Rebecca M Acosta, AP, DOM
941-209-8105
2055 Wood Street
Suite 200
Sarasota, FL 34237

REGISTRATION

PLEASE PRINT

Name: ____

Address: ____

City: _____________________ **State:** _____ **Zip:** ___________

Home Phone: (   ) _________________________________

Work Phone: (   ) ______________________ **Ext.**______

Cell Phone: (   ) _________________________________

E-Mail Address: ______________________________________

How did you hear about us: Family/Friend /Dr./ Yellow Pages /

Other: ____

Date of Birth: ________________ **Age:**_______

Marital Status: M   S   D   W

Social Security#: ________-_______-_________

Employer: ____________________________________

Occupation: ___________________________________

Student: ( ) Yes ( ) No ( ) Fulltime ( )Part time

Primary Care Physician: _________________________

Primary Care's Phone: (   ) _____________________

EMERGENCY CONTACT

Name: ____

Address: ____

City: _____________________ **State:** _____ **Zip:** _____________

Home Phone: (   ) ___________________________________

Work Phone: (   ) ___________________________________

Relationship: ____

INFORMATION ON SPOUSE/PARENT

Name: ____

Social Security #: ______________________________

Employer: ____________________________________

Occupation: ___________________________________

Phone Number: (   ) _________________________

Date of Birth: __________________________________

INSURANCE INFORMATION

Please note that our medical office does not accept insurance. We will provide a superbill upon request that you may submit to your own insurance company for reimbursement. Payment for services rendered will be the patient's and/or patient's conservator guardian's responsibility. We offer the following payment options:

1) Cash or Check: Patients can pay the full amount in cash or check at the time of the appointment.
2) Credit/Debit Card: We accept major credit and debit cards for payment.

I understand that I am financially responsible for any and all balances. By signing below, I acknowledge that I understand and accept the terms mentioned above regarding payment responsibility. A copy of this signature is as valid as the original

SIGNATURE: ____ **DATE:** ___________________________

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

Rebecca M Acosta, AP, DOM

Notice of Privacy Practices

To our patients. This notice describes how health information about you as a patient of this practice, may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
   You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to contact the office Rebecca M. Acosta for further information.
3. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to 4230 Castlebridge Lane, Sarasota, FL 34238. You must provide us with a reason that supports your request for an amendment.
4. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Private Practices. You may ask us to give you a copy of this Notice at any time.
5. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office at (941) 209-8105 for further information. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

I acknowledge receipt of the Notice of Privacy Practice of Rebecca M. Acosta, AP, DOM

Signature: ____ **Date:** __________________

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

Rebecca M Acosta, AP, DOM

INITIAL PATIENT VISIT

Patient Name ___________________________________ Date of Service________________ Age_________

Please note: You should continue to see your primary care provider for routine medical care.

Signature ____ Date _______________
(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

Your reason for coming in today (If you have already written this down, skip this

section)____

____

PAST MEDICAL HISTORY	CURRENT MEDICATIONS

LIST ANY ALLERGIES TO MEDICATIONS	Please list any SURGICAL PROCEDURES that you have had.

FAMILY HISTORY
Please list any illness that the following relatives have:
Mother
Father
Sister(s)
Brother(s)
Grandparents
Aunts and uncles

Rebecca M Acosta, AP, DOM

Name ____ Date of Service ___________ Age _______

SOCIAL HISTORY		
Do you smoke?	If so, how many packs per day?	
Do you drink alcohol?	If so, how many per day?	How often?
Do you drink caffeine?	How often?	
What do you do for a living?		
Do you exercise?		

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Changes in vision __________
- Headaches ________________
- Jaw Pain __________________
- Difficulty swallowing ________
- Mass or lump in neck ________
- Chest Pain _________________
- Heart Palpitations ___________
- Difficulty Breathing _________
- Wheezing _________________
- Cough ____________________
- Abdominal Pain ____________
- Nausea or vomiting
- Diarrhea or constipation
- Skin rash
- Atypical mole or other skin lesion
- Weakness in legs, arms, hands, or feet
- Shooting pain in back, legs, arms or neck
- Muscle soreness
- Gum bleeding
- Difficulty urinating
- Difficulty sleeping
- Depression, anxiety or memory loss
- Decreased libido

- Women only: Please list date of last Pap smear and mammogram ______________________

•Vaginal dryness ______ • Hot Flashes ____________________
•Irregular periods _____ • Breast lumps or tenderness ________
•Painful periods _______

Please describe any other complaints not covered in the list:

____

____

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Acupuncture Intake Form

Patient Name: ____ Date: ____________________

Date of Birth: __________________

Please describe your reason for your visit today: ____
____
____
____
____
____

How long have you had this complaint? ____

Was there an injury or accident that originally caused the problem? If so, please describe.

____
____

Have you had any medical treatments for your symptoms, such as exams, blood work, x-rays or medical procedures?

____
____
____

Have you ever had acupuncture before? If so, what for and did it work?

____
____
____

How did you hear about us / who may we thank for the referral? ________________________________

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CONFIDENTIALITY QUESTIONNAIRE

1. Please list the persons with whom we discuss your general medical condition and your diagnosis (including treatment, payment and healthcare options): □ **None**

Name: ____ Phone Number ( ) ___________________

Name: ____ Phone Number ( ) ___________________

2. Please list the family members or significant others with whom we may discuss your medical condition ONLY IN AN EMERGENCY: □ **None**

Name: ____ Phone Number ( ) ___________________

Name: ____ Phone Number ( ) ___________________

3. Please print the address where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope and marked "CONFIDENTIAL" ( ) YES ( ) NO

5. Please print the telephone number where you want to receive calls about your appointments, lab, or other healthcare information if other than your home phone number: (_____)____________________

6. May we leave a message on your answering machine/voicemail regarding your test results or healthcare information?
( ) YES ( ) NO

7. Would you like to be reminded of your appointments? ( ) YES ( ) NO

8. If yes, may we leave a message on your answering machine/voicemail? ( ) YES ( ) NO

I AM FULLY AWARE THAT A CELLPHONE IS NOT A SECURED AND PRIVATE LINE

PATIENT NAME: ____

SIGNATURE ____ DATE: _______________________

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

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Fee Schedule

Appointment and Treatment Prices:

- Consultation Fee: $45
- Establish Patient 1st visit: $275 (1 ½ hour visit)
- Comprehensive Wellness Panel: $875 (includes lab work and report with visit)
- Methylation Testing: $550 (2-hour visit, 1st visit)
- Follow-up Nutrition: $85 per 15 minutes
- B12 Injection: $45 each or 4 for $125, 8 for $200
- Lipo-weight Loss Injection: $55
- AcuPoint Injection Therapy: $85 (1-3 sites)
- Microneedling/Collagen Induction: $400 for face, $100 for additional area

Package pricing is available.
Effective 08-01-23 a 3% charge will be added for payment by credit card

Missed Appointment

Please note that if you fail to notify the office of an appointment cancellation 24 hours prior to that appointment, you will be charged a $50 fee for that appointment.

I understand the above text and agree to comply.

___

Print name of patient

___

Signature of patient **(PATIENT/PARENT/CONSERVATOR/GUARDIAN)**

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Credit Card on File Policy - Natural Primary Care LLC

1. **Introduction**
   This Credit Card on File Policy ("Policy") outlines the terms and conditions governing the requirement for patients to provide a valid credit card on file at Natural Primary Care LLC ("the Practice"). This Policy is designed to streamline the billing and payment process, enhance efficiency, and ensure the financial stability of the Practice.

2. **Scope**
   This Policy applies to all patients seeking services at the Practice, including new and existing patients.

3. **Credit Card Authorization**
   3.1 Requirement
   All patients are required to provide a valid credit card on file before receiving any medical services at the Practice. This includes but is not limited to consultations, treatments, procedures, and follow-up appointments.
   3.2 Cardholder Consent
   By providing their credit card information, patients authorize the Practice to charge the credit card for any outstanding balances resulting from medical services rendered. The Practice will use reasonable measures to protect the security and confidentiality of credit card information.
   3.3 Cardholder Responsibility
   Patients are responsible for ensuring the accuracy and validity of the credit card information provided.

4. **Billing and Payment Process**
   4.1 Charges
   The Practice will generate itemized statements detailing the services provided, along with the corresponding charges. Patients will receive these statements via email or regular mail, depending on their preferred communication method.
   4.2 Payment
   The Practice will automatically charge the credit card on file for the outstanding balance upon the issuance of an invoice or statement. Patients will receive a notification of the transaction, including the date, amount charged, and description of services.

5. **Dispute and Refunds**
   5.1 Disputes
   In the event of a billing dispute, patients should promptly contact the Practice's billing department to initiate a resolution process. The Practice will make reasonable efforts to investigate and resolve disputes within a reasonable timeframe.
   5.2 Refunds
   Refunds, if applicable, will be issued to the original credit card on file. The Practice will follow applicable laws and regulations regarding refunds and reimbursements.

6. **Confidentiality and Data Security**
   The Practice will implement appropriate measures to protect the confidentiality and security of patients' credit card information in accordance with applicable laws and regulations.

7. **Non-Compliance**
   Failure to comply with this Policy may result in the refusal of medical services until a valid credit card is provided. The Practice reserves the right to modify or terminate this Policy at any time.

By signing below or providing credit card information, patients acknowledge that they have read, understood, and agreed to comply with the terms and conditions of this Credit Card on File Policy.

Name: ______________________________ Signature: ____
(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

Date: __________________________

Effective Date: 07-01-2023