yes
- ☐ No

How often do you relax?

Do you have a meditative practice?

What gets you calm?

Do you feel like a part of a community?

- ☐ Yes
- ☐ No

How do you spend your free time?

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Exercise

Do you exercise regularly?
- ☐ Yes
- ☐ No

If yes, how often? (How my times a week? What span of time?)

What type of exercise?

Do you enjoy it?
- ☐ Yes
- ☐ No

Do you walk often?
- ☐ Yes
- ☐ No

Stress/Sleep/Sex

Are you stressed?
- ☐ Yes
- ☐ No

How would you rate your stress level on a scale of 1-10?

Can you manage your stress?
- ☐ Yes
- ☐ No

What stresses you out?

Do you sleep well?
- ☐ Yes
- ☐ No

Do you awaken feeling rested?
- ☐ Yes
- ☐ No

Do you get enough sleep?
- ☐ Yes
- ☐ No

Average hours of sleep per night:

What time do you sleep usually?

Do you have trouble falling asleep?
- ☐ Yes
- ☐ No

Do you have trouble staying asleep?
- ☐ Yes
- ☐ No

Do you dream?
- ☐ Yes
- ☐ No

Do you drool?
- ☐ Yes
- ☐ No

Are you in a relationship?
- ☐ Yes
- ☐ No

Are you in love?
- ☐ Yes
- ☐ No

Do you have sex? If yes, how often?
- ☐ Yes
- ☐ No

Are you happy with you sex?
- ☐ Yes
- ☐ No

Do you feel supportive for your significant other?
- ☐ Yes
- ☐ No

Happiness

Do you consider yourself to be generally happy these days?
- ☐ Yes
- ☐ No

Do you have a strong support system? (People to talk to, share things with, friends and family?
- ☐ Yes
- ☐ No

Would friends and family be supportive of lifestyle changes?

Do you have a significant other?
- ☐ Yes
- ☐ No

Do you enjoy your job/career?

If there were three things you could change about yourself what would they be?

1.

2.

3.

Please describe 2-3 of your greatest strengths and/or achievements:

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Please list main interests and hobbies/what you do for fun?

What do you do creatively / what are your creative outlets?

Do you consider yourself happy?

What brings you happiness?

How much time do you spend doing the things that make you happy?

Do you consider yourself healthy?

Are you grateful? If yes, what are you grateful for?

- ☐ Yes
- ☐ No

Are you hopeful that you can change/improve?

- ☐ Yes
- ☐ No

Medication use: please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs

Medication Type	Dosage

Do you do drugs? If so, what type and how often?

Do you consider your drug use a problem?

Do you drink alcohol?

- ☐ Yes
- ☐ No

How many alcoholic drinks do you have in a week?

Ever been treated for alcoholism?

- ☐ Yes
- ☐ No

Informed Consent for Treatment

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I, acknowledge that I have read and understand the foregoing. (Print Name)

Patient Signature: ____ **Date Signed:**______/______/ _______

If patient is a minor or physically/legally incapacitated, representative signature: ______________________________

Assignment & Instruction for Direct Payment

Policy Holder: ____ **DOB:**_____/_____/ _______

I certify that I (or my dependent) have insurance coverage with_________________________________and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/ MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient Signature: ____ **Date Signed:**______/______/ _______

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health and related health care services.

Uses and Disclosures of Protected Health Information. Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your case and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment. Your PHI will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality of assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk were you will be asked to sing your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: food and Drug Administration requirements: Legal Proceedings: Law Enforcement; Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity, Military Activity and National Security; Workers Compensation; Inmates Required Uses or Discloses: Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures. Will be made Only with Your Consent, Authorization, Or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

<u>Your Rights</u>. Following is a statement of your rights with respect to your PHI.

<u>You have the right to inspect and copy your PHI</u>. Under federal law, however, you may not inspect or copy the following record; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

<u>You have the right to request a restriction of your PHI</u>. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclose of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location</u>. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, ie. Electronically.

<u>You have the right to have your physician amend your PHI</u>. If we deny your request for amendment, you have the right to file a statement or disagreement with us and we may prepare to rebuttal to your statement and will provide you with a copy of any such rebuttal.

<u>You have the right to receive an accounting of certain disclosers we have made, if any, of your PHI.</u>

We reserve the right to change the terms of this notice and will inform you by mail of those changes. You then have the right to object or withdraw as provided in this notice.

<u>Complaints</u>. You may complaint o us or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. We may file a complaint with us by notifying our privacy contact by your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before June 25, 2010.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Signature below is only acknowledgement that you received this Notice of Privacy Practices:

Patient Name:_________________________**Patient Signature:**__________________________**Date Signed:**________/______/ _______

Appointment Cancellation Policy

Our goal is to provide quality medical care in a timely manner. When you make an appointment, we reserve a significant amount of time for your visit/ procedure. In order to do so, the implementation of a strict appointment cancellation policy has become necessary. This policy enables us to better utilize available appointments for all patients in need of medical care. Failure to keep or to arrive on time for a scheduled appointment jeopardizes the ability of our office to provide you and other patients with a high level of care. In order to be respectful of the medical needs of the community, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone else who is in need of treatment. If it is necessary to cancel or reschedule your appointment, we require that you call *24 hours in advance* and *within office hours*! Appointments are in high demand, and your early cancellation will give another person the possibility to be treated. In addition, if you are more than 15 minutes late for an appointment, it may not be possible for the clinician to see you, but we will always work with the time available.

Cancellation charges are not covered by insurance
and are due and payable prior to any future appointments.

1. If you cancel or reschedule your appointment 24 hours in advance *and* during our office hours there is no charge. This means that you must cancel a Monday appointment during office hours on Saturday, in order to avoid a late cancellation fee. (for example: If you need to cancel an 11am appointment on Monday, you must call by 11am on the previous Saturday .)

2. Any appointments for chiropractic, acupuncture, or nutrition that are not cancelled 24 hours in advance will result in a **$40.00 charge**.

3. Any appointments for physical therapy or our medical doctors that are not cancelled 24 hours in advance will result in a **$75.00 charge**.

* We maintain our 24 hour cancellation policy for all NEW PATIENTS.
All cancellations of first time appointments will require a **$75.00 deposit** to hold a future appointment. This amount will be used as a credit towards your account. *

It is our wish that each and every one of our patients receive the very best care possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you do not follow the treatment plan, then you will not receive the desired progress in your rehabilitation.

Patient Copy