Intake Form

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

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 #________________

Describe Problem	Mild/Moderate/Severe	Treatment Approach	Success?
Ex: postnasal drip	Moderate	Elimination Diet	Moderate
1.			
2.			
3.			
4.			
5.			
6.			

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have been 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?

____

____

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister

____

____

____

Do you have any pets or farm animals? If yes, do they live indoors or outdoors?

____

Have you lived or travelled outside the United States?

____

Have you or your family experienced any major life changes? If yes, please comment.

____

Have you experienced any major losses in life? If yes, please comment.

____

How important is religion (or spirituality) for you and your family's life?
a. _____ not at all important
b. _____ somewhat important
c. _____ extremely important

How much time have you lost from work or school in the past year?
a. _____ 0-2 days
b. _____ 3 –14 days
c. _____ > 15 days

Previous Jobs

____

____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:
a. Did you feel safe growing up?
________Yes ________No

b. Have you been involved in abusive relationships in your life?
________Yes ________No

c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
________Yes ________No

d. Do you currently feel safe in your home?
________Yes ________No

e. Do you feel safe, respected and valued in your current relationship?
________Yes ________No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
________Yes ________No

g. Would you feel safer discussing any of these issues privately?
________Yes ________No

Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
ILLNESSES	**WHEN**	**COMMENTS**
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		
q. High blood pressure (hypertension)		
r. Irritable bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic fever		
w. Sinusitis		
x. Sleep apnea		
y. Stroke		
z. Thyroid disease		
aa. Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
ab. Back injury		
ac. Broken (describe)		

Head injury

ae. Neck injury		
af. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag. Barium Enema		
ah. Bone Scan		
ai. CAT Scan of Abdomen		
aj. CAT Scan of Brain		
ak. CAT Scan of Spine		
al. Chest X-ray		
am. Colonoscopy		
an. EKG		
ao. Liver scan		
ap. Neck X-ray		
aq. NMR/MRI		
ar. Sigmoidoscopy		
as. Upper GI Series		
at. Other (describe)		

OPERATIONS	WHEN	COMMENTS
au. Appendectomy		
av. Dental Surgery		
aw. Gall Bladder		
ax. Hernia		
ay. Hysterectomy		
az. Tonsillectomy		
ba. Other (describe)		
bb. Other (describe)		

HOSPITALIZATIONS	WHEN	FOR WHAT REASON	OUTCOME

HAVE YOU TAKEN ANTIBIOTICS?	<5 Times	>5 Times
Infancy		
Teen		
Adulthood		

HAVE YOU TAKEN ANTIBIOTICS?	<5 Times	>5 Times

Infancy		
Teen		
Adulthood		

ARE YOU TAKING ANY MEDICATIONS?	**Date Started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Are you allergic to any medications? If yes, please list: ____

____

ARE YOU TAKING ANY SUPPLEMENTS?	**Date Started**	**Dosage**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Question	Yes	No	Unsure	Comment
Were you a full term baby?				
Were you breast fed?				
Were you bottle fed?				
As a child, did you eat a lot of sugar/candy?				

As a child, were there any foods that gave you symptoms? (Ex: milk- diarrhea and gas): ____________________

____

Please mark next to the food/drink that applies to your current eating habits.

	Usual Breakfast	Yes		**Usual Lunch**	Yes		**Usual Dinner**	Yes
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee (caffeinated)	
Decaf coffee or tea	
Cups of hot chocolate	
Caffeinated teas	
Diet sodas	
Ice cream	
Salty foods	
Takeout/ dining out	
White bread, rolls, or bagels	
Caffeinated sodas (energy drinks)	
Non-caffeinated sodas	

Are you on a special diet? ________Yes ________No

_______ ovo-lacto _________vegetarian ________other (describe): ____
_______ diabetic _________vegan
_______ dairy restricted ___________blood type diet

Is there anything special about your diet that we should know? _________ Yes ________No

Do you have symptoms *immediately after* eating (bloating, belching, sneezing, hives, etc)? _________ Yes ________No

If yes, are they associated with a specific symptom associated with the food/supplement, and explain further: ______
____
____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? _________ Yes _________ No

Do you feel worse when you eat a lot of:
________ High fat foods _________ High protein foods ________ High carbohydrate foods (bread, pasta, etc)
________ Refined sugars _________ Fried foods ________1-2 alcoholic drinks
_______ Other: ____

Does skipping a meal greatly affect your symptoms _______Yes _______No
If yes, please explain: ____

Have you ever had a food that you craved or really "binged" on over a period of time? _______ Yes ________ No
Food craving may be an indicator that you may be allergic to that food.
If yes, what food(s)? ____

Do you have an aversion to certain foods? _______ Yes ________ No
If yes, what foods? ____

Please fill in the chart below with information about your bowel movements:

a. Frequency	**Yes**	**b. Color**	**Yes**
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Thin, long, and narrow			
Small and hard			
Alternating between hard and loose or watery			

Do you have intestinal gas? _______ Daily _______ Occasionally _________ Excessively
Does it… _______ Present with pain ________ Smell foul ________ Has little or no odor

Do you drink alcohol?	Check the box that applies
Never used alcohol	
No longer drink alcohol	
Average 1-3 drinks per week	
Average 4-6 drinks per week	
Average 7-10 drinks per week	
>10 drinks per week	

Have you ever had a problem with alcohol? _______ Yes _______ No
If yes, please indicate the time period: ____

Have you ever used recreational drugs? ________ Yes _______ No

Have you ever used tobacco? ________ Yes _______ No
If yes, how many years have you been a nicotine user? ______________ Amount per day?____________________
Have you quit? If yes, what year did you quit? ____
What type of nicotine have you used (cigarette, cigar, pipe, smokeless, vaping)? ______________________
Are you regularly exposed to second-hand smoke? ____

Do you have any mercury amalgam fillings? If yes, how many? ________________________________
Do you have any artificial joints or implants (Ex: screws, plates, etc)? If yes, please elaborate: ______________
____
Are you sensitive to certain odors? If yes, please explain: ______________________________________
____
Do you feel worse at certain times of the year (Spring, Summer, Fall, Winter)? ______________________
To your knowledge, are you exposed to any toxic metals at work or at home (lead, mercury, cadmium, aluminum, arsenic)? ____
____

Overall how well have things been going for you?

	Very Well	Fairly	Poorly	Very Poorly	N/A
At school					
At work					
In your social life					
With sex					
With your attitude					
With your boyfriend/ girlfriend/ spouse					
With your children					
With your parents					

Have you ever had psychotherapy? If yes, please explain (include time, what kind, and if this treatment is ongoing):_
____
____

Are you married?__________________________________
Have you ever been married?____________________________

Are you divorced/separated? If yes, when: ___________________________
Did you remarry? ___________________________________
Comments: ____

Please explain any hobbies or leisure activities you enjoy: ______________________________
____
____

How many days per week do you exercise? ___________________________
How long are your exercise sessions?______________________________
What type of exercise do you enjoy? ______________________________
____

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:____

REVIEW OF SYSTEMS
Please answer the following as accurately as possible.

GENERAL	Mild	Moderate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			

HEAD, EYES & EARS:			
	Mild	**Moderate**	**Severe**
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problem			

MUSCULOSKELETAL:	Mild	Mod-erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			

TMJ problems			
MOOD/NERVES:			
	Mild	**Moderate**	**Severe**
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			

DIGESTION	**Mild**	**Moderate**	**Severe**
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating (lower abdomen)			
Bloating (upper abdomen)			
Blood in stools			

	Mild	Moderate	Severe
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at the corner of the lips			
Dentures			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in			
Upper abdominal pain			
Vomiting			

SKIN PROBLEMS:			
	Mild	**Moderate**	**Severe**
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Eczema			
Herpes- genital			
Hives			
Jock itch			
Lackluster skin			
Moles w/ size & color			
Oily skin			
Pale skin			
Patchy dryness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:	**Mild**	**Moderate**	**Severe**
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			

Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			
SKIN, DRYNESS	**Mild**	**Moderate**	**Severe**
Eyes			
Feet, cracking			
Feet, peeling			
Hair			
Hands, cracking			
Hands, peeling			
Mouth/throat			
Scalp			
Skin in general			
LYMPH NODES	**Mild**	**Moderate**	**Severe**
Enlarged, neck			
Tender, neck			
Other, enlarged/ tender			
NAILS	**Mild**	**Moderate**	**Severe**
Bitten			
Brittle			
Curve upwards			
Frayed			
Fungus- fingers			
Fungus- toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thick fingernails			
Thick toenails			
White spots/lines			

EATING	Mild	Moderate	Severe
Binge eating			
Bulimia			
Can’t gain weight			
Can’t lose weight			
Carb cravings			
Carb intolerance			
Poor appetite			

Salt cravings			
RESPIRATORY	**Mild**	**Moderate**	**Severe**
Bad breath			
Bad odor in nose			
Cough (dry)			
Cough (productive)			
Hay Fever			
Hoarseness			
Nasal stuffiness			
Post-nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR	**Mild**	**Moderate**	**Severe**
Angina, chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles, feet			
Varicose veins			
URINARY	**Mild**	**Moderate**	**Severe**
Bedwetting			
Hesitancy			
Infection			
Kidney disease			
Leaking			
Pain/burning			
Prostate enlarged			
Prostate infection			
Urgency			
REPRODUCTIVE (MALE)	**Mild**	**Moderate**	**Severe**
Discharge			
Ejaculation problems			
Genital pain			
Impotence			
Lumps in testicles			
Poor sex drive			
REPRODUCTIVE (FEMALE)	**Mild**	**Moderate**	**Severe**
Breast cysts			

	Mild	**Moderate**	**Severe**
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor sex drive			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
PREMENSTRUAL			
Bloating			
Breast tenderness			
Carb cravings			
Chocolate cravings			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
MENSTRUAL			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

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. We reserve the right, at our discretion, to change, modify, add or remove portions of these terms and conditions of use, at any time without giving prior notice. All changes will become immediately applicable to all users of this website. You should check these terms and conditions of use periodically for changes. By using this website after we post/publish any changes to these terms and conditions of use, you agree to accept and be bound by those changes, whether or not you have reviewed them. If you do not agree to these terms and conditions of use, please do not use our websites and, if applicable, please arrange to terminate your registration with us by notifying us of your unwillingness to accept the changes to the Terms and Conditions of Use.
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, insideouthealthwellness.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.

Terms & Conditions
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.

The information contained in this website has been prepared solely for the purpose of providing general information about , its partners and the services that they offer and no information given is an alternative to seeking professional medical advice where appropriate.

While every effort has been made to ensure that the information provided is accurate, it does not constitute any form of advice, recommendation, representation, endorsement or arrangement by Inside Out Health & Wellness.

The information presented is believed to be reliable but it is subject to change at any time without notice. Inside Out Health 7 Wellness does not guarantee its completeness or accuracy. By working together, you agree that Inside Out Health & Wellness will not be liable for any direct, indirect, or consequential loss arising from the use of the information and material contained in this website or from your access of other material on the internet via web links from this site.

Inside Out Health & Wellness RECOMMENDS THAT YOU ALWAYS CONSULT A MEDICAL PRACTITIONER BEFORE FOLLOWING ANY COMPLEMENTARY THERAPIES IF YOU HAVE ANY SYMPTOMS OF ILLNESS, HAVE ANY DIAGNOSED AILMENT, OR ARE RECEIVING CONVENTIONAL MEDICATION OR ANY TREATMENT FOR AN EXISTING CONDITION. DO NOT STOP CONVENTIONAL TREATMENT OR MEDICATION FOR ANY REASON WITHOUT CONSULTING A DOCTOR. ALWAYS INFORM BOTH YOUR DOCTOR AND YOUR COMPLEMENTARY MEDICAL PRACTITIONERS OF ANY TREATMENT, MEDICATION OR REMEDIES, BOTH CONVENTIONAL AND UNCONVENTIONAL THAT YOU ARE TAKING, OR ARE INTENDING TO TAKE. DO NOT DELAY IN SEEKING MEDICAL ADVICE AS A RESULT OF ANY INFORMATION OBTAINED FROM THIS WEBSITE WHICH SHOULD NOT BE REGARDED AS AN ALTERNATIVE TO MEDICAL ADVICE CONCERNING PARTICULAR MEDICAL CONDITIONS OR TREATMENTS.

WE WOULD ALWAYS ADVISE THAT YOU SEEK A PROFESSIONAL OPINION BEFORE COMMENCING ANY NUTRITIONAL SUPPLEMENTATION.

Inside Out Health& Wellness, OR ANY, OR ALL OF ITS DIRECTORS AND STAFF SHALL NOT BE HELD RESPONSIBLE FOR ANY CLAIMS RELATING TO ILLNESS OR AILMENTS OR DAMAGE THAT IS DEEMED TO HAVE POSSIBLY ARISEN AS A CONSEQUENCE OF USING ANY PART, OR ALL OF THE CONTENT PROVIDED ON THIS OR RELATED WEBSITES OR IN THE USE OF ANY PRODUCTS SOLD ON THIS WEB SITE. THE CONTENT IS PROVIDED FOR GENERAL USE, AND MAY BE INAPPLICABLE, UNSUITABLE OR BOTH TO PERSONS SUFFERING FROM CONDITIONS DIAGNOSED OR NOT.

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. 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.
2. If your insurance company denies coverage or payment, you are financially responsible for the visit
3. 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.
4. Payments can be made via cash, check, or credit card (Visa, MasterCard, American Express) via PayPal.
5. You will be responsible for the full fee or the first payment twenty-four (24) hours prior to the first appointment's scheduled time.

6. You will not be seen if you have an outstanding balance.
7. 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_________________