Integrated Health & Wellness Center, PC
211 Welsh Pool Road
Suite 100
Exton, PA 19341
610-561-6100

Todays Date: _____ Referred By: _____

Name: _____ DOB: ____/____/____ Sex: M F

Address: _____
Street City State Zip

SSN#: _____ Occupation: _____ Work Phone: _____

Employers Name & Address: _____

Cell Phone: _____ Home Phone: _____ Email: _____

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 the patient's bill)

Guarantor Name: _____ Policy holder SSN# : _____

Address: _____

Insurance Carrier: _____ Policy Number: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and I. Furthermore, I understand that the Integrated Health & Wellness Center, PC 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 & Wellness Center, PC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged 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 to me will be immediately due and payable. I hereby authorized the Doctor to treat my conditions as he or she deems appopriate and I give authority for these procedures 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 office, the Doctor's may recommend certain vitamin supplements and/or orthopaedics 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 & Wellness Center, PC notice of Privacy Practices for protected health information.

Patient Name Printed: _____ Patient Signature: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

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Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY (Circle One)

Alcoholistm	Yes	No	Epilepsy	Yes	No
Anemia	Yes	No	Heart Attack	Yes	No
Anxiety	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No
Bleeding Disorder	Yes	No	High Cholesterol	Yes	No
Cancer	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Migraine Headaches	Yes	No
Depression	Yes	No	Stroke	Yes	No
Drug Abuse	Yes	No	Thyroid Disease	Yes	No
Eating Disorder	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
Do you drink caffeine (tea/coffee)?	Yes	No
Do you use drugs now or in the past?	Yes	No

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

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medication, X-Ray Dyes, or other Substances:

_____
_____

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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 arrier 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 insurnace 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 insurnae may deny.
- In the even 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 willbe 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 understant 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)

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Medical Information Release Form
(HIPAA Release Form)

Printed Patient Name: _____ Date of Birth: _____

Release of Informtation
(Mark one of the following statements with an X to allow or not allow the release of information)

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

This information may be released for (Mark one or more of the following with an X) :

_____ Spouse _____

_____ Child (ren) _____

_____ Other _____

_____ Information is not to be released

Voicemail Messages

Please call (Mark with an X): _____ My home _____ My work _____ My cell number

Print Number Here: _____

If you are unable to reach me (Mark with an X)

_____ 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.

Signature: _____ Date: _____

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24 Hour Appointment Reschedule / Cancellation Policy / No-Show Policy

Integrated Health & Wellness Center, PC calls and confirmed appointments 24-48 hours in advance using the most recent number on file. If at any time your contact numbers changes, please notify the office.

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

Office Visit $50.00
Chiropractic Visit $50.00
Massage Therapy Visit $50.00

This policy is in place out of respect for our providers, therapists, and our patients. Cancellations with less then 24 hours notice are difficulty 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 or cancelled by 1:00pm on Friday.

By signing below, you acknowledge that you have read and understand the above policy. Failure to sign this agreement will prevent us from scheduling these services in advance.

Thank you for your understanding and cooperation.

_____(Printed Name)

_____(Signature)

_____(Date)