Innovative
HEALTH AND WELLNESS

PATIENT INFORMATION FORM

Name:_____ Date of Birth:_____
First Middle Last

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

Soc Sec#:_____ Marital Status: SINGLE MARRIED DIVORCED WIDOWED SEPERATED

What is your preferred method of communication? Phone ☐ Email ☐ Mail ☐

Patient's Employer:_____ Work #: _____

Primary Care Doctor (PCP): _____ Phone number: _____

Emergency Contact: _____ Phone Number: _____

Do you have medical insurance? ☐ Yes ☐ No

Insurance Company: _____ Policy Number:_____

Group Number:_____ Policy Holder's Name:_____

Policy Holder's Date of Birth: _____ Relationship: _____

Who may we thank for referring you: _____

RESPONSIBLE PARTY

Name Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____
Street City State Zip

Phone Number: _____ Email: _____

Patient Signature:_____ ***Date:***_____

Innovative
HEALTH AND WELLNESS

Patient Name: _____ DOB: _____
Have you seen a Chiropractor before? ___ Yes ___ No If yes, when: _____
Where:_____ Results: _____

If we could wave a "magic wand" and grant you exactly what you would like out of this program, what would it be?
Try to be as honest and specific as possible. Please list at least 3 different things

1. _____
2. _____
3. _____

PLEASE LIST ALL OF YOUR SYMPTOMS AND CONCERNS

Complaint #1 _____ _____ _____ **Began:** _____ **Have you had in past?** **( ) Yes ( ) No** **Is it getting worse?** **( ) Yes ( ) No** **( ) Constant**	**Type of Pain:** ☐ Aching ☐ Tight ☐ Burning ☐ Stiff ☐ Deep ☐ Tender ☐ Dull ☐ Tingling ☐ Numb ☐ Throbbing ☐ Sharp/ Stabbing ☐ Shooting ☐ Sore	**Is it made worse by any activity?** **( ) Yes ( ) No** **What activity?** _____ **Result of:** ☐ Auto Accident ☐ Work Injury ☐ Other: _____
Complaint #2 _____ _____ _____ **Began:** _____ **Have you had in past?** **( ) Yes ( ) No** **Is it getting worse?** **( ) Yes ( ) No** **( ) Constant**	**Type of Pain:** ☐ Aching ☐ Tight ☐ Burning ☐ Stiff ☐ Deep ☐ Tender ☐ Dull ☐ Tingling ☐ Numb ☐ Throbbing ☐ Sharp/ Stabbing ☐ Shooting ☐ Sore	**Is it made worse by any activity?** **( ) Yes ( ) No** **What activity?** _____ **Result of:** ☐ Auto Accident ☐ Work Injury ☐ Other: _____
Complaint #3 _____ _____ _____ **Began:** _____ **Have you had in past?** **( ) Yes ( ) No** **Is it getting worse?** **( ) Yes ( ) No** **( ) Constant**	**Type of Pain:** ☐ Aching ☐ Tight ☐ Burning ☐ Stiff ☐ Deep ☐ Tender ☐ Dull ☐ Tingling ☐ Numb ☐ Throbbing ☐ Sharp/ ☐ Shooting ☐ Stabbing ☐ Sore	**Is it made worse by any activity?** **( ) Yes ( ) No** **What activity?** _____ **Result of:** ☐ Auto Accident ☐ Work Injury ☐ Other: _____

General Symptoms/ Conditions

- ☐ Migraines
- ☐ Allergy (what)

_____

- ☐ Bronchitis
- ☐ Chills (constant)
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Numbness or Pain in extremities
- ☐ Wheezing
- ☐ Polio
- ☐ Alcoholism
- ☐ Anemia
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Mumps
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ HIV Positive
- ☐ Diabetes
- ☐ Measles
- ☐ Serious Injury
- ☐ Other

Gastro- Intestinal

- ☐ Belching or Gas
- ☐ Acid Reflux
- ☐ Heart Burn
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Bloody Stool
- ☐ Irritable Bowel
- ☐ Ulcers

Cardio-Vascular

- ☐ High Blood Pressure
- ☐ Strokes
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Heart Trouble
- ☐ Poor Circulation
- ☐ Rapid Heart
- ☐ Slow Heart
- ☐ Swollen Ankles
- ☐ Varicose Veins
- ☐ Pacemaker

Eye/ Ear/ Nose/ Throat

- ☐ Sinusitis
- ☐ Asthma
- ☐ Deafness
- ☐ Earache
- ☐ Ear Discharge
- ☐ Ear Noises
- ☐ Thyroid Problems
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Pain in Eyes
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Sore Throats
- ☐ Tonsillitis

Muscles & Joints

- ☐ Backache
- ☐ Pain Between Shoulders
- ☐ Stiff Neck
- ☐ Foot Trouble
- ☐ Hernia
- ☐ Painful Tail Bone
- ☐ Spinal Curvature
- ☐ Swollen Joints
- ☐ Tremors
- ☐ Spinal Disc Disease
- ☐ Dislocated Joints

Respiratory

- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood
- ☐ Spitting Phlegm

Genito-Urinary

- ☐ Bed Wetting
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Inability to Control Urine
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Prostate Trouble

Neurological

- ☐ Anxiety
- ☐ Mood Swings
- ☐ Phobias
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Memory Loss or Impairment
- ☐ Depression

For Females Only

- ☐ Irregular Cycle
- ☐ Cramps
- ☐ Hot Flashes
- ☐ Painful Periods

Pregnant at this time?

☐ **Y** ☐ **N**

Last Menstrual Cycle:

ADDITIONAL INFORMATION

List all medications you are taking now including over the counter medication:

_____

_____

_____

Do you have or have you ever had any diseases or medical problems not listed? If so, please list:

_____

_____

I have read the above information and certify that it is to be true and correct to the best of my knowledge, and hereby authorize this office to provide care, in accordance with state's statutes.

Patient or Guardian Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

Your Auto Insurance Company

Name _____
Address _____
City _____ State ____ Zip _____
Policy # _____
Purchased from _____
Phone # _____

Your Health Insurance Company

Name _____
Address _____
City _____ State ____ Zip _____
Policy # _____
Purchased from _____
Phone # _____

Vehicle Owner

Name _____
Address _____
City _____ State ____ Zip _____

Vehicle Owner's Auto Insurance Company

Name _____
Address _____
City _____ State _____ Zip _____
Policy # _____
Purchased From _____
Phone # _____

Your Driver's Information

Name _____
Address _____
City _____ State _____ Zip _____

Your Driver's Auto Insurance Company

Name _____
Address _____
City _____ State _____ Zip _____
Policy # _____
Phone # _____

IF ANOTHER VEHICLE WAS INVOLVED IN THE COLLISION, ANSWER THIS SECTION COMPLETELY.

Driver of Other Vehicle

Name _____
Address _____
City _____ State _____ Zip _____

Other Driver's Auto Insurance Company

Name _____
Address _____
City _____ State ____ Zip _____
Policy # _____
Purchased from _____
Phone # _____

IF THE DRIVER WAS OPERATING SOMEONES ELSE'S VEHICLE:

Vehicle Owner's Name

Name _____
Address _____
City _____ State _____ Zip _____
Phone # _____

Vehicle Owner's Auto Insurance Company

Name _____
Address _____
City _____ State _____ Zip _____
Policy # _____
Purchased from_____
Phone # _____

Accident History Questionnaire

1. Date of accident: _____
2. Time: _____AM/PM
3. Driver of car: _____
4. Where were you seated: _____
5. Who owns the car: _____
6. Year & Model of your car: _____
7. Year & Model of the other car: _____
8. What was the approximate damage done to your car: $ _____
9. Visibility at the time of accident: Poor □ Fair □ Good □ Other □ (Describe below)
   _____
10. Road conditions at the time of the accident: Icy □ Rainy □ Wet □ Clear □ Dark □ Other □
    _____
11. Where was your car struck : Front □ Rear □ Driver side □ Passenger side □
12. Type of accident : Head on collision □ Broad-side collision □ Front impact □
    Rear-end □ Non-collision □
13. At the time of the accident, recall what parts of your head or body hit what parts on the
    Inside of your car: _____
14. Did you see the accident coming? Yes □ No □
15. Did you brace for the impact? Yes □ No □
16. Were seatbelts worn? Yes □ No □
17. Were shoulder harnesses worn? Yes □ No □
18. Does your car have headrests? Yes □ No □
19. If yes what was the position of the headrests compared to your head before the accident:
    Top of the headrest with bottom of head □
    Top of headrest even with top of head □
    Top of head rest even with middle of the neck □
20. Was your car braking? Yes □ No □
21. Was your car moving at the time of the accident? Yes □ No □
22. If yes, how fast would you estimate your speed? _____ mph
23. How fast would you estimate the other car was going? _____ mph
24. Head/body position at the time of impact:
    Head turned left / right □ Body straight in the sitting position □
    Head looking back □ Body rotated right / left □
    Head straight forward □ Other: □ _____
25. As result of the accident were you: Rendered unconscious □ In shock □
    Dazed/Confused □ Other: □ _____
26. How was the shoulder harness adjusted? Loose □ Snug □
27. Were you wearing a hat or glasses? Yes □ No □
28. Could you move all parts of your body? Yes □ No □
29. If no, what parts couldn't you move and why? _____
    _____
30. Were you able to get out of the car and walk unaided? Yes □ No □

31. If no, why not? _____
32. Did you receive any bleeding cuts? Yes ☐ No ☐
33. Did you get any bruises? Yes ☐ No☐
34. Please describe how you felt _____
    Immediately after the accident: _____
    Later that day: _____
    The next day: _____
35. Check the symptoms below apparent since the accident:

Headache ☐	Neck pain ☐	Mid back pain ☐	Eyes light sensitive ☐	Pain behind eyes ☐
Dizziness ☐	Fainting ☐	Sleeping problems ☐	Numbness in fingers ☐	Numbness in toes ☐
Loss of smell ☐	Loss of taste☐	Loss of memory ☐	Fatigue ☐	Shortness of breath ☐
Irritability ☐	Depression ☐	Ringing /Buzzing ☐	Loss of balance ☐	Tension ☐
Cold hands ☐	Cold feet ☐	Diarrhea ☐	Constipation ☐	Chest pain ☐
Nervousness ☐	Cold sweats ☐	Anxious ☐	Low back pain ☐	Other: ☐ (describe)

    _____
36. Occupation: _____
37. Employer: _____
38. Have you missed time from work? Yes ☐ No ☐
39. If yes, full time off work: _____ to _____
40. If yes, part time off work: _____ to _____
41. Did you seek medical help immediately after the accident? Yes ☐ No ☐
42. If yes, how did you get there? Ambulance ☐ Police ☐ Drove own car ☐ Someone else drove me ☐
    Other:☐ _____
43. Doctor # 1 name _____
44. First visit date: _____
45. Were you examined? Yes ☐ No ☐
46. Were X-rays taken ? Yes ☐ No ☐
47. Did you receive treatment? Yes ☐ No ☐ Medications ☐ Braces ☐ Collars ☐
48. If yes, what kind of treatment did you receive? _____
49. What benefits did you receive from the treatment? _____
    _____
50. Date of last treatment? _____
51. Doctor #2 name _____
52. First visit date: _____
53. Were you examined? Yes ☐ No ☐
54. Were X-rays taken? Yes ☐ No ☐
55. Did you receive treatment? Yes ☐ No ☐
56. If yes, what kind of treatment did you receive? _____
57. What benefits did you receive from the treatment? _____
    _____
58. Date of last treatment? _____

59. Do you have an attorney on this claim? Yes □ No □
60. If yes, who? _____
    Address: _____
    City: _____ State _____ Zip _____ Phone # _____

Illustrate below how the accident happen

Past medical history:

Please " X " if it applies and describe.

None related to current complaints: □ _____

Hospital or operation: □ _____

Auto accident: □ _____

Illness: □ _____

Work accident: □ _____

Other: □ _____

SYSTEM REVIEW

Place an (X) next to the symptoms you know you have.

Genito-Urinary System

☐ Bladder Trouble ☐ Excessive Urination ☐ Scanty Urination ☐ Painful Urination ☐ Discolored Urine

Gastro-Intestinal System

☐ Poor Appetite ☐ Excessive Hunger ☐ Difficulty Chewing ☐ Difficulty Swallowing
☐ Excessive Thirst ☐ Nausea ☐ Vomiting Food ☐ Abdominal Pain
☐ Diarrhea ☐ Constipation ☐ Black Stool ☐ Bloody Stool
☐ Hemorrhoids ☐ Liver Trouble ☐ Gall Bladder Trouble ☐ Weight Trouble

Nervous System

☐ Numbness ☐ Loss of Feeling ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Headaches
☐ Muscle Jerking ☐ Convulsions ☐ Forgetfulness ☐ Confusion ☐ Depression

Cardio – Vascular System

☐ Chest Pain ☐ Pain over Heart ☐ Difficulty Breathing ☐ Persistent Cough
☐ Coughing Phlegm ☐ Coughing Blood ☐ Rapid Heartbeat ☐ High Blood Pressure
☐ Heart Problems ☐ Lung Problems ☐ Varicose Veins ☐ Other: _____

Eye, Ear, Nose and Throat System

☐ Eye Strain ☐ Eye Inflammation ☐ Vision Problems ☐ Ear Pain ☐ Vision Problems
☐ Ear Pain ☐ Ear Noises ☐ Ear Discharge ☐ Hearing Loss ☐ Nose Pain
☐ Nose Bleeding ☐ Sore Mouth ☐ Sore Throat ☐ Sore Gums ☐ Speech Difficulty
☐ Dental Problems

THE FOLLOWING INFORMATION IS REQUIRED FOR ALL PATIENTS

Has this accident been reported to the police? Yes _____ No _____

If yes, did they come to the scene of the accident? Yes _____ No _____

If yes, did they cite anyone with a traffic violations? Yes _____ No _____

If yes, Whom? Myself _____ My Driver _____ The Other Driver _____

Have you reported this accident to any insurance company? Yes _____ No _____

If yes, Which one(s) My Own ____ My Drivers ____ The Owner of My Driver's Vehicle _____

The Other Drivers _____ The Owner of The Other Driver's Vehicle _____

If a claim number has been assigned, please state _____
Claim #

Have you retained the services of an attorney? Yes _____ No _____

If yes, what is the attorney's name _____

Address: _____

City: _____ State _____ Zip Code _____

Phone # _____ Fax # _____

The information given in this questionnaire is true and accurate to the best of my knowledge.

Signed _____ Date _____

The staff of this chiropractic center appreciates you taking the time to gather this vital Information. Please be assured we will do everything possible to assist you in your recovery. We will also make effort to secure coverage's that will enable you to receive whatever care you may need.

Thank you for your cooperation.

MEDICAL RECORDS RELEASE

To: _____ Fax # _____

Patient Name: _____ DOB: _____

I hereby authorize you to release records to Innovative Health and Wellness any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of _____ to _____.

Signature of Patient: _____ Date: _____

Signature of Parent/ Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Missed Appointment Policy

Definitions: Policy: a way of managing affairs so as to achieve some purpose.

Appointment: a meeting with someone at a certain time and place.

Missed: fail to keep, or be present at.

It is our wish that each and every one of our patients receive the very best care and service possible. Your treatment program consists of a specific series of treatment given over a pre-planned time span. If you do not follow this plan, then you will not receive the desired results.

1. Meet all your appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because treatment will help you recover.
3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.
4. With exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled or missed appointments must be rescheduled and made up within the week.
6. We have the right to charge 5.00 for no call/no show appointments.
7. There could also be a $20.00 charge for missing an appointment with the medical doctor.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Staff Witness: _____

Innovative
HEALTH AND WELLNESS

FINANCIAL RESPONSIBLITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. I authorize payment directly from my insurance company to Innovative Health and Wellness. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered to me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2% will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and herby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this three part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Innovative Health and Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____ Date: _____

Patient Name (print)_____ D.O.B._____

Signature of Parent/ Guardian: _____ Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a care for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Innovative Health and Wellness treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent/ Guardian: _____ Date: _____

CONSENT OF TREATMENT OF A MINOR CHILD

I hereby authorize Dr. Orlando and whomever he may designate as assistance to administer chiropractic care as deems necessary to my _____ (indicate relationship to minor).

Name of Minor: _____ Date: _____

Signature of Parent/ Guardian: _____

Signature of Staff: _____ Date: _____

Assignment of Health Plan Benefits and Rights as well as an Appointment as an ERISA*/PPACA** Representative Designation

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay **Innovative Health and Wellness, LLC** the balance due on my account for any professional medical and chiropractic services rendered and for any ancillary supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to **Innovative Health and Wellness, LLC** for medical/healthcare services rendered and for any ancillary supplies, tests, and medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, of to pursue any other remedies necessary in connection with same.

I hereby assign directly to **Innovative Health and Wellness, LLC** all rights to payments, benefits, and all other legal rights under, or pursuant to, any health plan, ERISA plan, PPACA plan, or insurance contract rights that I (or my child, spouse, or dependent) may have under my/our applicable health plans(s) or health insurance policy(ies). This assignment includes, but not limited to, a designation that **Innovative Health and Wellness, LLC** can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to **Innovative Health and Wellness, LLC** as a result of services rendered by **Innovative Health and Wellness, LLC** and to pursue any and all remedies to which I/we may be entitles, including the use of legal action against the health plan or insurer. This assignment and designation remains in effect unless revoked in writing and a photocopy or scan is to be considered as a valid and enforceable as the original.

Assignment of Insurance Benefits: I hereby authorize payment to be made directly to PROVIDER'S OFFICE of all benefits which may be due and payable under insurance coverage for the undersigned patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to PROVIDER'S OFFICE. Furthermore, I hereby **IRREVOCABLY ASSIGN to PROVIDER'S OFFICE**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state, Georgia statutes for any service and/or charges provided by PROVIDER'S OFFICE

Signed this _____day of _____20___

_____ _____

Patient Signature Office Staff Signature

_____

Patient's Printed Name

_____

Signature of Guardian (if applicable)

*ERISA – Employee Retirement Income Security Act

**PPACA – Patient Protection and Affordable Care Act

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations; you have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the practice does not have to agree to the restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by: _____D.O.B._____

(Printed name of Patient or Representative)

Signature: _____ Date: _____

295 Molly Lane. Suite #150
Woodstock, GA 30189

3115 Piedmont Road, A102
Atlanta GA 30305

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____DOB_____

I hereby acknowledge that I received the Notice of Privacy Practices statement of Innovative Health and Wellness, LLC

Signature: _____ Date: _____