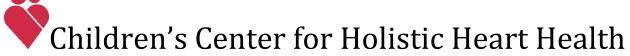


| Patient Intake Form | |
|---|--|
| Date: Personal Information: Name: | |
| Address: | |
| City: | State: Zip Code: |
| Cell Phone: | Work/Home Phone: |
| SSN: Gende | r: M or F or Binary Age: |
| Date of Birth: | mail:Occupation: |
| Marital Status: E | mail: |
| Parent's Name: | Occupation: |
| Reason for Visit: Chief Complaint (W | hy are you here?): |
| | |
| Primary Care Physician, address an | d phone: |
| | d phone: |
| Local Pharmacy: | d phone: |
| Local Pharmacy: Mail Order Pharmacy: | d phone: |
| Primary Care Physician, address an Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: | |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: | Phone: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: | Phone: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: | Phone: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: Primary Insurance: Policy Number: | Phone: Phone: Relationship with patient: Group Number: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: Primary Insurance: Policy Number: | Phone: Phone: Relationship with patient: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: Primary Insurance: Policy Number: Subscriber's Name: | Phone: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: Primary Insurance: Policy Number: Subscriber's Name: Subscriber's ID/Policy Number: Secondary Insurance Name: | Phone: |
| Local Pharmacy: Mail Order Pharmacy: Emergency Contact Information: Name of Person: Relationship with the person: Insurance/ Billing Information: Primary Insurance: Policy Number: Subscriber's Name: Subscriber's ID/Policy Number: Secondary Insurance Name: | Phone:Relationship with patient:Group Number:Subscriber's Date of Birth: |



| Medical History Form | | | | | |
|---|--------------------------|-------------------|--|--|--|
| Date: | | | | | |
| Patient's Name: | | | | | |
| DOB: | | | | | |
| Past Medical History: (Circle all that app | | | | | |
| Congenital Heart Disease Asthma Breathi | ing problems Diabetes Hi | gh blood pressure | | | |
| Growth problems Feeding problems | | | | | |
| List here if not mentioned above: | | | | | |
| Diuth History | | | | | |
| Birth History: Wooks of gostation | . Pirth woight | | | | |
| Birth order: Weeks of gestation Vaginal Delivery/C-section: | | | | | |
| | | | | | |
| Pregnancy complications if any: | | | | | |
| Medications (please list name, dose, and | d froguency | | | | |
| | | | | | |
| | | | | | |
| Past Surgical History: | | | | | |
| | | | | | |
| Allergies: No Drug Allergies (Circle it if no | o drug allergies) | | | | |
| | | | | | |
| Social History: (Circle all that apply) | | | | | |
| • School | Grade | Siblings | | | |
| Leisure activities/Sports: | | | | | |
| Tobacco exposure or personal history of | of smoking: | | | | |
| Alcohol/Illicit drugs: | | | | | |
| | | | | | |
| Family History: | | | | | |
| Relationship Condition | | | | | |
| Father | | | | | |
| Mother | | | | | |
| BrotherSister | | | | | |
| Crandparents | | | | | |

Symptoms in last 6 months (Circle if symptoms present):

No Symptoms

- 1 Constitutional Fever, fatigue
- **2 Eyes** Droopy eyelid, double vision
- **3 Ear, Nose, Throat ENT** Hearing loss, difficulty in chewing/swallowing, nasal congestion/discharge
- **4 Endocrine Hormone** Weight gain/loss, Heat/cold intolerance
- **5 Cardiovascular Heart** Chest pain, shortness of breath, excessive sweating, palpitations, dizziness, fainting
- **6 Respiratory Lung** Shortness of breath, cough, chest congestion
- **7 Gastroenterology GI** Constipation/diarrhea, nausea, vomiting
- **8 Renal Kidney** Swelling of feet, foul smelling urine, blood in urine
- **9 Extremities** Swelling, redness on legs
- **10 Skin** Rash, ulcer, itching
- **11 Hematology** Easy bruising, enlarged glands
- **12 Psychiatry** Depression/anxiety, mood swings
- 13 Neurology Seizure, passing out episode, confusion, tingling, numbness
- **14 Musculoskeletal** Neck pain, lower back pain



Children's Center for Holistic Heart Health

| Patient Name: | Date of Birth: | | | |
|---|--|--|--|--|
| Financial Policy | | | | |
| o Copays, deductibles and outstanding balances are due upor are rendered. We accept Cash, Credit/Debit Cards, HSA Cards for NSF of a returned check. | | | | |
| o It is the patient's responsibility to inform our office if you n least 24 hours in advance. There will be a \$25 No Show/ Sam notice. | | | | |
| o Patients are responsible to pay for any test/injections or problems of the patient's responsibility to verify with their insurance covered by their insurance. If we submit claims and insurance responsible for the payment. | ce about what service and treatment plans are | | | |
| o All payments and balances due must be paid within 30 days appointment can be created until this balance is paid in full. I the patient will be discharged from the practice. Once a patie cannot be treated by this office any longer. This includes but any paperwork. | f payment is not paid within 3 billing cycles, then nt has been discharged from this practice, he | | | |
| o If we turn the pending balance on account to the collection agency will be the responsibility of the patient. | | | | |
| o There is a \$ 35 charge for ALL forms needed to be filled out | by the doctor. | | | |
| Medication Refills | | | | |
| o We cannot fill any medication refills if you do not come for o Due to the high volume of telephone refill requests, we ask the time of their visit. If you call us after your visit, a fee of \$ 2 o All referrals/pre-certifications and authorizations will be cannot be a support of the control of the support of the suppor | all patients to have all their medicines refilled at 25 will be charged. | | | |
| appointment. | | | | |
| Updated Patient Information and Insurance | | | | |
| o You must bring all your insurance cards to your appointme | nt. We re-verify insurance coverage at every | | | |
| visit. o Please be sure to inform staff of any changes to your address possible. We cannot give you any important information regard of If you have new insurance, please call our office as soon as a verify BEFORE you come to your next appointment. This allow to be spent on verifying your insurance. It is the patient's resinsurance. If your insurance denies any payment, it is the patient Photo Consent | ording your health if we do not have this. you get your new ID number so that we can ws us to get you in quicker as less time will have ponsibility to verify that our office accepts their | | | |
| o By signing this form, you are authorizing our practice to ob | tain photo documentation so that we may be | | | |
| able to properly identify you for medical treatment. | | | | |
| Patient or Responsible Person: | Relationship: | | | |
| Signature of Patient or Responsible Person: | Date: | | | |

Children's Center for Holistic Heart Health

4 Forest Avenue, Suite 203, Paramus, NJ 07652 Phone: 551-276-2710 Fax: 201-820-3375

Due to recent federal privacy guidelines (HIPAA), Children's Center for Holistic Heart Health (C2H3) is not allowed to release information to anyone other than the patient (or guardian of the patient) unless there is explicit authorization given to authorize C2H3 permission to discuss personal medical information with someone other than the patient or guardian of the patient. Please fill this form to allow us to discuss your information with the people of your choosing as listed below.

I, give Children's Center for Holistic Heart Health permission to release/ discuss personal health information, which includes the pickup of prescriptions and/or financial information

to/with:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

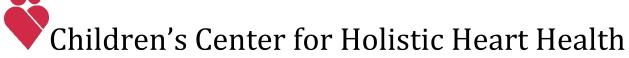
Name: Relationship: Phone:

I understand that I may revoke this authorization at any time by sending a written notification to C2H3. **By signing this form, all previous lists of allowable contacts become invalid.**

Patient Signature: Date: Witness Signature: Date:

I, decline to give C2H3 permission to release/discuss my personal health and/or financial information to anyone other than myself.

Patient Signature: Date: Witness Signature: Date:



| | of Protected Health Information (PHI) Patient DOB: | | | |
|---|--|--|---|--|
| Address: | | | | |
| | City: | State: | _ Zip: | |
| Social Security Number: | Telephor | Telephone: | | |
| I hereby AUTHORIZE Children's C Release Information to AND/OR Obtain Name of Person/Company: | | t Health to | | |
| Phone Number: | Fax Numl | Fax Number: | | |
| Address: | - City: | State: _ | Zip: | |
| All my PHI (medical records) Lab Reports I History and Physical Billing/ Financial Info Other: Purpose of Disclosure of Information: Continuation of Care My Personal Use Litig I understand that I may revoke this authorizatio listed above. I understand that revocation of thi authorization before they received my written in By signing this authorization, I hereby authorization understand that information contained in my Placquired immunodeficiency syndrome (AIDS), cabout behavioral or mental health services, and understand that my PHI described herein may be PHI described herein may no longer be protected. | rmation Medication List gation Other: on at any time by giving written r s authorization will not affect any notice of revocation. e the entities listed above to discibility HI may include information relator human immunodeficiency viru treatment for alcohol and drug a be disclosed by the entities above | y action taken in reli lose my personal hea ed to sexually transn is (HIV). It may also i abuse. By signing this e to receive and use r | ance on this alth information. I nitted disease(s), nclude information s authorization, I | |
| Patient Name: | | Date: | | |
| Legal Representative: | | _Date: | | |
| Relationship to Patient: | | | | |
| XA7*4 | | Data | | |

ASSIGNMENT OF BENEFITS, AGREEMENT, AND GUARANTY

I authorize C2H3 to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to C3H3. If the check must be made out to me, I understand the check must be sent to this address: Children's Center for Holistic Heart Health, 4 Forest Avenue, Suite 203, Paramus, NJ 07652.

I understand that C2H3 must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect necessary otherwise is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

C2H3 NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

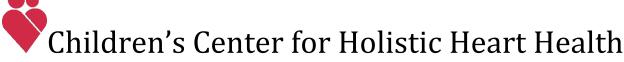
I acknowledge that a copy of the Notice of Privacy Practices for C2H3 has been made available to me. In connection with the notice, I also acknowledge that I have been provided with an opportunity to ask any questions regarding the notice and its contents.

EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE

I agree in order for C2H3 to service my account or collect monies I owe C2H3 their/our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which can result in charges to me. C2H3 may also contact me by sending text messages or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing divides as applicable. I have read this disclosure and agree that C2H3, its employees, and/or agent may contact me as described above.

Patient/ Legal Rep Signature: Date:

Legal Rep Relationship to Patient Date:



Patients' Rights and Responsibilities

Please Keep for Your Records

- 1. Care shall be provided impartially without regard to race, creed, sex, or national origin.
- 2. Patients are entitled to considerate, respectful, and dignified care always.
- 3. The patient has the right to receive care in a safe setting.
- 4. Patients are entitled to personal and informational privacy as required by law. This includes the right to:
- a. Refuse to see or talk with anyone not officially affiliated with C2H3.
- b. Wear appropriate personal clothing, religious, or other symbolic items that do not interfere with prescribed treatments or procedures.
- c. Examination in reasonably private surroundings, including the right to request a person of one's own gender present during certain physical examinations.
- d. Have one's medical records read and discussed discreetly.
- e. Confidentiality regarding one's individual care and/or payment sources'
- f. Data Privacy Rights as described in the Notice of Privacy Practices.
- 5. Patients and/or patients legally designated representatives have the right of access to information contained in the patient's medical record, within the limits of the law and in accordance with C2H3 policies.
- 6. Patients of C2H3 have the right to know the identity and professional status of all persons participating in their care.
- 7. Patients are entitled to know the status of their condition including diagnosis, recommended treatment and prognosis for recovery.
- 8. Patients have the right to be free from physical restraints which are not medically indicated or necessary.
- 9. Patients have the right, in collaborating with their physicians to make decisions involving their health care, including acceptances or refusal of medical care or treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- 10. Patients are entitled to formulate advance directives and appoint a surrogate to make healthcare decisions on their behalf of the extent permitted by law.
- 11. Patients are entitled to receive an itemized detailed explanation of charges related to services rendered on their healf
- 12. Patients will not be transferred to another facility or location without explanation of the necessity of such action.
- 13. A patient's guardian, next of kin, or legally authorized responsible person may exercise, to the extent permitted by law, the rights delineated on behalf of the patient if the patient has been judged incompetent in accordance with the law, or procedure, or is unable to communicate his/her wishes regarding treatment or is a minor.
- 14. Patients have the right to appropriate assessment and management of pain.
- 15. Patient have the right, subject to the patient's consent, to receive visitors whom they designate, including, but not limited to, a spouse, domestic partner (including same-sex domestic partner), another family member, or a friend. Patients have the right to withdraw or deny any such consent at any time. 16. Patients are responsible for providing C2H3 with complete and accurate information regarding present and past illnesses and operations, hospitalizations, medications, and other health related issues, including any unanticipated changes in their condition.
- 17. Patients are responsible for following recommended treatment plans prescribed and/or administration.
- 18. Patients who refuse prescribed treatments or do not follow their practitioner's instructions assume full responsibility for the consequences of such actions.
- 19. Patients are responsible for ensuring prompt and complete payment of their account at C2H3.
- 20. All patients must follow C2H3 rules and regulation relative to patient care and conduct. This includes consideration and respect for the rights and property of other patients and C2H3 providers and staff, as well as responsibility for the actions of their visitors and guests.



Children's Center for Holistic Heart Health

4 Forest Avenue, Suite 203, Paramus, NJ 07652 Phone: 551-276-2710 Fax: 201-820-3375

Patient Credit Card on File Agreement Preauthorized Credit

We have implemented a policy which enables you to maintain your credit card information securely on file with Children's Center for Holistic Heart Health, LLC. In providing us with your credit card information, you are giving us permission to automatically charge your credit card on file for your co-pay, deductible etc. at the time of service. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays & deductible (not met) are due at time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, we will notify you via phone and/or email. If we do not receive a response from you or your payment in full within 5 days, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below. I authorize ______, to charge co-pays and outstanding balances on my account to the following credit card: Visa MasterCard American Express Discover Credit Card Holder's Name: _____ Card number _____ CVV number: _____ Expiration Date: _____ If you wish to leave this credit card on file for other patient(s), please print name(s) below: Patient Full Name: _____ (Please Print) Patient Full Name: Patient Full Name:

Patient/Parent Signature: ______ Date: ______