New Patient Intake Form

Please fill out all questions thoroughly. Please Circle or mark "X" next to the YES/NO questions. If a question does not apply, please fill in the space with "No" or "None." Thank you.

Date:_______________________________

PERSONAL INFORMATION

Last Name:_________________________First Name:_______________________________MI___________

DOB: _______________________________Age: _________Ethnicity:__________________________

Address:____City:________________________________

State:________________ZIP:_________________________

Primary Phone #: _________________________Alternate Phone #:________________________

Email Address:____

Occupation:____SSN#_______________________________

Marital Status:______________Spouse's Name:____________________Phone #:____________________

Emergency Contact:_______________________Relation:____________________Phone #:____________________

How did you hear about this office?____

Primary Physician________________________________Physician Phone #_________________

Insurance Provider Name______________________________ID #_________________________

Have you ever visited a chiropractor before?____

Are you taking and BLOODTHINNERS? (Xarelto, Pradaxa, Warfarin, Eliquis, Coumadin, etc.)________________

Please list your health concerns in order of priority

1.____

2.____

3.____

4.____

5.____

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have were successfully solved? What would you be able to do? How would you feel?____

What do you believe is your greatest challenge in reaching your goals?____

And finally, what do you think you need to do in order for you vision of health to happen?____

PLEASE CHECK AND DESCRIBE ANY PROBLEMS OR CHANGE IN FUNCTION IN THE PAST OR PRESENT IN ANY OF THESE AREAS (the notes in parentheses are examples. Please don't limit your responses to these).

_____ Weight____

_____ Energy ____

_____ Sleep____

_____ Mood (e.g. anxiety, depression) ____

_____ Body temperature ____

_____ Headaches ____

_____ Visual changes or other eye conditions (e.g. styes, cataracts, glaucoma, double vision, floaters)
____
_____ Nose/sinuses (e.g. allergies, sinus infections)
____
_____ Mouth/teeth/gums (including dental procedures)
____
_____ Throat and lungs (e.g. recent or recurrent infections, asthma, COPD)
____
_____ Heart disease (e.g. rheumatic fever, chest pain, palpitations)
____
_____ Digestive tract problems (e.g. low appetite, constipation, diarrhea, bloating, hemorrhoids)
How often do you have a bowel movement?
____
_____ Stomach (ulcers, reflux, etc):
____
_____ Skin (eczema, infections, rashes) ____
_____ Musculoskeletal concerns (arthritis, joint pain, muscle pain, weakness, osteoporosis)____
_____ Urinary tract problems (infection, incontinence)
____
_____ Other: ____

In regards to your listed complaints, have you ever had…

Night Sweats?	YES_____	NO_____
Pain that wakes you up at night?	YES_____	NO_____
Unexplained weight loss?	YES_____	NO_____
Unexplained weight gain?	YES_____	NO_____
Bowel/Bladder problems?	YES_____	NO_____
Loss of sensation in the buttocks/inner thighs?	YES_____	NO_____
Headaches?	YES_____	NO_____
Recent Fever?	YES_____	NO_____
Pain with no position of relief?	YES _____	NO_____
Painful Urination?	YES_____	NO_____
Blood in the urine/stool?	YES_____	NO_____

GENERAL HISTORY INFORMATION

Height_____________________Weight_____________________________Usual Weight______________________
Lowest/highest weight in past 5 years:_________________/____________________________
Infections____
History of Cancer____
Hospitalizations? List when and why:____
____
Current Medications? List here: ____
____

Current Vitamins/Supplements? List here:____
____

Allergies of Food Sensitivities? List here:____

Previous Surgeries or Operations? List type and date here:______________________________________
____

History of sexually transmitted diseases?__________________________________

Personal History of:
Cancer: YES_____ NO_____ If yes, list what type and when:______________________________
Diabetes: YES_____ NO_____ If yes, when was it diagnosed?______________________________
Heart Disease: YES_____ NO_____ If yes, when was it diagnosed?____________________________
Stroke: YES_____ NO_____ If yes, when?____
History of eating disorders? List when and what:____

FAMILY MEDICAL HISTORY
To the best of your knowledge, has your mother, father, siblings, or grandparents ever had any of the following conditions? If so, list who and the age of onset.

High cholesterol ________________________Anxiety/Panic Attacks___________________
Arthritis ______________________________Ulcerative Colitis______________________
Alcoholism ____________________________Obesity______________________________
Thyroid Disease ________________________Asthma______________________________
Heart Disease __________________________Crohn’s Disease________________________
Kidney Disease _________________________Hypertension__________________________
Osteoporosis ___________________________Eczema______________________________
Stroke _________________________________Autoimmune Disease____________________
Cancer ________________________________Mental Illness_________________________
Allergies ______________________________Depression___________________________
Alzheimer’s ____________________________Diabetes_____________________________
Other:____

SOCIAL HISTORY
Stress Level: None______ Minimal______ Moderate______ High______

Physical activity at work: None______ Minimal______ Moderate______ High_____

What are your top 3 stressors?
____
____
How much do you think they impact your life? ____

Do you like your work?___________ How many hours do you work per week?_________________
How many hours do you have for relaxation/play per week?_______________________________
How much sleep do you get per night?____
Do you feel well-rested upon waking in the morning?______________________________________
How many days per week do you exercise?____
What type of exercise do you do?____

Alcohol use? How often? How much? ______________________________
Tobacco use? How often? How much? ______________________________
Recreational drug use? ______________________________
Sexual Activity? How many partners? ______________________________
Do you skip meals? YES_____ NO_____
If YES, explain further: ______________________________
Do you have times where you eat uncontrollably? YES_____ NO_____
If YES, explain further: ______________________________

Please mark if these apply:
Do you eat because you are:
_______Lonely _______Bored _______ Anxious ____________ Stressed____________Sad___________Depressed
___________Happy_____________ Angry____________________Tired
Where do you eat?
________ In the car___________ In bed_______ Watching TV________On the Computer
_______Reading______ Standing Up_________Sitting Down________When not Hungry

REVIEW OF SYSTEMS
Please circle or highlight any of the symptoms you have had previously of presently, regardless of the chief complaint.

Constitutional:
A. Recent weight change?_______________ B. Weakness, fatigue or chills?_____________
C. Convulsions?_____________ D. Fainting or Dizziness?________________
E. Tremors?______________ F. Difficulty Sleeping?____________ G. Nausea?________________

Eyes:
A. Difficulty seeing? _______________ B. Contact Lenses? ______________ C. Temporary loss of vision?________
D. Loss of or excessive tearing?___________

Ears, Nose, Throat:
A. Dentures ________________ B. Problems with hearing?_______________ C. Hoarseness?_____________
D. Pain or lump in the front of the neck?_____________ E. Vision problems?_________________
F. Discharge?_______________________

Cardiovascular:
A. Chest pain (heart pain, angina)?_______________ B. Known heart rhythm problems?______________
C. Leaky heart valves? _____________ D. Problems with circulation?____________________
E. High or low blood pressure?________________

Respiratory:
A. Chronic cough? _________________ B. Shortness of breath with exertion? ___________
C. Wheezing or asthma symptoms?______________ D. Coughing up blood or mucus? _____________
E. Wheezing or chest pain?_______________

Gastrointestinal:

A. Constipation/ diarrhea? ________________ B. History of jaundice? ____________________
C. Recent change in appetite? ___________________ D. Blood per rectum?______________________
E. Frequent heartburn or indigestion? _________________ F. Hemorrhoids _______________________
G: Gall bladder issues? _____________________ H. Vomiting /vomiting up blood?_____________________
I. Bloating? _________________ J. Loss of appetite/excessive appetite?____________________

Genitourinary:
A. Frequent bladder infections?___________________ B. Frequent nighttime urination?________________________
C. Incontinence? ___________________ D. Blood/pus in the urine?________________________
E. Kidney infection?________________________

Musculoskeletal:
A. Joint pain requiring medicine? ________________________ B. Calf or leg pain with walking?__________________
C. Arthritis? _________________ D. Pain/numbness? Where?______________________
E. Joint Swelling?__________________ F. Hernia?__________________

Skin:
A. Rashes? __________________ B. Skin Cancers?___________________ C. Ulcers?___________________
D. Other major skin problems? _________________ E. Bruise easily?_________________
F. Varicose veins?__________________

Neurological:
A. TIA's or minor stroke?__________________ B. Recent numbness or weakness?_______________
C. History of seizures?______________________ D. History of concussions?________________________

Psychological:
A. Depression? ______________ B. Anxiety? _________________
C. Other psychiatric problems?____________ D. Low energy levels?_____________________
E. Mood Swings?____________ F. ADHD/ADD?____________________________

Endocrine:
A. History of high or low blood sugar? ____________ B. Thyroid problems?_____________________

Blood/Lymph:
A. Bleeding tendencies/bruising, or frequent nose bleeds?_____________________
B. Any history of anemia? _________________ C. Do you have sickle cell disease?_______________________

Breasts:
A. Pain? _____________________ B. Discharge?______________________
C. Other changes or abnormalities?_______________________

DATE OF LAST (and reason for test)
A. Physical examination:___________________ B. Blood test:_______________
C. X-ray:_____________________ D: MRI:_____________________ E: Other imaging study:__________________________
F: Urine test:_______________________________________

FEMALES ONLY – Gynecological History:

A. Age of onset of menses:__________________ B. Age of menopause:_____________________
C. Age at first pregnancy:__________________ D. Number of children:____________________
E. Last menstrual period:__________________
F. Are you pregnant now? Yes_____ No_____
G. Is there a possibility you of becoming pregnant? Yes_____ No_____
H. Do you take birth control or have ever taken birth control? If yes, when and for how long?_____________
____
I. Hot flashes?______________________ J. Vaginal discharge?______________

Patient Name:______________________________DOB__________________Date__________________

Weekly Food Intake Log

Food **(Indicate which type if parentheses are present)**	**Daily**	**4-6x times per week**	**3 or less times per week**	**Rarely/ Never**
Vegetables				
Fruits				
100% Fruit Juice				
Smoothie				
Breads (Whole Grain or White)				
Cereals (Whole Grain or White)				
Pasta				
Rice (Brown or White)				
Potatoes				
Corn				
Other Whole Grains (ie. Quinoa)				
Poultry (Duck, Chicken, Turkey)				
Fish				
Shellfish (Shrimp, Lobster, Mollusks)				
Red Meat (Beef, Lamb, Pork, Veal)				
Deli Meat				
Meat Sauces, Casseroles, Stews				
Hamburgers				
Hot Dogs				
Beans, Legumes, Hummus				
Soy Foods (Tofu, Tempeh, Edmame)				
Veggie Burgers				
Plant-Based Meal Substitutes				
Nuts and/or Seeds				
Peanut Butter/ Other nut butters				
Milk (Dairy or Non-Dairy)				
Cream (Dairy or Non-Dairy)				
Cheese (Dairy or Non-Dairy) (Full or Low-Fat)				
Cheese (Vegan)				
Yogurt (Dairy or Non-Dairy)				
Eggs				
Oils (Indicate Types)				
Butter				
Margarine				
Chocolate				
Energy Bars				
Dining Out				

Food **(Indicate which type if parentheses are present)**	**Daily**	**4-6x times per week**	**3 or less times per week**	**Rarely/ Never**
Snack Foods (ie. Potato Chips/Corn Chips)				
Popcorn				
Sorbet and Ices				
Ice Cream/Frozen Yogurt				
Candy				
Canned Soups				
Frozen Meals				
International/Ethnic Foods				
Fast Food				
Pizza				
Take-Out Meals				
Soda (Regular)				
Soda (Diet)				
Water				
Seltzer/Club Soda				
Energy Drinks				
Sports Drinks				
Wine				
Beer				
Mixed Drinks				
Hard Alcohol				
Tobacco				

Symptom Questionnaire

Name____ Date______________________

Answer the questions below to the best of your ability. Mark either "Yes" or "No" for each of the questions listed. At the end of each category, mark how many answers you marked YES. Do your best to be as honest as possible, and your answers will dictate the strategies we use going forward. You will see duplicates of questions. That is intentional. Please do your best to answer as consistently and honestly as possible.

Category 1 (MCP):	**Yes**	**No**
1. I get headaches.		
2. I struggle with depression.		
3. I have cold hand & feet.		
4. I do not eat green leafy vegetables daily.		
5. Eating leafy greens makes me feel better.		
6. I excessively sweat when exercising.		
7. I occasionally get exercise-induced asthma.		
8. I have been diagnosed with hypothyroid.		
9. I do not tolerate alcohol well.		
10. I have a hair-trigger temper.		
11. I am often irritable.		
12. I have mood swings between depression and irritability.		
13. I feel generally tired.		
14. I have difficulty falling asleep.		
15. When I get irritated, I need some time to cool off.		
16. I get shortness of breath.		
17. One or more of my children are on the autism spectrum or have Down's syndrome.		
18. I suffer from menstrual cramping and have noticed clotting in my menstrual fluid.		
19. I have high homocysteine levels.		
20. I have high folate or B_{12} levels.		
Category 1 Score:	/20	
Category 2 (PC)	**Yes**	**No**
1. I have high blood pressure (just for reference, 120/80 is normal).		
2. I have cold hands and feet.		
3. I've noticed my memory has begun to fade.		
4. I have been diagnosed with Type II Diabetes Mellitus.		
5. I am asthmatic.		
6. I have mood swings.		
7. I have an autoimmune condition.		
8. I know I am chronically inflamed.		
9. I have a family/personal history of heart attacks.		
10. I have a family/personal history of strokes.		
11. I have a family/personal history of atherosclerosis.		
12. I was diagnosed with preeclampsia while pregnant.		
13. I am a mouth-breather.		

	Yes	No
14. I heal slowly following an injury or surgery.		
Category 2 Score:	/14	
Category 3 (LDCM)	**Yes**	**No**
1. I have generalized muscle pain.		
2. I am a vegan/vegetarian, or I do not eat beef, eggs, poultry, pork, or organ meats.		
3. I have had my gall bladder removed.		
4. My estrogen levels are low.		
5. I have a heavy metal toxicity.		
6. I have a history of gall stones.		
7. I have a personal/family history of fatty liver disease.		
8. I do not tolerate fatty foods well.		
9. I take antacids.		
10. I notice I have pain in the upper-right quadrant of my abdomen.		
11. I have pain/tightness in my right shoulder, by the scapula.		
12. I have a previous or current diagnosis of Small Intestinal Bacterial Overgrowth (also known as SIBO).		
13. I am postmenopausal.		
14. I do not eat many green leafy vegetables.		
15. My hair went gray at an early age.		
16. I have a history of asthma, diabetes, an autoimmune disease, inflammatory bowel disease, eczema, psoriasis, or another chronic condition.		
17. Following intense exercise, I feel better.		
18. Following a session in a hot sauna, I feel better.		
19. I gain weight even when I am eating right.		
20. I suffer from a neurological disorder.		
21. I am sensitive to chemicals and/or other smells.		
22. I know I have chronic inflammation.		
23. I have an autoimmune disease.		
Category 3 Score:	/23	
Category 4 (DCD)	**Yes**	**No**
1. I get headaches.		
2. I struggle with focusing or remaining attentive.		
3. I have the ability to work hard for weeks at a time, but feel sluggish after and need time to recover.		
4. When it is dark or during the winter, I am especially irritable.		
5. I have been told I have seasonal affective disorder.		
6. I am easily irritable.		
7. I have heavy menstrual bleeding.		
8. I have trouble falling asleep.		
9. Eating a high-protein diet makes me feel worse.		
10. I need coffee to function in the morning.		
11. I have weak bones.		
12. I suffer from PMS.		
13. I feel depressed often.		
14. I am very sensitive to pain.		
15. I have/ have a history of uterine fibroids.		

	Yes	No
16. When I get stressed, it is tough for me to wind down.		
17. I feel a rush after eating carbs, but return to a depressive mood fairly quickly thereafter.		
18. I have an addictive personality (spend time on your phone, gaming, smoking, etc.).		
19. I have an autoimmune disorder.		
20. I tend to worry often.		
21. I lack true motivation.		
22. I have or have a history of:		
23. I have or have a history of Bipolar disorder or panic disorder.		
24. I have or have a history of ADHD.		
25. I have or have a history of Fibroids.		
26. I have or have a history of Uterine cancer.		
27. I have or have a history of Schizophrenia		
28. I have or have a history of PMS.		
29. I have or have a history of Preeclampsia.		
30. I have or have a history of Depression.		
31. I have or have a history of Learning disabilities.		
32. I have or have a history of Parkinson's disease		
33. I have or have a history of Fibromyalgia.		
34. I have or have a history of addictive personality.		
35. I easily get stressed out, am anxious, or panicked.		
36. I fall asleep early.		
37. I wake up earlier than I would like to.		
38. I can focus for long periods of time.		
39. I feel like my heart rate rises and I hyperventilate/breathe faster when I am stressed out.		
40. I like to eat cheese/chocolate and/or drink wine, but do not feel 100% after consuming them.		
41. I often get migraines or headaches.		
42. I feel like I am addicted to carbohydrates.		
43. My focus and attention is unaffected following a carbohydrate-heavy meal.		
Category 4 Score:	/43	
Category 5 (AHR)	**Yes**	**No**
1. I am sensitive to alcohol, especially red wine.		
2. I am sensitive or allergic to many foods.		
3. I feel hot or irritable following eating.		
4. I get random intermittent joint pains.		
5. I do not tolerate fermented foods, like yogurt, kimchi, or sauerkraut well.		
6. I do not tolerate gluten well.		
7. I do not tolerate dairy well.		
8. I do not tolerate shellfish well.		
9. I do not tolerate chocolate well.		
10. I often take antihistamines.		
11. I do not tolerate most probiotics well.		
12. I react negatively to many different types of foods.		

	Yes	No
13. Sometimes I get tinnitus (ringing in the ears) following a meal.		
14. I have a previous or current diagnosis of Small Intestinal Bacterial Overgrowth (also known as SIBO).		
15. I frequently get heartburn.		
16. I frequently take antacids.		
17. I have a history of asthma or have trouble breathing.		
18. I have been diagnosed with ulcerative colitis.		
19. I noticed side effects from medications like NSAIDs, metformin, and antacids.		
20. I feel better 2-3 hours following eating.		
21. I get diarrhea for no particular reason from time to time.		
22. I have trouble falling or staying asleep.		
23. I suffer from exercise-induced asthma.		
24. My eyes itch often.		
25. I often get carsick/seasick.		
26. I frequently feel dizzy.		
27. I do not feel great in the 20 minutes or so following a meal.		
Category 5 Score:	/26	

NOTICE OF PRIVACY POLICIES
Effective Date: August 29, 2018

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:
Dr. Vincent Esposito
3023 Quentin Road
Brooklyn, NY, 11234
917-268-7377
drvincentesposito@gmail.com

OUR LEGAL DUTY:
We are required by applicable federal and state law to maintain the privacy of your health information. We reserve the right to change our policy. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available. You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information provided above.

USE AND DISCLOSURE OF HEALTH INFORMATION:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment for Services: We may use or disclose your health information to obtain payment for services provided to you.
Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, case management, review the competence of or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and other activities.
Required By Law: We will disclose your health information about you when required to by federal, state, or local law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe you are a victim of abuse, neglect, or domestic violence, or other possible victim of other crimes. We may disclose this type of information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.
Business Associate: We may disclose information to business associates who perform services on our behalf (such as billing companies), however we require them to appropriately safeguard your information.
Appointment Reminders: We may use or disclose your health information to contact you as a reminder (such as a voicemail, messages, email, postcards, or letters) that you have an appointment for treatment or medical care with Dr. Vincent Esposito.
PATIENT/CLIENT RIGHTS:
Access: You have the right to inspect and copy your health information, with limited exceptions. Submit your request in writing to Dr. Vincent Esposito. A fee will be charged for the costs associated with these requests. There are certain situations in which we are not required to comply with your request/. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.
Disclosures Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain activities, for the last 6 years but not before the effective date listed above. If you request an accounting more than once in a 12-month period, you will be charged a reasonable cost-based fee for responding to these requests.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.
Restrictions: You have the right to request we place additional restrictions on our use of your health information. We are not required to agree to these additional restrictions, but if we do, we still abide by our agreement (except in an emergency).
Alternative Communications: You have the right to request that we communicate with you about medical manners in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request alternative communications, you must request it in writing. We will accommodate all reasonable requests.
Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice at any time by contacting Dr. Vincent Esposito.

INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Inside Out Health & Wellness provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.

b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive email from their place of employment risk having their employer read their e-mail.

2. Inside Out Health & Wellness Email and Internet Policies:
It is our policy that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. We will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

3. Patient Consent
Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, all of our health coaching practitioners and upon written authorization other healthcare providers will have access to e-mail messages contained in protected personal health information.

b. Our practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. We at Inside Out Health & Wellness will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.

d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. We cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication. However, DrJockers.com is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

f. If consent is given for the use of e-mail, it is the responsibility of the patient to inform our staff of any type of information you do not want to be sent by e-mail.

g. It is the responsibility of the patient to protect their password or other means of access to email sent, or received, from our staff, to protect confidentiality. Inside Out Health & Wellness is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing. I understand that my consent to the use of e-mail may be withdrawn at any time by email, or written communication, to Inside Out Health & Wellness and I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with the use of email.

Health Coaching Policy

Inside Out Health & Wellness does not aim to diagnose or treat any sort of medical condition. We are not acting as primary care physicians at all and are not licensed to treat any medical condition. Instead, we provide health coaching to help people improve their health. Our health coaching does not substitute for a Doctor – Patient relationship and we encourage you to work and consult with your primary care physician before beginning any lifestyle change. With any sort of lifestyle change or use of nutritional supplements, there are risks, and although the chances are slim, your health may get worse during this process. Inside Out Health & Wellness does not take legal responsibility for any changes in your health but will work with you to get the best health outcome. I understand that the health coaches at Inside Out Health & Wellness are not diagnosing or treating any medical condition I may have. I also understand that there are risks to any lifestyle change and to taking supplements. I accept full responsibility for my health condition and for any risks that may come with following the instructions set out by Inside Out Health & Wellness.

QUESTIONS AND COMPLAINTS:

If you want more information about our privacy policies or have questions or concerns, please contact use using the information provided above.

If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your health information or in response to a request you may have made to amend or restrict the use of disclosure of your health information or to have use communicate with you by alternative means or at alternative locations, you may record a complaint to us by using the information provided at the beginning of this Notice. You may submit a request to the Secretary of the Department of Health and Human Services. We support the right to the privacy of your health information. If you file a complaint, we will not take any action against you or change our treatment of you in any way. We support the right to the privacy of your health information.

Your signature with date acknowledges that you have received and read Dr. Vincent Esposito's Notice of Privacy Practices.

Signature:____

Relationship to Patient:____

Print Name:____

Date:_________________________

Office Payment Policies

1. Member authorizes Inside Out Health & Wellness to charge the below credit card 6 monthly consecutive payments of $599 or a one-time charge of $3000 beginning with the date below for the member services set forth in this agreement. This agreement is non-transferable.
2. You are responsible for obtaining a referral if your insurance policy requires one. You will not be seen if you do not have a referral. If you want to be seen without a referral from an insurance provider, you then agree to pay the amount agreed upon for the initial visit and/or for a follow-up visit.
3. If your insurance company denies coverage or payment, you are financially responsible for the visit
4. If we are not a provider for your insurance, a superbill will be provided to you. You can submit the superbill to your insurance company for you to be reimbursed.
5. Payments can be made via cash, check, or credit card (Visa, MasterCard, American Express) via PayPal.
6. You will be responsible for the full fee or the first payment twenty-four (24) hours prior to the first appointment's scheduled time.
7. You will not be seen if you have an outstanding balance.
8. Outstanding balances after 60 days will be sent out to collection. When an account is sent out for collection, you are responsible for a 20% fee on the balance.

I have read, understand, and agree to these statements.

Signature____Date__________________

Payment Policy Statement

Payment for services is due 24 hours prior to the initial visit, unless other agreements have been made in advance. The payment will reserve your appointment time. This is done to ensure you receive the highest quality care possible. Your credit card will not be charged until 24 hours prior to the appointment. I accept major credit cards (Visa, Mastercard, American Express) through Paypal, Zelle, cash, and checks as forms of payment. If you are looking for a reimbursement claim from your insurance company, I will be happy to help with an insurance claim form, as I do not accept payments from third party providers directly. If your insurance company denies coverage, you are financially responsible for the payment of services provided.

I choose to pay a one-time fee of $3,000_________

I choose to pay 6 monthly payments of $599________

By signing, I understand the payment policy and abide with the customs stated above.

Payment Method: Visa_______ MasterCard________ AMEX_______

Cardholder Name: ____
Credit Card Number: ____
Exp. Date: ____________ Sec. Code: ___________

Credit Card Billing Address & Zip Code if different than above: ____

THE BELOW PARTIES HAVE EXECUTED THIS AGREEMENT FOR THE WRITTEN ABOVE

______________________________ Date__________________
Signature of Dr. Vincent Esposito

______________________________ Date__________________
Client Signature