

Boca Integrative Health, PA

A Group of Independent Professional Associations

7100 W. Camino Real, Ste. 207, Boca Raton, FL 33433 • Tel: 561-391-2770 • Fax: 561-391-2930

Physicians Healing Mind and Body

THANK YOU for contacting [*Boca Integrative Health*](#) to address the issues concerning your health. We are happy to help you, and please feel free to contact us with any questions.

[*Boca Integrative Health*](#) is a practice unlike any other. We offer, in the same office, board certified physicians in primary care, psychiatry and psychological testing. Although many of our patients see only one specialty in our office, some others benefit from having their challenges addressed by multiple specialists who collaborate and discuss the impacts of mind and body issues on their shared patients.

We also believe strongly that complete health and wellness are functions of mind and body, and part of that connection is good nutrition. Did you know, for example, that depression and fatigue can be caused by a micronutrient deficiency? We have the ability to perform extremely comprehensive micronutrient testing that is not commonly offered in physicians' offices. Please see our link to Comprehensive Micronutrient Analysis on our homepage. That link is very interesting- you can match your symptoms with possible micronutrient deficiencies or, conversely, you can look up a micronutrient and see what symptoms a deficiency can cause. Or, if you'd like to learn about the really exceptional nutrition products we offer or the books we recommend, please check out those links.

Enclosed are the initial documents to get you started with our office. We apologize for their length, but our care is comprehensive. You should also read our policies – they're important and determine the terms of our relationship.

Please look around the site, and we look forward to seeing you.

Good Health!

Boca Integrative Health

PATIENT INFORMATION FORM

Date: _____

Name: _____ Address: _____

Parents/Guardian: _____

Phone: H- _____

Phone: C- _____ W- _____

Employer: _____ Position: _____

School: _____ Level of Education: _____

DOB: _____ Age: _____ Race: _____ Height: _____

Weight: _____ Religion: _____

Marital Status: _____ Significant Other Name: _____

Name of Primary Insured: _____ Policy #: _____

Group #: _____ Pharmacy Name/Phone: _____

Social Security #: _____

Emergency Contact Name: _____ Phone: _____

Relation: _____

Source of Referral: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Date of last visit: _____

Prior/Current Therapist: _____ Phone: _____

Address: _____ Date of last visit: _____

Prior Psychiatrist: _____ Phone: _____

Address: _____ Date of last visit: _____

Self Assessment Form

To be filled out by or with Adolescent

I am here today because: _____

My symptoms include (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Can't sit still | <input type="checkbox"/> Troubling thoughts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Can't concentrate | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Can't work | <input type="checkbox"/> Feeling paranoid |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Can't eat | <input type="checkbox"/> Feeling out of control |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Eating too much | <input type="checkbox"/> Thought to harm other |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Distrustful |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Worrying too much | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> No pleasure | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> No energy | <input type="checkbox"/> Often confused/forgetful | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pain | <input type="checkbox"/> Headaches |

Medical History Form

Have you or your parents ever had or have any of the following:

You	Mom	Dad	
Y N	Y N	Y N	High Blood Pressure
Y N	Y N	Y N	Heart Trouble
Y N	Y N	Y N	Rheumatic Fever
Y N	Y N	Y N	Rheumatism or Arthritis
Y N	Y N	Y N	Kidney Trouble
Y N	Y N	Y N	Stomach or Duodenal Ulcer
Y N	Y N	Y N	Diabetes
Y N	Y N	Y N	Tuberculosis if yes, date of last TB test or chest x-ray_____
Y N	Y N	Y N	Asthma
Y N	Y N	Y N	Hay Fever
Y N	Y N	Y N	Allergies
Y N	Y N	Y N	Shortness of Breath
Y N	Y N	Y N	Rupture of Hernia
Y N	Y N	Y N	Cancer
Y N	Y N	Y N	Tumor
Y N	Y N	Y N	Skin Conditions
Y N	Y N	Y N	Anemia
Y N	Y N	Y N	Yellow Jaundice
Y N	Y N	Y N	Fainting Spells
Y N	Y N	Y N	Gall Bladder Problems
Y N	Y N	Y N	Epilepsy
Y N	Y N	Y N	Dislocation of

Joints

You	Mom	Dad	
Y N	Y N	Y N	Broken Bones
Y N	Y N	Y N	Back Pain
Y N	Y N	Y N	Back Injury
Y N	Y N	Y N	Knee Injury
Y N	Y N	Y N	Head Injury
Y N	Y N	Y N	Varicose Veins
Y N	Y N	Y N	Severe Headaches/Migraines
Y N	Y N	Y N	Eye or Ear Problems
Y N	Y N	Y N	Eating Disorder
Y N	Y N	Y N	Psychiatric History
Y N	Y N	Y N	Alcoholism or Drug Abuse
Y N	Y N	Y N	Thyroid Disease Or Endocrine problem

Have you ever had an injury which caused you to lose time from school? _____ If yes, please describe _____

Are you currently under a doctors care? _____ If yes, doctors name: _____

Phone #: _____ When was your last physical Exam? _____

Are you sexually active: _____ Type of birth control used: _____

Have you had any surgical procedures? _____ If yes, please list type and date: _____

Nutritional Patterns: How many meals do you eat, typically? _____ Describe a typical days food intake:

Do you have any allergies (including allergies to medications)? _____

Please describe any medical concerns you may have: _____

Has any biological relative been diagnosed with **ANY** psychiatric disorder? (please list relation - father, mother, aunt, etc and the disorder) Examples include: Anxiety Disorder, Depression, Bipolar Disorder, Manic Depression, Attention Deficit/Hyperactivity Disorder, Obsessive Compulsive Disorder, Schizophrenia, Developmentally Disabled or Mentally Retarded, Alzheimer's Disease or Dementia, Motor Tics, Tremors or Tourette's?

Please list all current medications (prescriptions or over-the-counter), vitamins or herbal remedies you regularly use: _____

The SNAP-IV Adolescent and Parent Rating Scale

James M. Swanson, Ph.D., University of California, Irvine, CA 92715

To be filled out by or with both parents

Check the column which best describes this adolescent:

	Not At All	Just A Little	Quite A Bit	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks	_____	_____	_____	_____
2. Often has difficulty sustaining attention in tasks and play activities	_____	_____	_____	_____
3. Often does not seem to listen when spoken to directly	_____	_____	_____	_____
4. Often does not follow through on instruction and fails to finish schoolwork, chores, or duties	_____	_____	_____	_____
5. Often has difficulty organizing tasks and activities	_____	_____	_____	_____
6. Often avoids, dislikes or reluctantly engages in tasks requiring sustained mental effort	_____	_____	_____	_____
7. Often losses things necessary for activities (e.g. toys, school assignments, pencils or books)	_____	_____	_____	_____
8. Often is distracted by extraneous stimuli	_____	_____	_____	_____
9. Often is forgetful in daily activities	_____	_____	_____	_____
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions	_____	_____	_____	_____
11. Often fidgets with hands or feet or squirms in seat	_____	_____	_____	_____
12. Often leaves seat in classroom or in other situations in which remaining seated is expected	_____	_____	_____	_____
13. Often runs about or climbs excessively in situations in which it is inappropriate	_____	_____	_____	_____
14. Often has difficulty playing or engaging in leisure activities quietly	_____	_____	_____	_____
15. Often is "on the go" or often acts as if "driven by a motor"	_____	_____	_____	_____
16. Often talks excessively	_____	_____	_____	_____
17. Often blurts out answers before questions have been completed	_____	_____	_____	_____
18. Often has difficulty awaiting turn	_____	_____	_____	_____
19. Often interrupts or intrudes on others (e.g. butts into conversations/games)	_____	_____	_____	_____
20. Often has difficulty sitting still, being quiet, in inhibiting impulses in the classroom or at home	_____	_____	_____	_____
21. Often loses temper	_____	_____	_____	_____
22. Often argues with adults	_____	_____	_____	_____
23. Often actively defies or refuses adult requests or rules	_____	_____	_____	_____
24. Often deliberately does things that annoy other people	_____	_____	_____	_____
25. Often blames others for his or her mistakes or misbehavior	_____	_____	_____	_____
26. Often touchy or easily annoyed by other people	_____	_____	_____	_____
27. Often is angry and resentful	_____	_____	_____	_____
28. Often is spiteful or vindictive	_____	_____	_____	_____
29. Often is quarrelsome	_____	_____	_____	_____
30. Often is negative, defiant, disobedient or hostile towards authority figures	_____	_____	_____	_____
31. Often makes noises (e.g. humming or odd sounds)	_____	_____	_____	_____
32. Often is excitable, impulsive	_____	_____	_____	_____
33. Often cries easily	_____	_____	_____	_____
34. Often is uncooperative	_____	_____	_____	_____
35. Often acts "smart"	_____	_____	_____	_____
36. Often is restless or overactive	_____	_____	_____	_____
37. Often disturbs other children	_____	_____	_____	_____
38. Often changes mood quickly and drastically	_____	_____	_____	_____

39. Often easily frustrated if demands are not met	_____	_____	_____	_____
40. Often teases other children and interferes with their activities	_____	_____	_____	_____
Check the column which best describes this adolescent:	Not At	Just A	Quite	Very
	All	Little	A Bit	Much
41. Often is aggressive to other children (e.g. picks fights or bullies)	_____	_____	_____	_____
42. Often is destructive with property of others (e.g. vandalism)	_____	_____	_____	_____
43. Often is deceitful (e.g. steals, lies, forges, copies the work of others, "cons others")	_____	_____	_____	_____
44. Often and seriously violates rules (e.g. is truant, runs away, completely ignores class rules)	_____	_____	_____	_____
45. Has persistent pattern of violating the basic rights of others or major societal norms	_____	_____	_____	_____
46. Has episodes of failure to resist aggressive impulses (to assault others or destroy property)	_____	_____	_____	_____
47. Has motor or verbal tics (sudden, rapid, recurrent, nonrhythmic motor or verbal activity)	_____	_____	_____	_____
48. Has repetitive motor behavior (e.g. hand waving, body rocking, or picking at skin)	_____	_____	_____	_____
49. Has obsessions (persistent and intrusive inappropriate ideas, thoughts or impulses)	_____	_____	_____	_____
50. Has compulsions (repetitive behaviors or mental acts to reduce anxiety or stress)	_____	_____	_____	_____
51. Often is restless or seems keyed up or on edge	_____	_____	_____	_____
52. Often is easily fatigued	_____	_____	_____	_____
53. Often has difficulty concentrating (mind goes blank)	_____	_____	_____	_____
54. Often is irritable	_____	_____	_____	_____
55. Often has muscle tension	_____	_____	_____	_____
56. Often has excessive anxiety and worry (e.g. apprehensive expectations)	_____	_____	_____	_____
57. Often has daytime sleepiness (unintended sleeping in inappropriate situations)	_____	_____	_____	_____
58. Often has excessive emotionality and attention-seeking behavior	_____	_____	_____	_____
59. Often has need for undue admiration, grandiose behavior or lack of empathy	_____	_____	_____	_____
60. Often instability in relationships with others, reactive mood, and impulsivity	_____	_____	_____	_____
61. Sometimes, for at least a week, has inflated self esteem or grandiosity	_____	_____	_____	_____
62. Sometimes, for at least a week, is more talkative than usual or seems pressured to keep talking	_____	_____	_____	_____
63. Sometimes, for at least a week, has flight of ideas or says that thoughts are racing	_____	_____	_____	_____
64. Sometimes, for at least a week, has elevated, expansive or euphoric mood	_____	_____	_____	_____
65. Sometimes, for at least a week, is excessively involved in pleasurable but risky activities	_____	_____	_____	_____
66. Sometimes, for at least 2 weeks, has depressed mood (sad, hopeless, discouraged)	_____	_____	_____	_____
67. Sometimes, for at least 2 weeks, has irritable or cranky mood (not just when frustrated)	_____	_____	_____	_____
68. Sometimes, for at least 2 weeks, has markedly diminished interest or pleasure in most activities	_____	_____	_____	_____
69. Sometimes, for at least 2 weeks, has psychomotor agitation (even more active than usual)	_____	_____	_____	_____
70. Sometimes, for at least 2 weeks, has psychomotor retardation (slowed down in most activities)	_____	_____	_____	_____
71. Sometimes, for at least 2 weeks, is fatigued or has loss of energy	_____	_____	_____	_____
72. Sometimes, for at least 2 weeks, has feelings of worthlessness or excessive, inappropriate guilt	_____	_____	_____	_____
73. Sometimes, for at least 2 weeks, has diminished ability to think or concentrate	_____	_____	_____	_____
74. Chronic low self-esteem most of the time for at least a year	_____	_____	_____	_____
75. Chronic poor concentration or difficulty making decisions most of the time for at least a year	_____	_____	_____	_____
76. Chronic feelings of hopelessness most of the time for at least a year	_____	_____	_____	_____

Check the column which best describes this adolescent:

	Not At All	Just A Little	Quite A Bit	Very Much
77. Currently is hyper-vigilant (overly watchful or alert) or has exaggerated startle response	_____	_____	_____	_____
78. Currently is irritable, has anger outbursts, or has difficulty concentrating	_____	_____	_____	_____
79. Currently has an emotional (e.g. nervous, worried, hopeless, tearful) response to stress	_____	_____	_____	_____
80. Currently has a behavioral (e.g. fighting, vandalism, truancy) response to stress	_____	_____	_____	_____
81. Has difficulty getting started on classroom assignments	_____	_____	_____	_____
82. Has difficulty staying on task for an entire classroom period	_____	_____	_____	_____
83. Has problems in completion of work on classroom assignments	_____	_____	_____	_____
84. Has problems in accuracy or neatness of written work in classroom assignments	_____	_____	_____	_____
85. Has difficulty attending to a group classroom activity or discussion	_____	_____	_____	_____
86. Has difficulty making transitions to the next classroom topic or classroom period	_____	_____	_____	_____
87. Has problems in interactions with peers in the classroom	_____	_____	_____	_____
88. Has problems in interactions with staff (teacher or aide)	_____	_____	_____	_____
89. Has difficulty remaining quiet according to classroom rules	_____	_____	_____	_____
90. Has difficulty staying seated according to classroom rules	_____	_____	_____	_____

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OFFICE POLICY STATEMENT

Agreement to its Terms of Treatment

Please read these policies *carefully* before initialing- by initialing or by not initialing but receiving care after having had opportunity to read them, you are agreeing to all of our terms of treatment!

Thank you for visiting our office. As a patient of [Boca Integrative Health, PA](#), you will enjoy medicine the way it should be practiced- with the goal of developing a strong doctor-patient bond and the good health that relationship creates. We work hard to create a positive and educational environment, and your comments are always welcome! Please also be aware of the following office policies.

OUR GENERAL POLICIES

CONFIDENTIALITY: Issues discussed during the course of evaluation, treatment or therapies are confidential. No information will be released to anyone (including third party payers, physicians, schools, etc.) without written consent from the patient, or if a minor, by the legal guardian of the patient. Often, third party payers will request information from the provider of services in order to determine eligibility for reimbursement. Please be sure to ask your insurance carrier about the type and amount of information that they might request before giving your written consent. It is important to understand that the release of confidential information with or without consent is required in situations of potential harm to oneself or others, in instances where the court may subpoena records and in cases of suspected child abuse. Whenever possible, you will be notified in advance prior to any such disclosure. The laws of the State of Florida require health professionals to report suspected cases of abuse (physical and/or sexual) and neglect to appropriate agencies.

ETHICS AND PROFESSIONAL STANDARDS: The doctor is committed to uphold the most responsible ethical and professional standards possible and is accountable to you. If you have any questions or concerns about your course of treatment please discuss them directly with her. By obtaining services here, you are agreeing that should you have any dissatisfaction or concerns about your evaluation or treatment or should you wish to change your medical provider, you will do your best to indicate that you are making a change and why you wish the change to be made. If you need help finding additional or alternative assistance, the doctor will do her best to help you locate a more suitable referral. If, during the course of your care and treatment, you have any questions about the nature of your treatment (i.e. goals, procedures, etc.) or our billing practices please feel free to ask.

OFFICE HOURS: Generally, Monday through Friday, 9-5. We may also be open some evenings.

TELEPHONE CALLS: The doctor is available (on a call back basis) to patients for a short (5-10 minutes) telephone consult, however, telephone calls should not be used as a substitute for an office visit. Significant telephone calls will be billed by the doctor at the doctor's sole discretion.

EXTENDED SESSIONS (Psych and Nutrition Patients): From time to time, particularly when an important issue is being explored, a session extends longer than originally planned or scheduled. Because psychiatry fees are based on time, in those instances when the session does run long the patient will be charged accordingly.

PRESCRIPTION REFILLS: Prescription refills are best obtained while you are at the office for an appointment and some circumstances do require this. However, in some cases, medications can be refilled in between appointments with the doctor's approval. Please provide 72 hours notice before you will run out of medication. No refills will be filled on weekends, holidays or after hours. **AGAIN, expect 72 hours for all phone refill requests and plan accordingly.**

IN-OFFICE PRODUCTS: As a medical professionals, the doctors research and are knowledgeable about certain products that they believe promote good health and recommend those products to patients. The price we charge offsets our costs of providing the product, and we do make a small profit on the purchase. However, the purchase of these products is a recommendation only, not a medically necessary prescription, and your use of the product is entirely up to you. If you wish to purchase the product you may do so either from our office or from another provider.

EMERGENCIES: *In case of an emergency, call 911 or go to the nearest Emergency Room!* If you need to speak with someone urgently, please try the office telephone number. If you reach voicemail follow the instructions to leave an urgent message. If you reach a secretary/receptionist, urgent calls will be relayed to the doctor as soon as possible. The doctor will be in touch as soon as she is able. In the event you are unable to reach the doctor quickly enough and you feel your needs have become emergent please go to the emergency room of your local hospital.

OUR FINANCIAL POLICIES

NON-INSURED PATIENTS (including patients whose insurance we do not accept): Non-insured patients are expected to pay in full with cash, check or credit card the day service is rendered unless specific arrangements are made in writing in advance.

WE DO NOT ACCEPT MEDICARE! If you have Medicare, please come to the window and speak with our staff.

INSURED PATIENTS (Family Medicine patients only): we accept assignment of benefits. This means that you must sign the portion of your insurance form that “assigns” payment to our office. *Most medical insurance plans DO NOT COVER 100% of the cost of your treatment.* Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your copay, deductible and/or coinsurance the day service is rendered.

We will *estimate* as closely as possible your coverage, but until we actually receive payment from the insurance company, *it is just an estimate.* We will *assist* you in dealing with your insurance company, but the ultimate responsibility for payment lies with you. After 45 days, any remaining balance not covered or received from your insurance company will be due in full from you.

KNOW YOUR INSURANCE- you are responsible for your insurance policy! Due to the vast variety of policies *even within the same insurance company*, and the constant changing of policies, we cannot be responsible for interpreting each individual policy. We will verify that you have a current and active insurance policy only. Therefore we urge you, the patient, to know your personal coverage and its limitations, as well as who is a provider on you plan. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company. **It is your responsibility to know, or find out, whether or not we are providers for your specific network.**

FORENSIC, REPORT OR LETTER FEES: Fees for reports or letters for disability insurance, employer, school, etc. will be based on the time required by the doctor for preparation. If the doctor must be involved in litigation because of

professional services provided to you please note that *the forensic fee will be different from the regular in-office fee. A retainer must be paid in advance based on an estimate of the minimum time that will be required for the services. Out-of-office services will be charged on a portal to portal basis.* The forensic fee will be applied to all services connected to the litigation, including but not limited to telephone conferences, depositions and court appearances.

NON-COVERED SERVICES (patients for whom we accept insurance): We provide medical care according to what our doctors believe is in the best interests of our patients- not what insurance companies believe is in our patients' best interest. Therefore, some recommended services may not be covered by insurance. You agree to pay for non-covered services (we will always try to tell you in advance if a service isn't covered).

CANCELLATIONS and MISSED APPOINTMENTS: *Twenty-four (24) hours notice of cancellation of an appointment is required for all appointments. Failure to keep the scheduled appointment or failure to cancel an appointment more than twenty-four (24) hours in advance will result in a charge of the normal fee for the expected service. Monday appointments must be canceled by 10AM on Friday to avoid this charge. In addition, in those cases where your visit is paid by a third party payor, you are personally responsible for cancellation charges even if the third party payor does not pay.* _____ (initial here)

NOTE: Patients responsible for keeping their own appointments but not responsible for payment; 1st no show – the person responsible for payment will be called to inform them that they are paying for an appointment you failed to show up to. 2nd no show – you will be responsible for payment in cash for missed appointment before you can be seen by the doctor again.

OFF-HOURS FEE: We may offer you an appointment outside of our normal business hours, including weekends or after 5:00 pm. This appointment may carry an additional fee. You understand and agree that is a non-insurance-covered convenience and administrative (non-medical) charge and that you have the option of scheduling an appointment during normal business hours without incurring the additional fee. You agree to pay this fee, up front, and understand that **this is in addition to any copay, deductible or other normal charge.** _____ (initial here)

COLLECTION FEES and COSTS: There will be a fee for returned checks and thereafter payment must be made with credit card or cash. In addition, in the event we must institute collection and/or court proceedings to collect unpaid fees (including missed appointments), you agree to pay, in addition to the outstanding fee, our costs and the value of any attorneys services incurred in the collection of those fees or any part thereof. Our settlement for a smaller amount than we initially demand shall not constitute a waiver of our right to recover full fees and costs. _____ (initial here)

PRIOR AUTHORIZATION FEE: Our doctors prescribe medication based on our knowledge and experience. We do not allow insurance companies to dictate our prescribing patterns. This means that while sometimes we may feel comfortable prescribing less costly generic medication (which may be on your insurance company's formulary list), sometimes we must insist on non-formulary or brand name medication. This decision is made by the doctor at the time the prescription is written. Prior authorizations, which should be unnecessary, take up valuable staff time. Consequently, there will be a charge for any prescription requiring a preauthorization, and you agree to have this charge automatically (i.e., without prior notice) added to your account. _____ (initial here)

PRACTITIONERS ARE INDEPENDENT CONTRACTORS: Our practitioners are independent contractors of Boca Integrative Health, PA. They and they alone are responsible for the care and treatment they render, and all clinical decisions are made by them. You acknowledge that the practitioners are not the actual, express or apparent agents of Boca Integrative Health, PA. _____ (initial here)

RETURNED CHECKS: There will be a fee for returned checks and thereafter payment must be made with credit card or cash. In addition, in the event we must institute collection and/or court proceedings to collect unpaid fees (including

missed appointments), you agree to pay, in addition to the outstanding fee, our costs and the value of any attorneys services incurred in the collection of those fees or any part thereof. Our settlement for a smaller amount than we initially demand shall not constitute a waiver of our right to recover full fees and costs.

Statement of understanding: Please ask before signing below or obtaining treatment if you have any questions about our office policies. Your signature below, or your receipt of services after having had an opportunity to read these policies and terms, constitute your agreement to our office policies.

I have read this contract and agree to its terms.

Printed name of patient

Signature of patient/guardian/guarantor

Date

Printed name of guardian/guarantor

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Consent for Purposes of Treatment and Healthcare Operations (HIPPA)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. BOCA INTEGRATIVE HEALTH, PA is not required to agree to the restrictions that I may request. However, if BOCA INTEGRATIVE HEALTH agrees to a restriction that I request the restriction is binding on BOCA INTEGRATIVE HEALTH.

I understand I have the right to review BOCA INTEGRATIVE HEALTH's Notice of Privacy Practices prior to signing this document, in accordance with HIPAA. The BOCA INTEGRATIVE HEALTH Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in performance of health care operations of BOCA INTEGRATIVE HEALTH. This notice of privacy practices also describes my rights and the duties with respect to my health care information.

My "protected health information" means health information, including my demographic information, collected from me or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

The following are waivers to confidentiality. Unless otherwise specified in writing, you agree to the following limited waivers and release of confidential information:

- 1. To the professional who referred you to our office. You agree that we may contact the individual or agency who referred you and may convey the following information: (a) the fact that you have been seen and evaluated; (b) treatment initiated and anticipated length of treatment; (c) your prognosis; (d) fitness for employment and participation in employment or treatment; and (e) updates as needed.**
- 2. For medication consultation. You agree that we may consult with your other healthcare providers. You authorize the release of information from your healthcare provider to me and vice versa to facilitate such consultation.**
- 3. For consultation with other medical professionals. From time to time, we may discuss with other medical professionals regarding a clinical issue. The medical professionals are bound by laws and confidentiality. You authorize the release of information we believe reasonably necessary to such a consultation. Generally, identifying data will not be released to the consulting clinician.**
- 4. To hospitals or agencies accepting the patient for medical or mental health care.**
- 5. To your insurer or its agent, or to any collections company, court or other entity, to the extent we believe necessary to obtain reimbursement or payment.**

I have read and had any questions satisfactorily answered:

Signature of Patient or Parent/Guardian

Date: _____

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7100 W. Camino Real, Ste. 207

Boca Raton, FL 33433

Tel: 561-391-2770 Fax: 561-391-2930

Office Policy Acknowledgement and Authorization to Charge Credit Card And Waiver of Confidentiality to Secure Payment

RE: _____ (Patient)

I, _____ (Print Name), guarantor, understand that our nutritional, psychiatric and psychological services do **not** accept my insurance and I agree to guarantee and fully pay the entire amount due for any and all services rendered by the practitioners associated with Boca Integrative Health, PA to either myself or to Patient. **I further understand that the office policy is that any appointment cancelled with less than 24 hours notice incurs the normal fee. Missed appointments (i.e., no-shows) are similarly charged and that I will pay such fees.**

I hereby authorize Boca Integrative Health, PA to charge my credit card without prior notice to me for any outstanding fees, including those incurred for cancelled/missed appointments. I further agree to maintain a current and valid credit card on file with Dr. Rome's office. This agreement shall remain in effect until cancelled by either myself or Dr. Rome's office, but Dr. Rome's office may charge the card for any fees owed at the time of cancellation to ensure a zero balance.

In addition to the above, patient hereby acknowledges and authorizes Boca Integrative Health to notify guarantor of any cancelled or missed appointments and to disclose to guarantor any confidential information necessary (in our sole discretion) to secure payment of cancelled/missed appointments or recommend future appointments. In other words, Boca Integrative Health, PA may call the parents and/or guarantors and disclose any information necessary to collect owed fees and/or to ensure that payment for future appointments will be made.

_____ (Patient)

CIRCLE ONE: Visa Mastercard AmEx

Credit Card # _____ Expiration date _____

Name on Card _____

_____ (Parent/Guarantor)