Integrative Healing at OM

W-holistic Nutritional Counseling

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Today's Date:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Phone #: _____ **E-Mail Address:** _____

How may we help you? *(Please check your reason(s) for seeking wellness services.)*

- ☐ Dietary advice.
- ☐ I would like to lose weight.
- ☐ Lifestyle advice (i.e., exercise, relaxation, meditation).
- ☐ I need investigations to help find out what is happening to my body.
- ☐ I would like to increase my energy.
- ☐ I would like advice about supplements and herbs.
- ☐ I have been diagnosed with a disorder/condition that I would like to manage naturally.
- ☐ For ongoing support and management. I understand this may take time to remedy.

List your primary wellness goals today: _____

_____

Your Height: _____ *and* Your Weight: _____ lbs.

How would you classify your diet or food routine? For example, "I eat everything." "I am a vegetarian." or "Junk food is my thing." _____

Number of meals and snacks on average daily: _____

Do you live independently? Married? Widowed? Partnered? Family with one or more children? A primary caretaker for a loved one? _____

_____

Do you have any medical problems? Health concerns or issues? Please list or indicate "none".

_____

_____

_____

Do you take any medications and/or supplements? (Including vitamins, minerals, powders, health drinks, sports drinks?) _____

_____

How much liquid do you consume in one day (estimate)? _____

How easy is it to concentrate, memorize, or recall? (Please describe) _____

_____

Do you exercise? ☐ Yes ☐ No How is your sleep? _____

Are you someone who is willing to make a change to improve your life? ☐ Yes ☐ No

Do you grow food at home? ☐ Yes ☐ No

Where do you generally shop for food and drinks? _____

Integrative Healing at OM

Medical History Summary

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Today's Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: Home #: _____ **Work #:** _____ **Cell #:** _____

Email Address: _____

Occupation: _____ **Spouse's Name:** _____

How did you hear about us?

☐ Friend (Name): _____
☐ Driving by ☐ Website ☐ Social Media ☐ Google.com ☐ Other: _____

Emergency Contact: _____
Name **Phone #** **Relationship to you**

Personal Physician: _____ **Phone:** _____

Please list your top 5 major health concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History:

Have you ever been hospitalized with an illness? If yes, Please describe: _____

Please check if you have a history of the following:

Have you had any of the following disorders?
- ☐ Heart Disease
- ☐ Hypertension (High blood pressure)
- ☐ Elevated cholesterol or other blood fats
- ☐ Hypoglycemia
- ☐ Thyroid problem. If yes, specify: _____
- ☐ Cancer
- ☐ Other: _____

Have you had any of the following surgeries?
- ☐ Abdominal
- ☐ Thyroid
- ☐ Surgery to correct obesity
- ☐ Other: _____

For Women Only:
- ☐ Pre-menstrual
- ☐ Having menses (LMP): _____
- ☐ Menopausal
- ☐ Post-Menopausal
- ☐ Pregnant

Health / Social Habits

Alcohol use? ☐ Yes ☐ No
Tobacco or other smoking material used? ☐ Yes ☐ No
Recreational drug use? ☐ Yes ☐ No
Other: _____

Please list any allergies or sensitivities to food, medication, or environmental: _____

_____

Please list any medications you currently take and for what conditions: _____

_____

Please list any natural supplements you currently take and for what conditions: _____

_____

I have read all the information on this sheet, have completed the above answers, and certify this information is true and correct to the best of my knowledge. I will notify this office of any change in health status or information of the above-named patient.

_____ _____
Patient Signature (Guardian Signature if patient is a minor) **Date**

Appointment Cancellation Notice

Dr. Maria Scunziano-Singh and Integrative Healing at OM, maintain a strict notice of cancellation policy. Please review the policy below and sign upon acceptance of this agreement and fee for any cancellation made with less than 24 “business” hours’ notice before the start time of the scheduled appointment.

A MISSED APPOINTMENT OR NO SHOW OCCURS WHEN A CLIENT FAILS TO GIVE AT MINIMUM 24 BUSINESS HOURS NOTICE IN ADVANCE (Saturday and Sunday are not considered business hours)

Reminder calls or emails are a courtesy, and you are ultimately responsible to keep or cancel your appointment in a timely fashion.

Any no show or late cancellation fee must be paid before or at the next appointment.

Late cancel or “no show” appointment charges are based on your specific appointment type and will range from $100 to $150 dollars per occurrence.

In the event of multiple no shows or late cancellations, management reserves the right to request prepayment prior to rescheduling.

In the event you have purchased a package and scheduled specific dates and times, each date is treated as a single appointment and charges incurred are based on the appointment type within the series and is not included in the package price reductions range.

If you have an appointment that requires multiple scheduled return visits and miss a specific prescribed return visit, rescheduling of the missed visit is at the discretion and direction of Dr.Scunziano- Singh and will be made according to staff availability. There will be no reimbursement of missed appointments as part of any package purchased.

We value your time and appreciate your business; we will do our best to schedule your appointments at the most convenient time for you. Please abide by our policies to ensure the best experience for you and our staff.

By Signing below, I am aware that Integrative Healing at Om will charge a fee ranging from $100 to $150 in the event of a no show or late cancellation of any appointment as described above.

_____	_____
Printed Name	DOB
_____	_____
Signature	Date

Consent to Treat

I, the undersigned voluntarily give consent to my INTEGRATIVE HEALING AT OM, LLC medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Printed Name _____ DOB _____

Signature _____ Date _____

Payment Agreement

Because many of the treatments used in complementary medicine are not recognized by consensus mainstream medicine, we cannot guarantee the amount or availability of coverage for our services and treatment under your health care insurance policy. You are responsible for the payment without regard to insurance coverage.

I have sought the services of INTEGRATIVE HEALING AT OM, LLC, its associates, employees, and staff. I understand this practice uses some diagnostic and treatment methods that are known as complimentary, alternative, and/or holistic and are not covered by insurance.

I fully understand that INTEGRATIVE HEALING AT OM, LLC, is a fee-for-service provider that **does not accept insurance, and payment for any services rendered is due at the time of service.**

Signature _____ Date _____

****

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, have received/reviewed a copy of the INTEGRATIVE HEALING AT OM, LLC Notice of Privacy Practices and the Florida Patient Bill of Rights.

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective Date: March 24, 2017

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. ✧ We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. ✧ We will say "yes" unless a law requires us to share that information.

Your Rights (continued)

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. • *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: ✧ Preventing disease. ✧ Helping with product recalls. ✧ Reporting adverse reactions to medications. ✧ Reporting suspected abuse, neglect, or domestic violence. ✧ Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ✧ For workers' compensation claims. ✧ For law enforcement purposes or with a law enforcement official. ✧ With health oversight agencies for activities authorized by law. ✧ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a comment or complaint about our privacy practices by:

1) Mail to Corporate Privacy Officer, 14690 Spring Hill Drive, Spring Hill, FL 34609 or email to jtriana@ahcpllc.com;

2) Email anonymously to youmatter@wellcomeomcenter.com;

3) Phone (352) 277-5276;

4) Written communication to the facility following the process outlined in our Company's Patient Rights documentation; and/or

5) Written communication to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You will not be penalized for filing a complaint.

Integrative Healing at OM

Florida Patient's Bill of Rights and Responsibilities
Florida Statutes Chapter 381(026)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.