INTEGRATED
HEALTH & WELLNESS CENTER, P.C
855 Springdale Drive
Suite 120
Exton, PA 19341
610-561-6100

Today's Date: ____________________ Referred by: ____

Patient Name: ___________________________________Date of Birth: _____________ Sex :( ) M ( ) F

Address: ____

SS#: ____________________ Occupation: ____

Home Phone: __________________________ Work Phone: ____________________________________

Cell Phone: __________________________ Email: ____

Emergency Contact: ______________________________________ Phone: _______________________

Employment Information

Business Name: ______________________________ Address: _________________________________

Phone: (___) ___________________Occupation/Job Title: _______________________________________

If this is a worker's compensation or automobile injury please notify the front desk.

Insurance/Guarantor Information: (guarantor is the person financially responsible for this patient's bill)

Guarantor Name: __________________________________Policy Holder SS # _____________________

Address: ____

Insurance Carrier _________________ Policy Number_________________ Group Number_____________

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and I. Furthermore, I understand that the Integrated Health and Wellness Center, P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Integrated Health and Wellness Center. P.C. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorized the Doctor to treat my condition as he or she deems appropriate and I give authority for these procedure to be performed. The patient also agrees that he/she is responsible for all bills incurred at this office. During the course of your treatment in the office, the doctors may recommend certain vitamin supplements and/or orthopedic supports that may assist in your care. This is a recommendation and you are not under any obligation to purchase any products. I acknowledge that I have received Integrated Health and Wellness Center, P.C. notice of Privacy Practices for protected health information.

Patient Name Printed: ___________________________ Patient's Signature: ___________________________
Consent to treat a Minor: ____ Date: _________________
Guardian or Spouse's Signature of Authorizing Care: ____________________ Date: _________________

Patient Name: ______________________ Date of Birth: __________

PAST MEDICAL HISTORY

Alcoholism	___Yes	___No
Anemia	___Yes	___No
Anxiety	___Yes	___No
Asthma	___Yes	___No
Bleeding Disorder	___Yes	___No
Cancer	___Yes	___No
Diabetes	___Yes	___No
Depression	___Yes	___No
Drug Abuse	___Yes	___No
Eating Disorder	___Yes	___No
Epilepsy	___Yes	___No
Heart Attack:	___Yes	___No
Heart Disease:	___Yes	___No
High Blood Pressure	___Yes	___No
High Cholesterol	___Yes	___No
Kidney Disease	___Yes	___No
Migraine Headaches	___Yes	___No
Stroke	___Yes	___No
Thyroid Disease	___Yes	___No
Other (Explain)	___Yes	___No

PAST FAMILY MEDICAL HISTORY (Please list)

____

____

____

SURGICAL HISTORY (Please list any operations and the dates)

____

____

____

SOCIAL HISTORY (Please Circle)

Do you smoke?	Yes	No	
Do you drink alcohol?	Yes	No	How many per day? __________
Do you drink caffeine (tea/coffee)?	Yes	No	How many per day? __________
Do you use drugs now or in the past?	Yes	No	

MEDICATIONS (Please list all Prescription, Over-The-Counter, Supplements, Vitamins, Herbs)

__________	__________	__________
__________	__________	__________
__________	__________	__________
__________	__________	__________

Allergies to Medications, X-Ray Dyes, or other Substances: ( ) Yes ( ) No
(If yes, please list the name of medicines and type of reaction)

____

____

Provide Dates (If applicable)

Tetanus Shot __________ Pneumovax __________

Meningitis __________ Zostovax __________

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24 Hour Appointment Reschedule/Cancellation Policy

Integrated Health & Wellness Center, P.C. has a 24 hour rescheduling/cancellation policy

If you miss your appointment, cancel, or change your appointment with less than 24 hours notice you will be charged the following:

Office Visit $50.00
Massage Therapy Visit $50.00
Personal Training Visit $50.00
Laser Visit $200.00

This policy is in place out of respect for our therapists and our patients.

Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

All Monday appointments must be rescheduled by Friday 5:00 PM.

By signing below, you acknowledge that you have read and understand the Rescheduling/Cancellation Policy for Integrated Health & Wellness Center, P.C. as described above.

Failure to sign this agreement will prevent us from scheduling these services in advance.

Thank you for understanding and your cooperation.

____________________________ ____________________________
Printed Name Signature

____
Date

INTEGRATED
HEALTH & WELLNESS CENTER, P.C.

Medical Information Release Form
(HIPAA Release Form)

Printed Patient Name: ______________________ Date of Birth: ______________

Release of Information
(check one of the following boxes to allow or not allow the release of information)

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be release to (check one or more of the following):

☐ Spouse ______________________

☐ Child(ren) ______________________

☐ Other ______________________

☐ Information is not to be released

Voicemail Messages

Please Call (check one): ☐ my home ☐ my work ☐ my cell number

Print Number Here: ______________________

If unable to reach me (check one or more of the following):

☐ You may leave a detailed voicemail message

☐ Please leave a message asking me to return your call

☐ Other: ______________________

The best time to reach me is AM or PM (circle one) between the hours of (time) ______________

This *Release of Information* will remain in effect until terminated in writing by (me) the patient.

____
(Patient Signature)

____
(Date)

____
(Witness Signature)

____
(Date)

INTEGRATED
HEALTH & WELLNESS CENTER, P.C.
855 Springdale Drive Suite 120
Exton, Pa 19341
Phone: 610-561-6100 Fax: 610-524-0133

AUTHORIZATION TO RELEASE INFORMATION

I authorize and request the release of my records and/or exchange of information regarding services received from:

Provider: ____

Phone: ______________________ Fax: ______________________

Release records to Integrated Health & Wellness Center P.C.

The specific information to be disclosed is:

- Complete Health Record
- History and Physical Exam
- Laboratory, Radiology and Other Test Results
- Progress Notes
- HIV/AIDS Information
- Drug and Alcohol Treatment Information
- Other/Specify ______________________

The purpose for Disclosure is:

- Continuity of Care
- Case Consultation
- Determination of Insurance benefits
- Other Specify______________________

This consent is subject to written revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate in twelve months from the date of patient signature below. I have carefully read and understand the above statements. I voluntarily consent to disclosure of the above information about, or records of my condition to the person/s or agency/s names above. I understand that my records are protected under Federal Law 42 U.S.C 290 dd-2. Federal Regulation 42CFR Part 2. PA State Law 71 P.S. 1690. 108 (Act 63) and PS State Regulation 28 PA Code Subsection 709.28 and 4 PA. Code Subsection 255.5 governing the Confidentiality of Alcohol and Drug Abuse Patient Records and my records are protected by the Confidentiality of HIV Related Information Act 148.

Patient Name______________________ SS#______________________ DOB:______________

______________________ ______________________ ______________

Signature of Patient or Responsible Person Signature of Witness Date

INTEGRATED
HEALTH & WELLNESS CENTER, PC

Patient Financial Policy

Integrated Health and Wellness Center is committed to providing the best possible care and service to its patients. In order to do this efficiently and avoid confusion between patient and provider, we have adopted the following financial policies. Complete understanding of patient financial responsibilities is essential for both patient and provider.

Unless you, the patient or your health insurance carrier has made other arrangements in advance, full payment is due at the time of service

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment, co-insurance, or deductible at the time of service.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and submit the claim for you on an assigned basis. You will be responsible for your portion and also any payments your insurance may deny.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Outstanding balances that are past due will be forwarded to a collection agency.

Missed Appointments

- If you need to reschedule an appointment, we ask that you notify our office at least 24 hours prior to the appointment time. We reserve the right to charge a missed appointment fee of $50 for each appointment that is not cancelled in a timely manner.

Returned Check Fee

- In the unlikely event that your check is returned for insufficient funds, you will be charged a $30 handling fee in addition to the initial check amount.

Minor Patients

- For all services rendered to minor patients, the accompany adult and/or legal guardian will be held responsible for the payment of the services provided.

By signing this form, I confirm that I have read and fully understand the terms of Integrated Health and Wellness Center's financial policy. I also understand that these policies are subject to change at any given time in the future.

____

(Patient Printed Name)

____________________________________ ____________________________

(Patient Signature and/or Legal Guardian Signature) *(Date)*