INTEGRATIVE
Healing Wellness, Inc.

To prepare for your appointment:

1) Please fill out all New Patient forms included in this folder in their entirety. Bring these forms with you to the appointment.

2) Check your e-mail, and complete all forms sent to you online at least 24 hours prior to your appointment.

3) If you have any recent labs or other tests (within 12 months), remember to bring them with you as well.

4) If you are married or in a relationship, **please bring your spouse or significant other** with you to your appointment.
(There will be much information covered concerning your unique condition as well as the logistics and fundamentals of the program.)

5) Please arrive on time.

6) We require a 24-hour notice to change or cancel your appointment. If a cancellation is not made within that 24-hour period prior to the appointment, a $45 fee will be charged to your credit card.

Note: If these steps are not followed it may compromise the full value of your consultation, and we reserve the right to reschedule your appointment.

903 Main Street
Suite 105
Port Jefferson, NY 11777
631-509-6888 (voice & fax)
yourhealth@integrativehealingwellness.com

Integrative Healing Wellness, Inc
903 Main Street
Port Jefferson, NY 11777

.PATIENT INFORMATION

DATE: _____

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

Home Address: _____ **Home #: ( )**_____

_____ **Cell #: ( )**_____

Mailing Address: _____ **Email:** _____

_____

Marital Status (circle one): S M D W **Gender (circle one: Male Female**

Employer: _____ **Occupation:**_____

Work #: ( ) _____ **Ext.** _____

Work Address: _____

_____

NAME OF INSURANCE: _____

REFERRED BY:_____**RELATIONSHIP TO YOU:**_____

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY:

_____ **Phone#: (___)** _____

Relationship: _____

Credit Card Information:

Name on Card: _____

Card Number: _____

Exp. Date: _____

CVV : _____

Circle Type: Visa Mastercard American Express Discover

MEDICAL INFORMATION RELEASE

CHOOSE EITHER (A) OR (B):

(A) I, _____, do not wish to have any of my medical information released to anyone for any reason.

(B) I, _____ would like to grant permission to Integrative Healing Wellness, Inc to release my medical information to the following:

_____
Full Name and Relationship

_____ _____
Patient Signature Print Name

PRIVACY AGREEMENT

I, _____acknowledge that I have been provided with a copy of Integrative Healing Wellness privacy notice and have been given the opportunity to read and ask questions about this notice.

_____ _____
Signature Date

CONTACT INFORMATION

I give the practice permission to contact me in the following manner(s). Check all that apply, and please indicate your preferred method of contact with an asterisk:

___ Home Phone No: _____
__leave detailed message on machine
__leave message with family member
__leave call back message only

___ Cell Phone No: _____
__leave detailed message on machine
__leave call back message only
__Allow Text messages

___Mail information to home
___Fax Information to: _____
___Email address: _____

ERIKA JURASITS, D.O., P.C.

CONSULTANT AGREEMENT

Erika Jurasits, D.O. ("Dr. Jurasits") is committed to the functional medicine model that addresses the underlying causes of symptoms with specific nutritional and lifestyle recommendations. By signing below, I agree to abide by the terms of this agreement.

Consulting Services. Dr. Jurasits will serve as my consultant in conjunction with my primary care physician to assess and treat my health and wellness concerns. I am required to have a primary care physician, contact information for whom I will provide and will be included in my file. In the case of an emergency or the otherwise need for acute care, I will contact 911 and/or my primary care physician directly.
I understand that today's consultation is used to determine whether or not I am a candidate for care and that this initial consultation process does not establish me as a patient under Dr. Jurasits' care and there is no doctor-patient relationship or obligation based solely on this initial consultation.

I am aware that after the consultation, I may not be accepted as a patient. I understand that Dr. Jurasits is not able to and does not accept every case. Dr. Jurasits' schedule is extremely busy and she strictly limits the number of new patients she accepts so as to ensure a high quality of care.

Please fill out all paperwork completely to the best of your knowledge. Do not leave anything blank. If paperwork is not filled out completely Dr. Jurasits may refuse to do the consultation.
Claims. Dr. Jurasits will not bill Medicare, Medicaid, or any other third party payor for the services provided to me.

Nutritional and Herbal Supplements. As a service to me, Integrative Healing Wellness, Inc. Integrative Healing Wellness, Inc. ("Integrative Healing Wellness") makes nutritional supplements available in its office. **I am under no obligation to purchase nutritional supplements at Integrative Healing Wellness, Inc.** Integrative Healing Wellness, Inc. provides nutritional counseling and makes individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although Integrative Healing Wellness makes a profit from the sale of these products, the nutritional and herbal are purchased only from manufacturers for whom it has gained confidence through considerable research and experience, and for which quality has been determined by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of my healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones I may be taking.
I have read and understand the Consultant Agreement and I agree to be bound by the terms of this Agreement. I also understand and agree that such terms may be amended by Dr. Jurasits and/or Integrative Healing Wellness from time to time.

_____

Signature of patient (or responsible party, if minor) **Date**

_____

Please print the name of the patient

ERIKA JURASITS, D.O., P.C.

NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices
Effective:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer, Erika Jurasits, 631-509-6888.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. Any revised Notice of Privacy Practices would be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information

Prior to disclosing your protected health information to outside health care providers or to obtain payment, Erika Jurasits, D.O., P.C. (the "Practice") will obtain your general consent, usually at your first visit to our facility.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that already has obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to your primary care physician. We also may disclose protected health information to other specialist physicians who may be treating you.

***Payment*:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities like reviewing services provided to you for medical necessity and undertaking utilization review activities.

***Health Care Operations*:** We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to an insurer or accreditation agency which performs chart audits. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information, as necessary, to contact you to remind you of your scheduled procedure.

We will share your protected health information with third party "business associates" that perform various activities for our practice (e.g., computer consulting company, law firm or other consultants). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke your authorization at any time, in writing, except to the extent that the Practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The following uses and disclosures will be made only with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI;
- Most uses and disclosures of psychotherapy notes (if Practice maintains psychotherapy notes); and
- Other uses and disclosures not described in the notice

Other Permitted and Required Uses and Disclosures That May Be Made With Your Permission or Opportunity to Object

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment.

Information to your family members: Unless prior preference is expressed to the Practice, a deceased patient's health information may be disclosed to a family or other member or other persons who were involved in the individual's care or payment for health care prior to the individual's death if such protected health information is relevant to person's involvement.

Immunization Disclosure to Schools: Upon your agreement, which may be oral or in writing, Practice may disclose proof of immunization to a school where a State or other law requires the school to have such information prior to admitting the student.

Other Permitted and Required Uses and Disclosures that may be Made without your Consent or Authorization

***Required by Law*:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law.

***Public Health*:** We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We also may disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

***Communicable Diseases*:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

***Health Oversight*:** We may disclose your protected health information to a governmental agency for activities authorized by law, such as audits, investigations, and inspections.

***Abuse or Neglect*:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

***Product Monitoring and Recalls*:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, and biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or in connection with post-marketing surveillance, as required by law.

***Legal Proceedings*:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

***Law Enforcement*:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes included (1) legal processes, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on Practice's premises) and it is likely that a crime has occurred.

***Decedents*:** Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties. Protected health information does not include health information of a person who has been deceased for more than 50 years.

***Organ/Tissue Donation*:** Your health information may be used or disclosed for cadaver organ, eye or tissue donation purposes.

***Criminal Activity*:** We may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety or a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

***Military Activity and National Security*:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for authorized military purposes, as required by law.

***Workers' Compensation*:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

***Inmates*:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

***Required Uses and Disclosures*:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy regulations.

2. YOUR RIGHTS

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a medical record maintained by the Practice for as long as we maintain the protected health information. We may charge you our standard fee for the costs of copying, mailing or other supplies we use to fulfill your request.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You also may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

In most circumstances, your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if you request us to restrict disclosures to health plans that we would normally make as part of payment or health care operations, we ***must*** agree to that restriction if the protected health information relates to health care which you have paid out of pocket in full.

If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction using the form for requests for restrictions on protected health information from the Privacy Officer, or you may provide us your request, in writing. Your request must include (a) the information you wish restricted; (b) whether you are requesting to limit the Practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

You have the right to electronic copies of your protected health information when requested. Where information is not readily producible in the form and format requested, the information must be provided in an alternative readable electronic

format as agreed to by you and Practice may charge a reasonable cost based fee for labor in copying protected health information and postage where you request that information be transmitted via mail or courier.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may ask us to contact you by mail, rather than by phone at home. You do not have to provide us a reason for this request. We will accommodate reasonable requests. We also may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you that we maintain. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies generally to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. However, you do have the right to an accounting of disclosures for treatment, payment or health care operations if the disclosures were made from an electronic health record.

Your right to an accounting of disclosures excludes disclosures we may have made to you, or to family members or friends involved in your care, or for notification purposes.

You have the right to receive specific information regarding other disclosures that occurred up to six years from the date of your request (three years in the case of disclosures from an electronic health record made for treatment, payment or health care operations). You may request a shorter timeframe. The first list you request within a 12-month period is free of charge, but there is a charge involved with any additional lists within the same 12-month period. We will inform you of any costs involved with additional requests, and you may withdraw your request before you incur any costs.

You have the right to obtain a paper copy of this Notice from us.

You have the right to opt out of fundraising communications (if Practice conducts fundraising)**.**

You have the right to receive notice in the event of a breach of unsecured protected health information. This means that you will receive notice if a breach of your protected health information is discovered within 60 days of discovery.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Erika Jurasits, 631-509-6888 for further information about the complaint process.

3186887

MEDICARE PRIVATE AGREEMENT

This agreement is entered into by and between Erika Jurasits, D.O. (hereinafter called "Physician"), whose principal medical office is located at 903 Main St, Suite 104-5, Port Jefferson,NY 11777 and _____(hereinafter called "Beneficiary"), who resides at _____, and shall become effective on this __ day of _____, 20__ and shall expire on the __ day of _____, 20__ (the "Opt Out Period"), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

A. Physician Obligations

1. Physician acknowledges that she is not excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

2. Physician acknowledges that this contract shall not be entered into with Beneficiary, or Beneficiary's legal representative, during a time when Beneficiary requires emergency care services or urgent care services, except that Physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

3. Physician acknowledges that she must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

4. Physician shall provide a copy of this contract to Beneficiary, or to his or her legal representative, before items or services have been furnished to Beneficiary under the terms of this contract.

5. Physician acknowledges that she must enter into a contract for each Opt Out period.

B. Beneficiary Obligations

1. Beneficiary, or his or her legal representative, accepts full responsibility for payment of Physician's charge for all services furnished by Physician.

2. Beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by Physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

3. Beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what Physician may charge for items or services furnished by Physician.

4. Beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask Physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

5. Beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that Beneficiary is able to read this contract.

6. Beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners

who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that Beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

7. Beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

8. Beneficiary, or his or her legal representative, understands that this contract shall not be entered into with Physician during a time when Beneficiary requires emergency care services or urgent care services, except that Physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

9. Beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to Beneficiary, or to his or her legal representative, before items or services have been furnished to Beneficiary under the terms of this contract.

_____
Name of Physician (printed)

_____ _____
Signature of Physician Date

_____ _____
Principal Office Address Telephone Number

_____
National Provider Identifier

_____
Name of Beneficiary (printed) or
His/Her Legal Representative

_____ _____
Signature of Beneficiary or Date
His/Her Legal Representative

_____ _____
Home Address Telephone Number

PRIVATE PAY AGREEMENT
(Sign if you have private insurance other than Medicare or Medicaid)

This agreement is entered into by and between Erika Jurasits, D.O. (hereinafter called "Physician"), whose principal medical office is located at 903 Main St., Suite 104-5, Port Jefferson, NY 11777 and _____(hereinafter called "Client"), who resides at _____, and shall become effective on this __ day of _____, 20__.

Client understands Physician is accepted as a private pay patient and Client will be wholly responsible for paying for any services that received regardless of the existence of coverage for such items or services under any health insurance program. The Physician will not file a claim to any insurance plan for services provided to Client.

The Client, or his or her legal representative, acknowledges that a copy of this agreement has been provided to the Client, or to his or her legal representative, before items or services have been furnished to the Client under the terms of this contract.

_____
Name of Physician (printed)

_____ _____
Signature of Physician Date

_____ _____
Principal Office Address Telephone Number

_____
National Provider Identifier

_____
Name of Client (printed) or
His/Her Legal Representative

_____ _____
Signature of Client or Date
His/Her Legal Representative

_____ _____
Home Address Telephone Number