ACT Wellness Center
Alternatives • Chiropractic • Therapeutics

Dr. Carmelo F. Caratozzolo
Certified Chiropractic Sports Physician
Certified Chiropractic Extremity Practitioner
(703) 491-9355 • ACTWellness.com

NEW PATIENT HEALTH HISTORY FORM

WELCOME

Thank you for choosing **ACT Wellness Center**. As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you and your family the opportunity of improved health potential and wellness services in the future. We will be working together to help you and your family reach your health and wellness goals. We will conduct a thorough history and physical examination to decide if we can assist you. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better access the challenges to your health potential. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

When completing this form if you require assistance or need an interpreter, please initial here _____.

Patient Data

Today's Date: _____

Name _____ Social Security # _____

Address _____ Drivers License # _____

City _____ State ____ Zip _____

Phone: (H) _____ (Cell) _____ Marital Status: □Single □Married □ Divorced □Separated

E-mail _____ Spouse's Name _____

Date of Birth _____ (Age _____) Spouse's Social Security Number: _____

Sex: □ Male □ Female Spouse's Occupation _____

Name or Nickname I prefer to be called_____ Spouse's Business Phone: _____

Your Occupation _____

Work Address _____ Student at _____

Work Phone _____ □ Full-Time □ Part-Time

Other Addresses Where You Reside (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____ Phone _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/____ Phone: _____

Mother: _____ Date of Birth: ____/____/____ Phone:_____

Guardian: _____ Date of Birth: ____/____/____ Phone: _____

Who do you normally live with? □ Mother & Father □ Father □ Mother □ Legal Guardian □ None of these

Contact in case of emergency, Name: _____ Telephone # _____

Is any other friend or member of your family being treated in this office? _____

Who may we thank for referring you to our office? _____

Family physician's name _____

Please send a report to my family physician. □Yes □No

Is your condition or injury due to an accident or work-related cause? □ YES □ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? □ YES □ NO

Did it result from a *work-related* accident or cause? □ YES □ NO (briefly describe):

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur?

_____

Approximately, when did your injury or condition occur? ____/____/_____

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Insurance Information

Who is responsible for your bill? □You and: □Spouse □Workers' Compensation □Car Insurance □ Medicare
□Blue Cross/Blue Shield □ Other _____

Health Insurance (Name): _____ Health Card # _____

Insured Person's Name: _____ Insured Person's Date of Birth: _____

Does the policy holder have the insurance through his/her employer? □ YES □ NO

If yes, who is the employer? _____

Your Health Profile

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	YES	NO	UNSURE		YES	NO	UNSURE
●Did you have any childhood illnesses?	□	□	□	●Was there any prolonged use of			
●Did you have any serious falls?	□	□	□	medicine such as antibiotics or			
●Did you play youth sports?	□	□	□	an inhaler?	□	□	□
●Did you take / use any drugs?	□	□	□	●Did you suffer from other traumas			
●Did you have any surgery?	□	□	□	(physical or emotional)?	□	□	□
●Have you fallen / jumped from a height				●Were you vaccinated?	□	□	□
over 3 feet? (i.e. cribs, beds, trees)	□	□	□	●As a child were you under regular			
●Were you involved in any car accidents				chiropractic care?	□	□	□
As a child?	□	□	□				

Your Comments: _____
_____

Adult Years (18 to present)

	YES	NO		YES	NO
●Do / did you smoke?	□	□	●Do / did you play adult sports?	□	□
●Do / did you drink alcohol?	□	□	●Do / did participate in extreme sports?	□	□
●Have you been in any accidents?	□	□	●Have you had any surgery?	□	□

On a scale of 1 – 10 describe your stress level (1 = none / 10 = extreme): Occupational _____ Personal _____
On a scale of Poor, Good, Excellent describe your:
Diet _____ Exercise _____ Sleep _____ General Health_____
Are you presently taking any vitamins, herbs, or over the counter products (aspirin included)? □ Yes □ No
If yes, name them _____
Are you allergic to anything you are aware of? _____
_____

Have you ever had any cosmetic surgery, pacemaker, rods, clips, breast implants, etc.? _____Year _____
Do you have any reason to believe that you may be pregnant? □ Yes □No □Uncertain
Date of last menstrual period _____
Your Comments: _____
_____
_____

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In the past 14 days have you experiences any of the following symptoms?

- ❒ Headaches
- ❒ Neck Pain
- ❒ Sleeping Problems
- ❒ Back Pain
- ❒ Nervousness
- ❒ Tension
- ❒ Irritability
- ❒ Chest Pains
- ❒ Dizziness
- ❒ Face Flushed
- ❒ Neck Stiff
- ❒ Pins & Needles in Legs
- ❒ Pins & Needles in Arms
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Shortness of Breath
- ❒ Fatigue
- ❒ Depression
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Ears Ring
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Loss of Smell
- ❒ Loss of Taste
- ❒ Diarrhea
- ❒ Feet Cold
- ❒ Hands Cold
- ❒ Stomach Upset
- ❒ Lost sight in one eye
- ❒ Constipation
- ❒ Drooping eyelid
- ❒ Chest pain
- ❒ Difficulty swallowing
- ❒ visual disturbances
- ❒ Pass out easily
- ❒ Loss of Balance
- ❒ Night sweats
- ❒ Rapid eye movement
- ❒ Buzzing in Ear
- ❒ Slurred speech
- ❒ Vertigo (dizziness)
- ❒ nausea
- ❒ Take birth control pills
- ❒ Difficulty in arranging words properly
- ❒ Double vision recently
- ❒ Ringing in your ears
- ❒ Nagging cough

❒ Have a headache or head pain that is unlike any you have had before.

Do you have any health problems not listed above? _____

Family History

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse_____
Mother_____
Father _____
Brothers / Sisters_____
Others_____

Did you mother or father have any of the following: Put an **M** for mother, **F** for father and **B** for both.

( ) High Blood Pressure ( ) Ulcer or Stomach Problems ( ) Heart Attack
( ) Emphysema ( ) Seizure-Convulsions ( ) Arthritis-Rheumatism ( ) Cancer
( ) HIV Positive ( ) Mental Illness ( ) Asthma ( ) Diabetes
( ) Thyroid Disease ( ) Circulation Problems ( ) Kidney Disease
( ) Stroke (Please indicate age when stroke occurred, Mother _____ Father _____)

Comments: _____

Current Complaints or Reason for Your Visit Today — Please be as specific as you can.

<u>If you have no symptoms or complaints</u>, and are here for wellness services, please initial here: _____ "I Wish to have Chiropractic Wellness Services" and skip to section "My First Visit".

Others need to describe the chief area of complaint and the effect it has had on your life.
Major complaints and symptoms _____
Pain or Problem started on_____
Pains are: □Sharp □Dull □Constant (more than 75% present) □Intermittent (less than 25% present)
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Have you ever had this condition before or a similar condition? _____
When? _____
Is this condition getting progressively worse? _____

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What positions or activities aggravate your condition? _____
What positions or activities relieve your condition? _____
Have you lost any work? _____ Day and date you last worked _____
Have you ever been treated by a Medical Physician for this ailment? _____
Where? _____
Describe the type of treatment _____
Diagnosis of previous physician _____
Length of time under care_____ Results _____
Have you had Spinal x-Rays, MRI, CT Scan for your area(s) of complaint? □Yes □No
Dates Taken: _____ What areas were taken? _____
Any home remedies? _____
What medications are you taking? _____
How Long? _____
Have you had surgery? _____ What? _____ When? _____
What side effects have you experienced from the drugs and surgery? _____

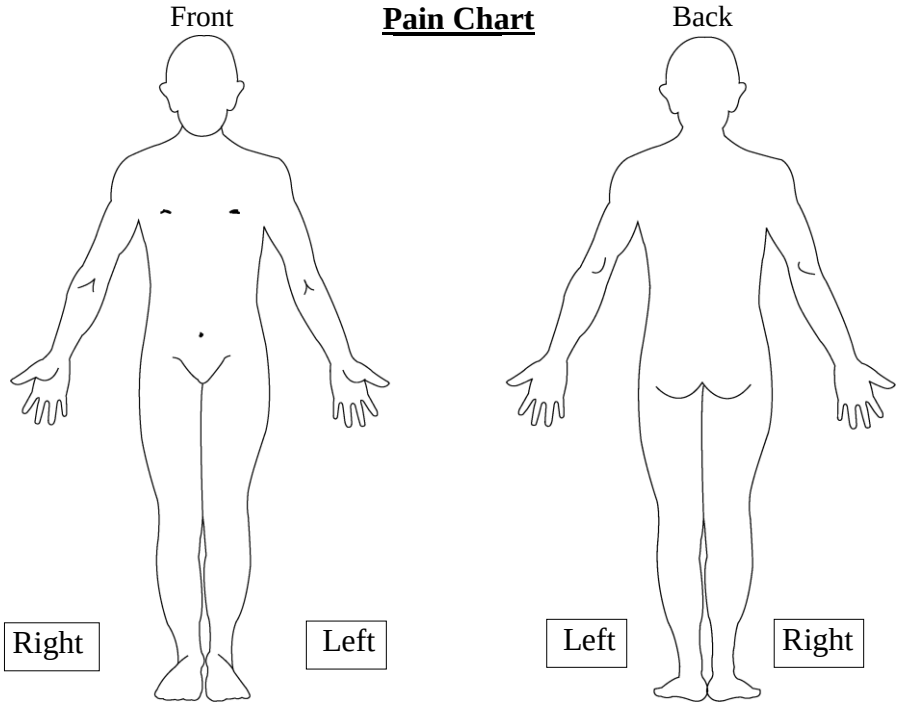
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

1. Mark the areas on this body where you feel the described sensations.
2. Use the appropriate symbols on the pain chart.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	000000	xxxxxx	*******	/ / / / / / /
- - - - - -	000000	xxxxxx	*******	/ / / / / / /

3. Mark areas of radiation.
4. Include all affected areas.
5. Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Your Comments: _____

This Box is for Office Use Only.
BP:_____ /_____ Pulse: _____ Weight:_____ Height: _____ CA Initials:

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Your First Visit...

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

Notice: Identity theft is a criminal act that may result in prosecution by the law. If medical treatment is obtained using a fraudulent identity, the potential exists for the medical records of the victim to become mixed with the medical history of the criminal who obtains the services. In order to reduce the risk of identity fraud we are requesting that you provide proof of your identity prior to treatment. We will request two (2) types of identification, one of which has been issued by a state or federal agency.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

As a result of my chiropractic care, I would like to... **(Check all that apply)** □ Feel better quickly
□ Have a healthier spin □ Live a healthier lifestyle □ Have a healthier body by keeping my nerve system healthy

If you wish to have a third person or chaperone present during your examination & treatment initial here: _____.

_____ _____
Signature Date

_____ _____
Consent to Treat a Minor / Guardian Signature Date

IN COMPLIANCE WITH MEDICARE REQUIREMENTS FOR THE GOVERNMENT EHR INCENTIVE PROGRAM, CMS REQUIRES PROVIDERS TO REPORT BOTH RACE AND ETHNICITY:

RACE (CIRCLE ONE): AMERICAN INDIAN OR ALASKA NATIVE / ASIAN / BLACK OR AFRICAN AMERICAN / WHITE (CAUCASIAN) NATIVE HAWAIIAN OR PACIFIC ISLANDER / OTHER / I DECLINE TO ANSWER

ETHNICITY (CIRCLE ONE): HISPANIC OR LATINO / NOT HISPANIC OR LATINO / I DECLINE TO ANSWER

Chiropractic Assistant's Observations: _____

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TERMS OF ACCEPTANCE & ASSIGNMENT

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, (print name) _____ have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____ _____ _____
Patient Signature Date *Parent / Guardian Signature* *Date*

ASSIGNMENT OF INSURANCE BENEFITS

I, (print name) _____ understand that my Payer may not pay for all of my care, even services that the ACT Wellness Center deems medically necessary. I agree that I will be responsible for verifying and understanding my own coverage and benefits. Right now, it appears that the following items or services may not be covered. I understand that there may be other items or services that are not covered and that if I have any questions, I will contact my Payer for more details. I agree that I am personally and fully responsible for all services rendered by ACT Wellness Center, including care which my Payer may determine is not medically necessary.

ASSIGNMENT OF INSURANCE BENEFITS: AUTHORIZATION
I authorize and direct that payment be made directly to: ACT Wellness Center / Dr. Caratozzolo C.C.S.P., C.C.E.P., 14111 Minnieville Rd., Woodbridge VA. 22193. For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_____ _____ _____ _____
Patient Signature Date *Parent / Guardian Signature* *Date*

RELEASE OF INFORMATION: I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan of Medicare.

_____ _____ _____ _____
Patient Signature Date *Parent / Guardian Signature* *Date*

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INFORMED CONSENT - Chiropractic Adjustments & Care
ACT Wellness Center, 14111 Minnieville Rd., Woodbridge VA 22193
Dr. Carmelo Caratozzolo C.C.S.P., C.C.E.P.

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Patient's Name: _____

Instructions: This document relates to your Informed Consent for care.
Please read carefully before signing.

General: I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition.

I understand that while the Care Plan lists you as the "Rendering Provider," at any moment, other associates or staff in your office with appropriate scopes of practice and training may need to provide the Recommended Care based on factors which are not necessarily within anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnoses and treatment and that the licenses of the primary Rendering Provider are listed below.

I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgment within your scope of practice during the course of the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities that would otherwise not come to your attention, as well as any pathological defects, illnesses, or deformities I may be experiencing.

Possible Risks of the Care; Alternatives

Chiropractic manipulation / adjustment. As with any healthcare procedure, I understand that there are certain complications, although rare, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as "rare."

X-Rays. I have been advised that x-rays can be hazardous to an unborn child. **To the best of my knowledge. I am not pregnant.**

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Other Potential Alternatives. I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; hospitalization with traction; and surgery.

Contraindications to Manipulation / Adjustment. I understand that you will not give me an adjustment / manipulation, x-rays, modalities, or therapies if you feel that such are contraindicated. In the event that the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

Definitions. "You" and "office" refer to any provider who renders care to me at the Location above. "Care" includes all care outlined in my Care Plan as well as any other care I receive from you in the future, including care related to other conditions.

Patient's Consent. I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and also all of the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all of the questions that I have, and have no additional questions and all my questions have been answered fully and satisfactorily. I voluntarily and knowingly elect to receive the recommended Care.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

Signature of Parent / Guardian / Authorized Representative: _____
Printed Name of Parent / Guardian / Authorized Representative _____ *Date:* _____

To be completed by Chiropractic Assistant_____
(CA Signature: witness to patient's signature & date)

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ABOUT YOUR COVERAGE & VERIFICATION OF BENEFITS POLICY

Insurance companies can be your best friend – or your worst enemy, particularly if you do not comply with their guidelines.

Since every insurance plan has its own special requirements, it is impossible for us to be familiar with each and every plan. Therefore, we must look to you, the patient, to assume the responsibility of knowing what your insurance coverage is. As a courtesy, we verify your insurance coverage during your first week of care. We cannot predict what they may pay for a particular service and you are ultimately responsible for knowing your benefits, the patient is always responsible for payment for any services rendered.

Unfortunately if your insurance carrier makes a mistake, by providing you with the wrong information, they are protected by legal disclaimers. That means, if your health benefits are misquoted, the insurance company does not have to pay according to what was stated. That is why we highly recommend that you call customer service to ask them to explain your chiropractic benefits. The number is on the back of your insurance card. **Only you, the policy holder, can affect how they choose to behave, because of the contractual relationship that exists between the two of you.**

It should be pointed out that our contract for services is with you, the patient. We work for you; not for your insurance company. ACT Wellness Center provides the best services that we are capable of providing and expect that payment for those services be made as promptly as possible. It is important, therefore, for you to become an informed consumer relative to your insurance coverage. **As always Co-pays and Co-insurances are due at the time of service.** If the information received by us, from your insurance company is ever incorrect, we will try our best to remedy the situation; however, the resultant bill is still your responsibility.

If your insurance company requires pre-certification or pre-authorization for any services, **it is your responsibility to obtain the authorization** and notify the doctor, as well as to provide ACT Wellness Center with the proper forms and to monitor the number of approved visits. (Please contact your Primary Care Doctor's office if you have any questions about pre-certification. On most insurance cards there is a telephone number listed to call which can help you in understanding your coverage and exactly what needs to be obtained for certain services.)

We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office immediately so that new arrangements can be made. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.
We hope this clarifies our billing policy. If you have any further questions, please do not hesitate to ask. We are here for you, and it is our pleasure to be of service to you.

I, _____ (print patient name) have read, understand and agree to the above office policy.

_____ _____ _____ _____
Patient Signature Date *Parent / Guardian Signature* *Date*

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PATIENT FINANCIAL POLICY

Your understanding of our financial policies is an essential element of your care and treatment. We are committed to providing you with the best chiropractic care possible and have established our Financial Policies to achieve that goal. If you have any questions, please discuss them with our front office staff or supervisor. In accepting care, you agree to the following:

Fee Schedule

Consultation……..... N/C	Cold Laser Session..... $30.00
Initial Exam/Computer Scan……..... $52.00-$144.10	Cold Laser Package of 6..... $150.00
Dynamic Exam/Computer Scan…….... $53.50-$98.60	Wellness/Corrective Adjustment Plans.... $100 - $500 per month
X-Rays (per view)..... $28.33-$33.00	Intersegmental Traction.....…... $22.55
Chiropractic Adjustment(s)……..... $50.00-$55.00	Electronic Muscle Stimulation…….…… $33.00

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check. I acknowledge responsibility for my account and guarantee payment of all charges against the account.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- I understand that this chiropractic office will assist me with any information, necessary reports or forms needed for me to personally file for reimbursement from my carrier.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $35.00 for all returned checks. Your insurance company does not cover this fee.
- I authorize ACT Wellness Center to release necessary information to my insurance carrier.
- I authorize ACT Wellness Center to accept assignment of benefit.

I understand that my Payer may not pay for all of my care, even services that the Office deems medically necessary. I agree that I will be responsible for verifying and understanding my own coverage and benefits. Right now, it appears that the following items or services may not be covered. I understand that there may be other items or services that are not covered and that if I have any questions, I will contact my Payer for more details. I agree that I am personally and fully responsible for all services rendered by the Office, including care which my Payer may determine is not medically necessary.

Printed Name of Patient/Responsible Party _____

_____ _____ _____ _____

Patient Signature Date *Parent / Guardian Signature* *Date*

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NOTICE OF PRIVACY POLICIES

This Notice briefly describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review It Carefully. For a more complete description of such uses and disclosures, please refer to ACT's Posted Notice of Privacy Practices. Copies are available… just ask!

Our commitment here at ACT Wellness Center (ACT) is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information (PHI). We here at ACT are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Policies. During the course of serving your interests it may be necessary to share information such as treatment, payment and healthcare operations with other Health Care Providers or Business Associated. For payment purposes, we do electronic billing; your information is protected by a firewall system. Your file is a personal record and will not be released without your signature.

With my consent, ACT may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ACT's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. ACT reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ACT's Privacy Officer, Christina Caratozzolo at 14111 Minnieville Rd., Woodbridge, VA 22193 / (703) 491-9355 / Fax: (703) 490-2298.

With my consent, ACT may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Also, ACT may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. ACT may e- mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements During treatment, if you feel the need for a private adjustment ACT can accommodate.

I have the right to request that ACT restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. As provided for by law, I may revoke this written authorization at any time. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ACT may decline to provide treatment to me.

If you have any questions, comments or concerns regarding your Protected Health Information, feel free to contact our Compliance Officer, Christina Caratozzolo at (703) 491-9355.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

"You May Refuse to Sign This Acknowledgement"

I have read, understand and received or reviewed a copy of the Notice of Privacy Policies for ACT Wellness Center. By signing this form, I am consenting to ACT's use and disclosure of my PHI to carry out TPO.

Printed Name of Patient/Responsible Party _____ Date of birth _____ Phone _____

_____	_____	_____	_____
Patient Signature	Date	*Parent / Guardian Signature*	*Date*

Comments, if any:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: □ *Individual refused to sign* □ *Communications barriers prohibited obtaining the acknowledgement* □ *An emergency situation prevented us from obtaining acknowledgement* □ *Other (Please Specify):*_____