INTEGRATED HEALTH

NEW PATIENT PAPERWORK

Today's Date: ___/___/____

Patient Name: _____ Date of Birth: ___/___/____ Gender: M F

Street Address: _____ _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different then street address): _____

City: _____ State: _____ Zip Code: _____

Social Security #: ___-___-____ Marital Status: S M W D E-Mail:_____

Phone Number: _____ Work/Cell Number: _____

Preferred Pharmacy: _____ Pharmacy Number: _____

Preferred Language: English Spanish Hindi Other: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Refused to Answer

Race: American Indian Asian Black/African American White Refused to Answer

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Insured's Name: _____ Insured's Date of Birth: ___/___/____

Secondary Insurance: _____ ID#: _____

Insured's Name: _____ Insured's Date of Birth: ___/___/____

EMPLOYMENT INFORMATION

Employment Status: Retired Full-Time Part-Time

Employer: _____ Phone: _____

(P) 844-365-2202
(F) 844-558-1878

INTEGRATED HEALTH

EMERGENCY CONTACTS

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

HIPAA Information can be disclosed to this emergency contact: YES NO

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

HIPAA Information can be disclosed to this emergency contact: YES NO

ANY ADDITIONAL PEOPLE THAT WE ARE ABLE TO DISCLOSE HIPAA INFORMATION PLEASE LIST ALL:

Name: _____ NAME: _____

Name: _____ Name: _____ **OTHER PHYSICIANS**

THAT YOU NORMALLY SEE-PLEASE PROVIDE FULL NAME AND THE SPECIALITY:

Dr.: _____ Specialty: _____ What are you seeing the doctor for: _____

Dr.: _____Specialty: _____ What are you seeing the doctor for: _____

Dr.:_____ Specialty: _____ What are you seeing the doctor for: _____

Dr.:_____ Specialty: _____ What are you seeing the doctor for: _____

MEDICATIONS

Current Prescription Medications (Include dosage and frequency):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Current Over the Counter Medications (include dosage and frequency):

_____

_____

_____

_____

_____

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INTEGRATED HEALTH

Medication Allergies:

_____

_____

_____

Food Allergies:

_____

_____

SOCIAL HISTORY

Do you smoke? YES NO If yes, How many? _____ packs per day.

For how many years? ____

If no, were you previous smoker? _____ When did you quit? _____ How long did you smoke? ____

Do you drink alcohol? YES NO If yes, How much? _____per day

Do you drink coffee? YES NO If yes, How much? _____per day

Do you exercise? Yes NO If yes, what type? _____ How frequently? _____

SCREENING FORM

Do you use or have Oxygen/ CPAP/ BiPAP machine? YES NO

Do you have any of the following (circle the ones you have):

LIVING WILL / ADVANCE DIRECTIVE / POWER OF ATTORNY / NONE

Do you walk with a cane or walker? YES NO

Review the following list and give the date of the last Time you had the tests and where they were performed

Test	Date	Location	Test	Date	Location
Mammogram:			Eye Exam:		
Breast Exam:			PAP Smear:		
Bone Density:			PSA:		
Colonoscopy:			Prostate:		

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Review the following list and give the date of the last Time you had the tests and where they were performed

Immunizations:	Date	Location	Immunizations	Date	Location
Influenza (FLU) Vaccine			Tetanus Vaccine		
Shingle (Shingrix) Vaccine			Pneumonia (Pneumovax 23) Vaccine		

MEDICAL HISTORY

CONDITION	SELF	FATHER	MOTHER	SIBLINGS	CHILDREN
ADD/ADHD					
ALCOHOL ABUSE					
ANEMIA					
ANGINA					
ANXIETY					
ARTHRITIS					
ASTHMA					
BLOOD CLOTS					
BLEEDING DISORDERS					
BONE DISORDERS					
BREAST CANCER					
CAROTID ARTERY DISEASE					
CIRCULATORY PROBLEMS					
COLON CANCER					

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INTEGRATED HEALTH

CROHN'S					
DEAFNESS					
DIABETES					
DEPRESSION					
DRUG ABUSE					
EMPHYSEMA					
EPILEPSY/SEIZURES					
GALL BLADDER DISEASE					
GERD/REFLUX/ULCER					
HEART ATTACK					
HEART MUMUR					
HEART VALVE DISORDERS					
HEARING LOSS					
HERNIA					
HIGH BLOOD PRESSURE					
HIGH CHOLESTEROL					
IRRITABLE BOWEL SYNDROME					
KIDNEY DISEASE					
LEUKEMIA OR LYMPHOMA					
LIVER DISEASE					
MENTAL ILLNESS					
MIGRAINES					

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MITRAL VALVE PROLAPSE/VALVE DISORDERS					
NEUROLOGICAL PROBLEMS					
NICOTINE USAGE					
OSTEOPOROSIS					
PEPTIC ULCER					
PANCREATITIS					
PROSTATE CANCER					
RHEUMATOID DISORDER					
SICKLE CELL DISEASE					
SKIN DISORDERS/SKIN CANCER					
SLEEP APNEA					
STROKE					
THYROID DISEASE					
OTHER CANCERS (SPECIFY):_____					

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INTEGRATED HEALTH

Fulfillment, Refund & Cancellation Policy

1. Description of Services

Integrated Health is a primary care medical practice providing comprehensive healthcare services both in-person and via telemedicine.

2. Purchase Currency

All prices for services and payments are displayed in United States Dollars (USD).

3. Payment Processing & Security

- We process credit/debit card payments securely through Stripe, a PCI-compliant and HIPAA-compliant payment processor.
- Stripe encrypts all payment information, ensuring that customer payment data is protected.
- Payments are processed immediately.
- Customers will see "Integrated Health" or "Stripe" on their bank statement for transactions made through our platform.
- We accept the following payment methods: Visa, Mastercard, American Express, Discover.
-

4. Cancellation & Refund Policy

- Refunds: Payments for services may be refunded if a billing error, duplicate charge, or incorrect service charge occurs.
- Billing Disputes: If you believe you were charged incorrectly, please contact us. Approved refunds will be processed within 5-10 business days back to the original payment method.

5. Insurance & Self-Pay Charges

- Insurance: Patients are responsible for verifying their insurance coverage before receiving services.
- Self-Pay Charges: If an error occurs in billing, self-pay charges may be refunded after review.

6. Legal & Privacy Policy

- We comply with all applicable laws regarding patient privacy and data protection.
- We do not sell or share customer payment data with third parties, except as required by law.

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INTEGRATED HEALTH

OFFICE POLICY AGREEMENT

(Initial)

_____ **COMMIT TO A MINIMUM OF ONE ROUTINE APPOINTMENT (S) YEARLY**

To provide the quality of care you deserve, we require that all patients have an annual office visit (wellness exam) and annual labs completed once a year. Sick appointments, routine visits and urgent visits are not the same as annual/wellness visits

_____ **TARDINESS TO AN APPOINTMENT MAY CAUSE RESCHEDULING OF YOUR APPOINTMENT**

In the event that you are 15 minutes late to a scheduled appointment, you may be required to reschedule your appointment.

_____ **NO SHOWS/LAST MINUTE CANCELLATIONS/LAST MINUTE RESCHEDULES (LESS THEN 24 HOURS)**

If you reschedule, cancel or no show to your scheduled appointment with less than 24 hours' notice you may be subject to a $25.00 fee that is the patient's responsibility not the insurances to pay. You will be responsible for this charge and it will need to be paid before any future appointments can be made.

_____ **MEDICATION REFILLS**

Medical staff tries their best to get all medications refills sent to the pharmacies as quickly as possible. Keep in mind that this is sometimes done between seeing patients and sometimes at the end of the day. For this reason, we do have a 24-to-48-hour turnaround Time frame. Please be mindful of your supply of medications to ensure that you do not run out and allow enough Time to get the refills sent successfully to the pharmacy.

By initialing and signing this form, I am in agreement with the above terms, or understand the office policies.

Patient Signature: _____ Date: _____

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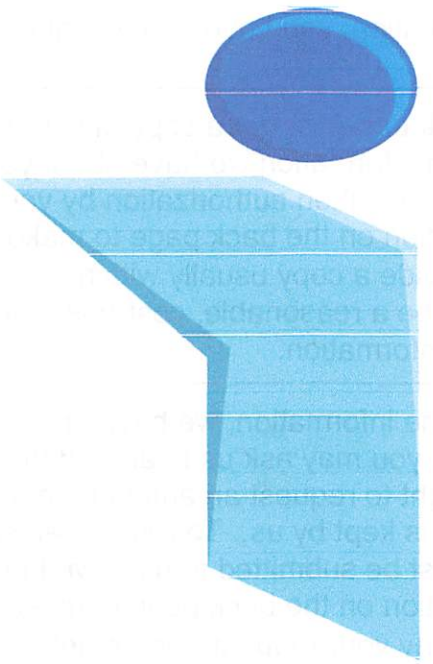
(F) 844-558-1878



INTEGRATED HEALTH

Notice of Privacy Practices

Effective 2/16/26

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.

Our Commitment to your Privacy

- We understand that information about you and your health is personal.
- We are committed to protecting information about you.
- We create a record of care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by us, whether made by our staff or your provider. Your provider may have different policies or notices regarding the use and disclosure of your information created in the provider's office or clinic.

  This notice will describe your rights, and certain responsibilities we have regarding the use and disclosure of your information. This notice will also tell you about the ways in which we may use and disclose information about you.

Your Rights

When it comes to your health information, you have certain rights. You have the right to:

Inspect or receive an electronic or paper copy of your medical record.	• You can ask to see or get a copy of your medical records and other health information we have about you. This request may require a written authorization by you. Contact us using the information on the back page to make this request. • We will provide a copy usually within 30 days of your request. There may be a reasonable, cost-based fee to provide the requested information.
Request an update to your medical record.	• If you feel the information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by us. To request an amendment, your request must be submitted to us in writing. Contact us using the information on the back page to make this request. • We may deny your request. We will let you know in writing the reason why within 30 days.
Request an accounting of disclosures we have made to share your information.	• You can request a list (accounting) of disclosures where we have shared your health information, to include who we shared it with, and why. The list will include all disclosures except for our own uses for treatment, payment and health care operations, and certain other disclosures (such as any you requested us to make, or exceptions required by law). • To request this list, you must submit your request in writing. Your request must state a time period which may not be longer than six years prior to the date of the request. Contact us using the information on the back page to make this request. • The first list you request within a 12-month period will be free. Additional lists may be charged for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Request confidential communications.	• You can request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. • To request confidential communications, you must make a written request. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Contact us using the information on the back page to make this request.
Receive a paper copy of this notice.	• You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Contact us using the information on the back page to promptly receive a copy of this notice. • You may also obtain a copy of this notice at our website: Centerpain.com
Choose someone to act for you.	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights have been violated.	• You may file a complaint with us if you believe your privacy rights have been violated. You may contact us by using the information on the back page. Complaints may be submitted by mail or email. • You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696- 6775, or visiting http://www.hhs.gov/ocr/privacy/hipaa/ complaints/. • You will not be penalized or retaliated against for filing a complaint.

Your Choices

For certain situations, you can tell us about your preference on what health information we can share. Talk to us, let us know what you would like for us to do, and we will follow your instructions.

Disclose information when requested by you.	The following disclosures may require a written authorization by you. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* • Sharing information with family, close friends or others involved in your care. • Sharing information in a disaster relief situation.
We do not use or disclose your information for the following purposes without your written permission, except as permitted by law:	Marketing purposes (except as permitted by law). Fundraising. We may contact you for fundraising; you may opt out at any time. Sale of your information.
Ask us to limit what we use or share.	• You may request to restrict or limit the information we use or disclose about you for treatment, payment or our health care operations. • You may request a limit on the information we disclose about you to someone who is involved in your care or the payment for your care. • If you, or someone else on your behalf (other than a health plan or insurer), has paid for the item or service full, you may ask us to not disclose that information for the purpose of payment or our operations with your health plan or insurer. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you. We will say "yes" unless the disclosure is required by law. • To request these limitations and restrictions, you must make your request in writing. In your request, you must tell us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply. • We are not required to agree to the above requests and may say "no" if it would affect your care.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. This will stop any further use or disclosure of your information for the purposes covered by your written authorization.

Our Uses and Disclosures of your Health Information

We typically share your health information in the following ways.

Provide treatment for you.	We can use information about you to provide you with medical treatment or services. We may disclose information about you to doctors, nurses, technicians, health care students, or other personnel who are involved in taking care of you.	For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process.
Payment for services provided to you.	We can use and disclose information about you so that the treatment and services you receive may be billed to and payment may be collected from health plans or other entities.	For example, we may need to give information about treatment you received to your health plan so it will pay for services.
Operate our organization.	We can use and disclose information about you for our health care operations. These uses and disclosures are necessary to run our organization and make sure that all of our patients receive quality care.	For example, we may use information to review our treatment and/or services to evaluate the performance of our staff and improve our services for you.

We are also allowed, or required, to share your health information in other ways. Usually in ways that contribute to the public good, such as public health and safety, or research. The following categories describe the different ways we may share your health information. We must meet conditions in the law before we can share your information for the purposes described. For each category of uses or disclosures, we will explain what we mean and give examples, as appropriate.

Public health and safety activities	We can disclose information about you for public health and safety situations such as to: • Prevent or reduce a serious threat to anyone's health or safety, • Prevent or control disease, injury, or disability, • Report births and deaths, • Report suspected abuse or neglect of children, elders and dependent adults, or domestic violence, • Report adverse reactions to medications or problems with products.
Required by law.	We will disclose information about you when required to do so by federal, state, or local law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.
Health Information Exchange.	We may disclose your health information electronically with other groups through a Health Information Exchange network. These other groups may include hospitals, laboratories, doctors, public health departments, and health plans. For example, if you travel and need treatment, it allows other doctors that participate to electronically access your information to help care for you.
Research.	We can use or share information about you for health research.
Address workers' compensation, law enforcement and other government requests.	We can use or disclose health information about you: • For workers' compensation claims. • For law enforcement purposes such as to report certain threats to third parties, about a death that may be the result of criminal conduct, criminal conduct at one or our facilities. • With health oversight agencies for activities authorized by law.

Organ and tissue donation.	We can disclose information about you with organ or tissue procurement organization.
Respond to lawsuits and legal actions.	We can disclose information about you in response to a court or administrative order, or in response to a subpoena. We can disclose health information to courts, attorneys, and court employees in the course of conservatorship, and certain other judicial or administrative proceedings. NOTE: PHI potentially related to reproductive health care may be subject to additional limits under HIPAA. We may be required to obtain a signed attestation before certain disclosures.
Work with coroners and medical examiners.	We can release information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Psychotherapy notes[1].	We do not share or maintain Psychotherapy notes at this practice.
Special considerations and/or disclaimers.	We generally do not disclose substance use disorder (SUD) treatment records protected by 42 CFR Part 2 without your written consent, except as permitted or required by law. If we receive records that are protected by 42 CFR Part 2, we will follow the more stringent requirements that apply. We do not create or manage a hospital directory. We do not create or maintain psychotherapy notes.

Who Will Follow this Notice

This notice describes Integrated Health's practices and that of:

- Any health care professional authorized to enter information into your health record.
- All departments, units, clinics, facilities, and offices.
- Any member of a volunteer group we allow to help you while you are in our care.
- All employees, staff, and other personnel.
- Any business associates we contract to conduct services on our behalf.

All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share your information with each other for treatment, payment or health care operations purposes described in this notice.

Changes in the Terms of this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for information we already have about you as well as any information we receive in the future. The new notice will be available on request, on our website and in all of our office locations. The updated notice will contain the effective date with the revisions.

Contact Information

For questions regarding this notice, additional information, or requests, contact

Privacy Officer: Jen Colonna
291 Carter Dr. Middletown, DE 19709
(P) 844-365-2202
jen@ih-360.com

Integrated Health 360
AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

Patient Name: _____

Account Number: _____ Date of Birth: ____/____/_____

1. Integrated Health 360 is authorized to disclose the health information of the above-named individual as described in this authorization:

2. Integrated Health 360 may discuss and/or release protected health information with the following individuals (User/Recipient):

   Name _____Phone: _____

   Name _____Phone: _____

   May we leave telephone messages at the telephone number provided? ____yes ____no

3. The following health information can be discussed and/or released by this authorization to the individuals listed above:
   ☐Complete medical record
   ☐Appointment information including reason for appointment and times
   ☐Results of diagnostic testing and other information related to your health
   ☐Exceptions (Please List):
   _____

   Psychotherapy notes will not be covered unless specifically covered in a separate authorization. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded below.

4. The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released

				Initials
Substance use disorder (SUD) treatment records (42 CFR Part 2, if applicable)	Yes ☐	No ☐	NA☐	_____
Mental health records protected by the Mental Health Procedures Act	Yes ☐	No ☐	NA☐	_____
HIV/AIDS related information	Yes ☐	No ☐	NA☐	_____

5. Please specify any other restrictions on the covered information:
   _____

6. I am requesting use or disclosure of the covered health information for the following purpose:
   ☐My personal use ☐Further medical treatment
   ☐ Insurance eligibility or benefits ☐School
   ☐Legal investigation or action ☐Other (please describe)
   _____

7. I understand that I have the following rights:

   - **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by the Integrated Health 360 except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.

   - Right to revoke. You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written

revocation to our privacy officer at the following address:

Integrated Health 360
Attention: Jennifer Colonna CHCO /Privacy/Security Officer
291 Carter Dr.
Middletown, DE 19709
Phone: 844-365-2202
Email: Jen@ih-360.com

- Re-disclosure. I understand that once the covered health information has been disclosed, it may no longer be protected by privacy laws and may be re-disclosed by the recipient. If the information disclosed includes substance use disorder (SUD) treatment records protected by 42 CFR Part 2, federal law generally prohibits the recipient from re-disclosing that information unless further disclosure is expressly permitted by the patient's written consent or as otherwise permitted by 42 CFR Part 2.

NOTICE TO RECIPIENT (only applies if you receive 42 CFR Part 2–protected SUD records): This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

8. **Expiration**. This authorization expires as of the following date or event_____

I have read and understand this authorization, and authorize the use or disclosure of the covered health information as described in this authorization.

_____ _____
Signature of patient (or personal representative/surrogate) Date

Personal Representative/Surrogate Information (as applicable):

_____ _____
Name of personal representative Relationship to patient