Rebecca M Acosta, AP, DOM
941-209-8105
www.NaturalPrimaryCare.com
6124 53rd Ave East, Bradenton, FL 34240
also at 3983 Destination Drive, Osprey 34229

REGISTRATION

PLEASE PRINT

Name: _____ **Date of Birth: _____ Age:_____**
Address: _____ **Marital Status: M S D W**
City: _____ State: ____ Zip: _____ **Social Security#: _____-_____-_____**
Home Phone: ( ) _____ **Employer: _____**
Work Phone: ( ) _____ Ext.____ **Occupation: _____**
Cell Phone: ( ) _____ **Student: ( ) Yes ( ) No ( ) Fulltime ( )Part time**
E-Mail Address: _____ **Primary Care Physician: _____**
How did you hear about us: Family/Friend /Dr./ Yellow Pages/ **Primary Care's Phone: ( ) _____**
Other: _____

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

Insurance Carrier: _____
Subscriber: _____
Policy ID#: _____
Group#: _____

SUPPLEMENTAL INSURANCE CARRIER

Insurance Carrier: _____
Subscriber: _____
Policy ID#: _____
Group#: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR BILLING PURPOSES

I authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable Rebecca M. Acosta. I authorize Rebecca M. Acosta to release natural Primary Care and its agents any information to determine these benefits or the benefits payable for related services. I declare all the information on this form is complete and correct to the best of my knowledge.

I understand that I am financially responsible for any and all balances not covered by my insurance carrier and for any required authorization for service. A copy of this signature is as valid as the original

SIGNATURE: _____ DATE: _____

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 informatio

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, A

Signature: _____ Date: _____

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

Rebecca M Acosta, AP, DOM

INITIAL PATIENT VISIT - Page 1

Patient Name _____Date of Service_____Age_____

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

Patient Signature _____

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

INITIAL PATIENT VISIT - Page 2

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
- ❑ Chest Pain
- ❑ Heart Palpitations
- ❑ Depression, anxiety or memory loss
- ❑ Difficulty Breathing
- ❑ Wheezing
- ❑ Cough
- ❑ Abdominal Pain
- ❑ Diarrhea or constipation
- ❑ Skin rash
- ❑ Decreased libido
- ❑ A typical mole or other skin lesion
- ❑ Weakness in legs, arms, hands, or feet
- ❑ Shooting pain in back, legs, arms or neck
- ❑ Muscle soreness
- ❑ Difficulty urinating
- ❑ Difficulty sleeping

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

- ❑ Vaginal dryness
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Hot Flashes
- ❑ Breast lumps or tenderness

Please describe any other complaints not covered in the list:

_____

_____

_____

Acupuncture Intake Form

Patient Name: _____

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? _____

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 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? ( ) YES ( ) NO

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

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE:_____

PATIENT GUARDIAN SIGNATURE:_____ DATE: _____

Missed Appointment & Fee Schedule

Please note: failure to notify the office of a cancellation 24 hours prior to appointment, there will be a $65 missed appointment fee

Appointment prices are as follows:

Intake Office Visit:	$175 (1+ hour visit)
Comprehensive wellness panel	$850 (includes labwork and report with visit)
Methylation Testing:	$525 (2 hour visit)
Follow-up Nutrition:	$85 (per 15 min)
B12 injection:	$45 4/$125 8/$200
Acupuncture Session:	$100
AcuPoint Injection Therapy:	$85 (1-3 sites)
Natural Botox “NoTox”	$2250 (10 sessions)
Herbs/supplements	individually priced
Package pricing available	

I understand the above text and agree to comply.

Print name of patient

Signature of patient Date