ADVANCED INTEGRATIVE MEDICINE

9305 KINGS HWY. KING GEORGE, VA 22485

Patient Name_____ Date: _____ Email: _____

SS #/SIN_____ DOB_____ Age_____ Home phone_____ Cell Phone _____

☐ Male ☐Female Check appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? ☐ Yes ☐ No

Do you have any Medical insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Name of Employer_____ Work Phone _____

Address of Employer_____ State _____ Zip_____

Insurance Company_____ Group #_____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **ADVANCED INTEGRATIVE MEDICINE** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

Health History

Patient Name: _____ **DOB:** _____ **Date:** _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____
_____
(What other associated problems have you been having?)

Modifying Factors _____
_____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO YES	Anemia	NO YES	Back Trouble	NO YES	Hepatitis	NO YES
Mumps	NO YES	Bladder Infection	NO YES	High Blood Pressure	NO YES	Ulcer	NO YES
Chicken Pox	NO YES	Epilepsy	NO YES	Low Blood Pressure	NO YES	Kidney Disease	NO YES
Whooping Cough	NO YES	Migraines	NO YES	Hemorrhoids	NO YES	Thyroid Disease	NO YES
Scarlet Fever	NO YES	Tuberculosis	NO YES	Asthma	NO YES	Bleeding Tendency	NO YES
Diphtheria	NO YES	Diabetes	NO YES	Hives	NO YES	Mitral Valve Prolepses	
Smallpox	NO YES	Cancer	NO YES	Eczema	NO YES		NO YES
Pneumonia	NO YES	Polio	NO YES	AIDS OR HIV	NO YES	Any Other Disease	NO YES
Rheumatic Fever	NO YES	Glaucoma	NO YES	Infectious Mono	NO YES	(Please List):	
Arthritis	NO YES	Hernia	NO YES	Bronchitis	NO YES	_____	
Venereal Disease	NO YES	Blood Transfusion	NO YES	Stroke	NO YES	_____	

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications: YES NO (If Yes, Please List Below)

_____
_____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			

CLINICIAN SIGNATURE: _____

DATE REVIEWED: _____

PATIENT NAME: _____

DATE: _____

Name:_____ **DOB** _____ **Date:**_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Siblings			
Spouse:			
Children:			

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Sore throat	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Itching	1 2 3 4 5
Hoarseness	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

Medication/Medical History List

MUST BE COMPLETE

Prescription	Dosage	Taken	Prescriber	For What	
EXAMPLE – Lialda	1.2mg	4 pills 1x a day	Dr. Smith	Ulcerative Colitis	

Over the Counter	Dosage	Taken	Prescriber	For What	
EXAMPLE - Aspirin	81mg	1 daily	Dr. Smith	Heart Prevention	

Supplements	Dosage	Taken	Prescribed	For What	
EXAMPLE – Fish Oil	1	2x a day	Self	Wellness	

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SHAWN PALLOTTI, D.C.
CANDICE OWENS, D.C.
LURIANE RAYMOND, FNP-BC

CONSENT TO TREAT

Patients Name:_____ **Procedure:**_____ **Date:** _____

I hereby request and consent to the performance of chiropractic manipulation, medical exam, manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic or medical doctors who now or in the future work at the clinic or office listed above.

I have had an opportunity to discuss with the Medical Director and Doctor of Chiropractic named below the nature and purpose of chiropractic adjustment and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Therapeutic modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infraction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor(s) to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor(s) to exercise judgement during the course of the procedure which the doctor(s) feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor(s) named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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NOTICE OF PRIVACY PRACTICES

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. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 16th, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law/ We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain., including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice to make the new notice available upon request.

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 listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operational. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible

for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement to your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms or health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for the lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format your request unless we cannot practicably do so. (You use make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request and alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.)

Disclosure 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 other activities, for the last 6 years, but not before April 14th, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) You request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this notice on your website or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we make about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact Officer: Bonnie Fisher
Telephone: (540) 775-2250
Fax: (540) 775-2448
E-mail: kgfcandpt@aol.com
Address: 9305 Kings Highway, King George, VA 22485

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet of paper indicate that you have been given the opportunity to review and request a copy of our Notice of Privacy Practices on the date indicated. If you have any questions regarding the information on this notice, please do not hesitate to contact a clinic representative as indicated on your notice.

Patient Name (Printed): _____

If Patient Representative, Name (Printed): _____

Signature: _____

Date Notice Received: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

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

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: Advanced Integrative Medicine **Facility Phone:** 540-775-2250

Facility Address: 9305 Kings Highway, Suite A **Facility Fax:** 540-775-2448

City, ST, Zip: King George, Virginia 22485

Dates and types of information to disclose:

_ 2 years prior from last seen date

_ Dates Other: _____

_ Specific Information Requested:

_____

The purpose of disclosure is:

_ Change of Insurance or Physician

_ Continuation of Care (e.g., VA Med Ctr)

_ Referral

_ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. **I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.**

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax: _____ **Phone:** _____ **___ Please mail records. ___ Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ Date _____

Signature of Patient/ Parent/ Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship/ Capacity to patient

_____

Address and telephone number of authorized representative

Advanced Integrative Medicine

Office Policies

The purpose of this agreement is to inform you of our office policies and to help you on your road to wellness. We have found that patients that follow this agreement can benefit the most from their care while saving you time and money.

Office Hours:

Monday: 7am-7pm

Tuesday: 7am-5pm

Wednesday: 7am-6pm ** **MON-THURS Office will be closed for lunch from 12-2****

Thursday: 7am-6pm

Friday: 9am-12pm

Office Closing and Delays:

Holiday closings/delays will be posted in the office and on our webpage/social media pages ahead of time in order to make any necessary changes to your schedule.

In the event our office needs to close or delay, we will do our best to contact you by phone, text, social media and emails. It is very important that we have all your correct info so we are able to contact you. We do not go off of school closings, so if you have any questions about the office please call us.

To help you stay consistent and get the rest results please adhere to the following:

1. Attend all scheduled appointments
2. Call us if you are unable to make your scheduled appointment.
3. If you miss an appointment, please make arrangements to make up this appointment on your designated makeup day which will be assigned to you on your Day 2 visit.

Starting treatment: (Please note the following when attending each visit.)

1. Sign in up front and get your assigned travel card
2. Pay copay, if applicable
3. Fill out the travel sheet and medicare form, if necessary. (remember if it isn't written, it didn't happen). Documentation is critical to get the best possible result and to have your care covered by your insurance.
4. Take the sheet with you to the rehab area (last door on left in back)
5. Trainers will meet with you, go over your current symptoms and direct you to begin stretching.
6. After stretching, you will be given exercises designed for you to address your specific condition.
7. After exercising, you will receive specialized soft tissue treatment by one of our trainers.
8. At completion of soft tissue, you will be directed to the adjustment area to be seen by the Doctor.
9. Upon completion of adjustment, please return to the front desk to check out and return travel card.

10. Remember to tell the staff if you have a new condition, exacerbation of a condition, if symptoms occur or your health status changes. We would rather you be honest through this entire process in order for us to keep you happy and healthy!

Payment of Bills:

We expect you to honor the financial agreement you have made with our office. If you find that you cannot fulfill that agreement, please advise our staff immediately, so that other arrangements can be made. We do not send bills to patients. Payment is expected at the time of service, unless other arrangements have been made. If you default on your payments, you will incur the cost of collections and will be held responsible for the balance plus these charges. We will bill insurance, however, if you received a check from them, please bring it into our office immediately. If your insurance isn't responding to our claims in a timely manner, you may be asked to call them to assist with collection for services rendered.

We accect cash, check, Care Credit, FSA card, debit cards, and major credit cards (Visa, Mastercard, American Express, and Discover).*

Missing or changing appointments:

We have set up a course treatment with a specific number of adjustments and therapies to get the results needed. Thus, if you need to change the time of your appointment, please let us know within 24 hours. If the same day is not possible, be sure to reschedule that appointment within the week on your designated makeup day. Adherence to your plan is crucial for optimal results.Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care. If your recommended plan calls for a certain amount of days a week, then you must follow that plan. Example: 3 times a week for 12 weeks, but you can only come 2 days, then the following week you will do your expected plan recommendations plus your makeup day visit(4 visits that week). Here at AIM, we want our patients to get the best results and in order to do so, staying on track with your recommended plan would be best!

Rehab area:

For your safety and benefit we encourage you to warm up your body prior to an adjustment. Rehab staff will walk you through specific exercises and warm ups that you can perform on your own, once comfortable. It is important to notify trainers of any issues, such as if something they are doing is causing you pain, makes you uncomfortable or if you don't understand why and purpose of such activities. If you don't tell us, we don't know. The life fitness weight stack is not to be used by patients without permission and signed waiver on file.

Patient concerns:

If, at any time, you have questions, concerns, ideas, or issues feel free to contact the office manager or our Patient educator. If you experience anything out of the ordinary and need to reach us outside business hours, please send us a message on facebook for quicker response. We will attempt to resolve your issue as soon as possible.

Patient: _____ Date: _____

Office Staff: _____ Date: _____

****Office staff will make copies of this form to give to all patients.

ATTENTION ATTENTION

NEW POLICY EFFECTIVE: March 1st, 2020

Cancelation/ no show/late Policy

Patients that are no shows (no call or communication and not showing up for appointment) or fail to contact the office 24 hours prior to an existing appointment will be charged a $20.00 fee. Patients that are currently on a plan and are recommended a specific number of visits will need to make up missed or cancelled appointments on their designated make up day. This fee is in addition to the copay or cash price.

Patients that show up more than 15 minutes late for an appointment will not be charged a fee, but the appointment **may** need to be rescheduled, depending on how busy we are. If you are late you may have a shortened time for treatments, and it may ONLY include an adjustment.

IF you are going to be late contact the office to see if a time later in the day is available.

If you no show to 2 appointments in a row you will be taken off the schedule and will need to call and be put back on the schedule. This may require a meeting with the doctor or case manager to restart care.

I, _____have read and understand the above policy.

Patients signature: _____ Date: _____

Advanced Integrative Medicine
9305 Kings Highway, King George, VA 22485
Phone: (540) 775-2250
Fax: (540) 775-2448

Photo / Video Release Form

Permission to Use Photography / Video

Subject: _____

I grant Advanced Integrative Medicine, representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize Advanced Integrative Medicine, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Advanced Integrative Medicine may use such photographs of me with or without my name and for lawful purpose, including such purposes as publicity, illustration, advertising, and web content.

I have read and understand the above.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Printed Name: _____ Date: _____

Office Signature: _____ Date: _____

Not Interested, Check here:

☐ **Initials:**