ZABRECKY
INSTITUTE of Biomedicine

The primary goals of the Zabrecky Institute of Biomedicine are threefold:

- To discover and inhibit degeneration of the body's systems
- To support a healthful constitution through homeostatic mechanisms
- To improve and/or maintain quality of life

These are accomplished through extensive evaluation of the individual. Everyone has a biochemical distinction. Even identical twins do not age at the same rate or die of like diseases, but there are similarities.

Stress, in any form (trauma, negative emotions, temperature changes and extremes, etc.) stimulates specific adaptations in each of us. If we have the energy to adapt or cope quickly enough, we regain homeostasis and total recovery is achieved. If our regulatory systems are overwhelmed, then we maladapt and enter a phase of imbalance. In acute injury, this is usually the formation of scar tissue followed by incomplete recovery. However, in chronic disease, the maladaption process may persist for months, years or decades. This situation produces most chronic degenerative disease such as arthritis, maturity onset diabetes, heart disease and cancer.

Many stresses burden us daily - such as poor diet, high pressure occupations, constant air travel and emotional upsets (divorce, death of a friend or family member). Many chronic diseases develop from maladaptation due to deficiency (malnutrition), mutation, infection and/or poisoning (environmental/ecological toxicity).

A major part of how our bodies react to stress is genetic. This is why diseases follow a family in its history. All chronic diseases have one common denominator; they are all forms of degeneration. Whether they are called atherosclerosis, arteriosclerosis or multiple sclerosis, they are all forms of degeneration.

Abnormal degeneration is inhibited in our bodies by maintaining biological efficiency and developing mature defense mechanisms (homeostatic mechanisms). To maintain highly efficient body responses, we must have the energy from our food to express the genetic potential necessary for rapid and complete adaptation. Our food must be properly ingested, digested, absorbed and utilized to provide the energy needed to suppress disease. This is why a competent hormonal system and intact nerve transmission are necessary to recognize and activate proper adaptive responses. This balance is maintained by recognizing and activating proper adaptive responses. Imbalance may be corrected through chiropractic, adjunctive nutritional support, aggressive vitamin and supplement therapy, acupuncture, intravenous nutrient therapy and health changes to lifestyle. Severe chronic disease states can be improved and palliated with medication.

We do not age and deteriorate at the same rate. The evaluation at the Zabrecky Institute of Biomedicine often yields significant information which we use to increase control of this rate by our patients.

789 E. Lancaster Ave. | Suite 230 | Villanova, PA 19085 office: 610-616-2500 fax: 610-616-2525
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Evaluation at the Zabrecky Institute of Biomedicine is expressly devoted to the following:

- to evaluate the body's current risk for disease
- to evaluate for interfering structural, biochemical and environmental factors
- to treat any active disease process
- to recommend a referral to other physicians or health care professionals for co-treatment, as required
- to support genetic weaknesses through prevention, which helps fortify and maintain the body's reserves
- to educate the patient to make changes which will reverse the degenerative process

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Office Policies

New Patient Appointments

A history, physical exam, blood testing or other laboratory testing may be taken at the new patient appointment. If records are reviewed in advance by our office, therapy may be initiated during this first appointment based on these medical records (please see Medical Records). Each new patient is typically given a follow-up appointment with one of the Institute's providers two to four weeks later to allow for all testing to return for review by one of our medical providers (please see Follow-Up Appointments). New patients will be charged for laboratory testing and supplements upon the completion of the first visit.

Telephone Consultations

Telephone consultations are utilized for some patients to provide an initial assessment of new patients who live long distances from our office or as an option for some follow-up office visits which do not require on site examination or treatment at the Institute. The new patient coordinator, along with our physician staff will determine if this is an appropriate option on a case by case basis. If you are a new patient and are planning to schedule a telephone consultation with any of our providers, the following is required for your appointment:

1. All medical records pertinent to the patient's diagnosis or disorder are required to be sent to our offices via fax or mail. An office staff member will instruct a patient on how to obtain your medical records from your other physicians if you do not have copies on hand.
2. The new patient letter must be read thoroughly, signed and sent or faxed back to our offices with the patient's medical records.
3. Fees for a new patient telephone consultation are billed at the rate of $300.00 - $550.00 per hour. A prepayment is required for all new patient Telephone Consultations. An Easy Pay Consent form is to be filled out, signed and returned to our office with a patient's medical records and signed new patient letter.

When the above items are received from the patient, an office staff member will telephone the prospective patient to schedule the telephone consultation date and time that the physician will call.

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After a new patient telephone consultation, a patient will be given recommendations and referrals, or this information will be reviewed during a follow-up appointment. A patient may be requested to make a follow-up appointment to come to our office, see one of our providers or attend a treatment session at another medical facility. These options are discussed with the patient during the initial contact and during the telephone consult. All patients are given specific therapies conjunctive to their specific case and diagnosis. Treatment may not be recommended to start before a follow-up appointment. A patient's credit card is charged after the appointment date, not before.

Follow-up Appointments

A report of findings and their significance will typically be given after your initial visit or telephone consultation. This second visit will be scheduled for two to four weeks after your initial visit with one of our health care providers. This will allow sufficient time for all laboratory testing to be completed and returned to our office for your follow-up visit. Consultation fees for follow-up appointments and telephone consultations are $225.00 per half hour. If you need to cancel your appointment, we require 48 hours' notice or there will be a missed appointment fee charged for your allotted scheduled time. Requests for information from an insurance carrier may require additional work, copying of records, etc. and will be billed at the rate of $50.00 per hour.

Please Initial _____

Perfume Notice

ATTENTION PATIENTS AND VISITORS:

Please refrain from wearing perfume or cologne in the office. There are many people (both patients and staff) who are chemically sensitive.

Thank you for your understanding and consideration.

Please Initial _____

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Fee Structure

The standard health consultation for a new patient with our providers ranges anywhere from one hour to an hour and a half. Consultation fees are charged at the rate of $300.00 - $550.00 per hour. A $150.00 deposit is required at the time the appointment is scheduled. Cancellations must be made 48 business hours prior to your appointment or your $150.00 deposit will be forfeited. Any lab tests will be billed in addition to the evaluation. We urge patients to bring any previous testing that they have from other health care providers for the physicians to review. We try to avoid repeating laboratory work when possible that has already been performed to reduce charges for the patient.

If results of testing or symptomatology warrant, further testing and/or treatment will be recommended. This may consist of food allergy testing, cardiac or diabetic risk factor assessment, specific mineral/toxic metal testing, functional vitamin assays for deficiencies, immune system or endocrine systems evaluations, evaluation for malignant/pre-malignant states or suspected chronic infections. The costs of these tests are an additional charge and the necessity will be discussed if recommended to the patient. The charges for any specific, non-routine tests are in addition to the initial cost of the visit.
Please Initial _____

Insurance and Billing

We do not accept insurance for any of the services provided at The Institute. The Institute is not affiliated with HMO, PPO, POS, or any managed care network. Some insurance companies may reimburse you for nutritional support, preventative health care, diagnostic testing or chiropractic services. We recommend you contact your insurance company. They will be able to provide you with information regarding your eligibility for services performed at our offices. All referrals, pre-certification and out-of-network benefits are the responsibility of the patient and NOT this office, AND WE DO NOT PARTICIPATE IN MEDICARE, MEDICAID, TRI-CARE OR ANY GOVERNMENTAL HEALTH CARE PROGRAM. If you are covered by any governmental program, you must sign a form authorizing the Institute to provide any services to you.

Our office will provide a superbill for your use in submitting claims for insurance reimbursement. This is not a guarantee of coverage. In order to keep our services as affordable as possible, our office is on a fee-for-service basis.

Please Initial _____

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Medical Records

If you have been treated in the past by your primary care physician, or any other health care provider, you may obtain copies of your medical records to bring to your first appointment.

To obtain medical records from another physician or medical facility, we suggest that you contact your physician's office or the hospital or outpatient facility where the testing was performed and request your medical records. As general rule, most offices request a signed medical release form from the patient to protect your confidential records. In some states, a medical office or hospital may require thirty (30) days' notice to release your medical records or require records to be sent directly to the physician at the office address. There may be a charge for this service. You may call your physician's office or make a request in writing (via fax or mail) to forward or fax your records directly to the Institute to expedite the request. It is always best to fax a written request to the medical facility or travel to your physician's office to pick-up copies of your records and sign the release. One of our staff members will try to assist you in obtaining records for an immediate appointment.

You may decide to copy your records for your own personal file. On your first appointment, our office will be happy to copy records, at no charge, that the Institute will keep on file. One copy of any your testing performed in our office is available at no charge to you. Additional copies are available for a small fee.

After careful review of your records, the Institute reserves the right not to accept a patient for care if our providers believe that you are unlikely to benefit from an assessment and possible treatment at the Institute. In that event, you may or may not be referred to another provider who might better serve your needs.

Most patients are accepted for treatment at our facility. If further treatment or medication is required which is not available, a patient may be referred to an outside medical provider or facility.

The Institute does not handle emergency situations and does not provide primary care for our patients. If you have a medical emergency, please call 911 and/or go to the nearest emergency room.

Please Initial _____

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Forms of Payment

Our offices are on a fee-for-service basis. Payment is expected in FULL at the time of each visit. As stated above, The Institute does not accept insurance assignment.

Forms of payment are cash, checks, and all major credit cards. An Easy Pay Consent Form is available for download via our web site. It is to be filled out and returned with all other paperwork and medical records for your file. This form will allow the Institute to charge telephone consultations, supplement orders to your credit card and any monthly balances that you may incur at our office.

All medical and financial records are kept completely confidential. If you have any questions concerning the Institute's payment policy, please do not hesitate to speak to our office manager.

Please Initial_____

Your Privacy

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

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Preparation for Your First Visit

For your first in-office appointment, please do the following:

1. Please read this information CAREFULLY!
2. Fasting may be required for blood testing during your first appointment.
3. Mail enclosed paperwork, signed forms, laboratory results and medical records pertinent to your diagnosis or major complaint back to this office prior to your scheduled appointment.
4. You may wish to bring a tape recorder. Some patients find it helpful to replay the information at home.
5. Make sure you or anyone that accompanies you does not wear perfume or cologne.

For your first telephone consultation, please do the following:

1. Please read this information CAREFULLY!
2. Please mail all paperwork, i.e. signed forms, laboratory results and medical records pertinent to your diagnosis or major complaint. These must be received prior to your scheduled appointment.

I have read this letter and understand its content. I have been informed that Dr. George Zabrecky utilizes chiropractic, nutrition and other conservative health care measures within the scope of his Pennsylvania chiropractic license. I understand if prescription medication, intravenous therapy or surgery is needed, I will be referred to the appropriate medical practitioner. I also understand that this facility does not provide insurance services, Medicare coverage, emergency or critical/crisis care.

_____

Patient Name (Print) Patient Signature

_____

Parent/Guardian Signature Date

Please remember to sign the introductory letter and fill out the questionnaire. Please bring all paperwork to your first appointment or fax back to our offices for a phone consultation. Please remember, the maintenance of health requires some discipline, moderation and maturity. The resolution of disease also requires vigilance and patience. I look forward to meeting with you!

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Patient's Name _____Sex _____ Age _____

Height _____ Weight _____ Date _____
Please bring this in with you on your first visit; or mail it. **We would appreciate a 48 hour cancellation notice.**

Your appointment is: _____

Patient Selection

At the Zabrecky Institute of Biomedicine, we understand that many of our patients…

● Are unresponsive or are poorly responsive to the conventional standard of care.

● Have acute or chronic conditions which have not been fully explored or diagnosed with conventional approaches.

● Have conditions which can be managed, in part, by conventional medicine, but with continued progression of the disease process and deterioration in quality of life.

● Have conditions for which no conventional standard of care is currently available.

The Zabrecky Institute of Biomedicine has limitations, as do all providers of medical care. In order to provide more effective care for our patients, we strive to accept those individuals we believe can benefit the most through our integrative medicine approach. Therefore, patient selection is a critical aspect of our progress. As a result, all prospective new patients are interviewed by our staff and screened to determine if they are appropriate candidates for treatment at the Zabrecky Institute of Biomedicine.

QUESTIONNAIRE

Please circle (NO) or (YES) if you have had any of the following life changes within the last two (2) years.

1.	Death of spouse ……	NO	YES	22.	Major revision of personal habit……	NO	YES
2.	Divorce……	NO	YES	23.	Changing to a new school……..……	NO	YES
3.	Marital separation……	NO	YES	24.	Change in residence……..……....	NO	YES
4.	Death of close family member……	NO	YES	25.	Major change in recreation…….	NO	YES
5.	Marriage……	NO	YES	26.	Major change in church activities……	NO	YES
6.	Marital reconciliation……	NO	YES	27.	Major change in social activities…….	NO	YES
7.	Major change in health of family……	NO	YES	28.	Major change in sleeping habits…….	NO	YES
8.	Pregnancy……	NO	YES	29	Major change in eating habits……	NO	YES
9.	Addition of new family member……	NO	YES	30.	Vacation in the last 3 months……..	NO	YES
10.	Major change in arguments with wife/husband	NO	YES	31.	Christmas in the last 3 months……..	NO	YES
11.	Son or daughter leaving home……	NO	YES	32.	Minor violations of the law……...	NO	YES
12.	In-law troubles……	NO	YES	33.	Being fired from work……..……	NO	YES
13.	Wife/husband starting or ending work……	NO	YES	34.	Retirement from work……..……	NO	YES
14.	Major change in family get-togethers……	NO	YES	35.	Major business adjustment……..…	NO	YES
15.	Detention in jail……	NO	YES	36.	Changing to different line of work……	NO	YES
16.	Major personal injury or illness……	NO	YES	37.	Major change in work responsibility…..	NO	YES
17.	Sexual difficulties……	NO	YES	38.	Trouble with boss……..	NO	YES
18.	Death of a close friend……	NO	YES	39.	Major change in working conditions…	NO	YES
19.	Outstanding personal achievement……	NO	YES	40.	Major change in financial state……	NO	YES
20.	Start or end of formal schooling……	NO	YES	41.	Mortgage or loan over 50,000……...	NO	YES
21.	Major change of living conditions……	NO	YES	42.	Mortgage foreclosure…….....	NO	YES
				43.	Mortgage or loan less than 50,000….	NO	YES

Please circle appropriate answer.

1. If female, are you pregnant? NO YES
2. Have you had any of the following diagnosed health history problems?
   - Heart disease NO YES
   - Cancer NO YES
   - Diabetes NO YES
   - High blood pressure NO YES
   - Kidney problems NO YES
   - Obesity NO YES
   - Stroke NO YES
   - Arthritis NO YES
   - Periodontal disease (oral, gum and bone problems) NO YES
3. Have you had a family history of any of the following conditions?
   - Heart disease NO YES
   - Cancer NO YES
   - Diabetes NO YES
   - High blood pressure NO YES
   - Kidney problems NO YES
   - Obesity NO YES
   - Stroke NO YES
4. Are you now taking any of the following medications?
   - Antihypertensive (blood pressure) NO YES
   - Antidiabetic NO YES
   - Antibiotic NO YES
   - Anticancer NO YES
   - Antidepressants NO YES
   - Drugs for ulcers or stomach upsets NO YES
   - Sleeping pills or muscle relaxants NO YES
   - Oral contraceptives NO YES
5. Do you exercise at least three times per week? NO YES
6. Do you use a seatbelt when in a car? NO YES
7. Do you have a history of high blood pressure? NO YES
8. Are you currently under greater than normal amounts of stress? NO YES
9. Do you brush your teeth after meals? NO YES
10. Do you floss your teeth each day? NO YES
11. What is your average daily alcoholic drink consumption? (1 drink = 1 ounce hard liquor, 1 beer or 1 glass of wine)
    1. none 2. 1-2 drinks 3. 3-4 drinks 4. 5 or more drinks
12. How much do you smoke daily?
    1. none 2. less than 1/2 pack 3. less than 1 1/2 packs 4. greater than 1 1/2 packs
13. Please give the daily overall hours for the following (should equal 24 hours):
    Sleep: _____ Rest: _____
    Physical Activity: Vigorous _____ Moderate _____ Light _____ Sedentary _____
14. What is your daily coffee, tea or cola consumption?
    1. one cup _____ 2. two to three cups _____ 3. more than three cups _____

Please place the appropriate number of your answer in the box to the right.

1.	If female, do you have irregular menstrual periods or menstrual pain? 1. no 2. slight 3. moderate 4. significant……	
2.	If female, do you have excess hair on your face, arms or legs? 1. no 2. slight 3. moderate 4. significant……	
3.	If male, are you subject to impotence, premature ejaculation, or difficulty in maintaining an erection? 1. no 2. slight 3. moderate 4. significant……	
4.	Do you have a history of a weight problem? 1. no 2. slight 3. moderate 4. significant……	
5.	Do you have white spots under your fingernails or ridges in your nails? 1. no 2. slight 3. moderate 4. significant……	
6.	Do you feel consistently cold or have cold hands and/or feet? 1. no 2. slight 3. moderate 4. significant……	
7.	Do you have allergies, asthma, or a chronic sniffle? 1. no 2. slight 3. moderate 4. significant……	
8.	Is it difficult for you to get started in the morning? Do you feel tired? 1. no 2. slight 3. moderate 4. significant……	
9.	Do you have dryness of the hair or skin or persistent dandruff? 1. no 2. slight 3. moderate 4. significant……	
10.	Do you get frequent colds or infections? 1. no 2. slight 3. moderate 4. significant……	
11.	Are you subject to constipation? 1. no 2. slight 3. moderate 4. significant……	
12.	Do you often have bloating, gas, or abdominal pain; particularly after eating? 1. no 2. slight 3. moderate 4. significant……	
13.	Do you suffer from aching and/or stiffness of the muscles and joints? 1. no 2. slight 3. moderate 4. significant……	
14.	Do you get headaches? 1. no 2. slight 3. moderate 4. significant……	
15.	After walking, do you have chest pain, a heaviness in your legs, or feel short of breath? 1. no 2. slight 3. moderate 4. significant……	
16.	Do you have frequent bad breath or bad tastes in your mouth? 1. no 2. slight 3. moderate 4. significant……	
17.	Does your stool appear yellow or clay-colored, foul-odored, or contain undigested foods? 1. no 2. slight 3. moderate 4. significant……	
18.	Do you have a history of anemia? 1. no 2. slight 3. moderate 4. significant……	
19.	Do you have symptoms aggravated by worry and/or tension? 1. no 2. slight 3. moderate 4. significant……	
20.	Are your eyes sensitive to light or dark? 1. no 2. slight 3. moderate 4. significant……	
21.	Does your heart pound and are you easily "shaken up" or startled by an unexpected noise? 1. no 2. slight 3. moderate 4. significant……	
22.	How long can you hold your breath? 1. < 60-75 seconds 2. 76-90 seconds 3. 10-30 seconds 4. > 110……	
23.	Does your heart seem to miss beats occasionally? 1. no 2. slight 3. moderate 4. significant……	
24.	At rest, what is your heart beat per minute? 1. < 60-75 seconds 2. 76-90 3. 91-110 4. > 110……	

25. Is your tongue cracked, bluish-red in color, or very smooth (no bumps)?
    1. no 2. slight 3. moderate 4. significant……

26. Are your teeth and gums infected, loose, or subject to periodontal disease?
    1. no 2. slight 3. moderate 4. significant……

27. Have you had major surgery including hysterectomy, coronary bypass, mastectomy, or other cancer surgery?
    1. no 2. yes……

28. Do you have difficulty urinating due to pain or poor flow?
    1. no 2. slight 3. moderate 4. significant……

29. Do you have muscle weakness?
    1. no 2. slight 3. moderate 4. significant……

30. Do you have bloodshot eyes or a feeling of sand in your eyes?
    1. no 2. slight 3. moderate 4. significant……

31. Do you have redness at the corners of your nose or mouth, cracked lips, or dermatitis?
    1. no 2. slight 3. moderate 4. significant……

32 Do you often feel drowsy after eating or feel shaky before meals?
    1. no 2. slight 3. moderate 4. significant……

33. Do your ankles swell in hot weather or do you have hay fever?
    1. no 2. slight 3. moderate 4. significant……

34. Is your skin rough or bumpy, particularly on the back of your arms?
    1. no 2. slight 3. moderate 4. significant……

35. To your knowledge, have you ever passed albumin (protein) in your urine?
    1. no 2. slight 3. moderate 4. significant……

36. Do you have night thirst or night sweats or are you constantly thirsty?
    1. no 2. slight 3. moderate 4. significant……

37. Do you have a history of boils, sores that do not heal, or acne?
    1. no 2. slight 3. moderate 4. significant……

38. Do you feel lightheaded when you stand up quickly?
    1. no 2. slight 3. moderate 4. significant……

39. Do you have recurring vaginal or urinary infections?
    1. no 2. slight 3. moderate 4. significant……

40. Do you have a history of kidney stones or blood in the urine?
    1. no 2. slight 3. moderate 4. significant……

41. Any further information important to your health:

All Medicare Patients are Required to Sign Before Consultation

Agreement by Medicare Beneficiary for Medical Services

_____, a patient and Medicare Part B beneficiary ("Patient"), and Aggie Hewitt, M.D., a physician licensed to practice medicine in Pennsylvania ("Physician"), enter into this agreement for the provision of medical services specified herein ("Services") in accordance with the provisions of Section 4507 of the Balanced Budget Act of 1997. Wherefore, in exchange for consideration the receipt and sufficiency of which the parties hereby acknowledge, Patient and Physician agree as follows:

1. Patient acknowledges and agrees that this Agreement had been entered into before Physician had provided the Services specified herein to Patient.
2. Patient acknowledges and agrees that this Agreement has not been entered into at a time when Patient is facing an emergency or urgent health care situation that cannot be postponed until a Medicare physician is available.
3. The Services to be provided Patient include office visits, infusion therapy, testing, medical services, ancillary health care services and nutritional counseling.
4. Patient agrees *not to submit a claim* (or request that Physician submit a claim on Patient's behalf) under the Social Security Act, as amended (42 U.S.C. 1395a) for the Services, even if such Services are otherwise covered under Medicare Part B.
5. Patient agrees to be responsible, whether through private insurance or otherwise, for the payment of Services.
6. Patient acknowledges that Medicare will not provide reimbursement for the Services and no Medicare fee limits [including those specified in 422 U.S.C. 1395a; 1848(g)] will apply to the amounts Physician charges for Services.
7. Patient acknowledges the Medigap plans under 42 U.S.C. 1882 do not, and other supplemental insurance plans may not, make payments for the Services.
8. Patient acknowledges that, as a Medicare beneficiary, a patient has the right to have the Services provided by other physicians or practitioners for whom payment would be made under Medicare, 42 U.S.C. 1395a.
9. Physician has informed Patient that Physician is not excluded from participating in the Medicare Part B under U.S.C. 1128, but has exercised his Constitutional Right to "opt out" of the Medicare program, and Physician now may not perform Medicare services to any patient.
10. By signing this Agreement, Patient understands that Patient is foregoing his or her right to receive Medicare benefits for the Services from Physician, but that Patient is not forfeiting Medicare benefits for services from other Medicare providers.

Signature of Patient: _____ Date: _____

Signature of Physician: _____ Date: _____

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Authorization to Release Information

Patient's Name _____
Last First Middle Initial

Address_____
Street City State

Home Phone_____ DOB_____ Patient #_____

I,_____, authorize the release of medical information from my medical records to:

- ☐ Dr. George P. Zabrecky, Dr. Aggie Hewitt, and Diane M. Coughlan, CRNP
- ☐ Myself: _____
- ☐ Other: _____
  Please specify name or organization where records are being sent
- ☐ My Insurance Company:_____

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

- ☐ Entire Record
- ☐ Specific Information:_____
- ☐ Old Records from Previous Physicians:_____

I give special permission to release all information regarding: [initial on applicable line(s) below]

_____Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Information

Reason for request: _____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date_____
If not patient, state relationship

Witness_____ Date_____

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Spouse/Family Information Disclosure

I,_____ _____/_____/_____
(Print Name) (Date of Birth)

Request the following restrictions to the use or disclosure of my protected information.

Zabrecky Institute of Biomedicine may discuss my medical condition/information with the following people:

Please circle YES or NO and print in the appropriate person's name.

Spouse:	YES	NO	Name:_____
Parents:	YES	NO	Name:_____
	YES	NO	Name:_____
Children:	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____
Significant Other:	YES	NO	Name:_____
	YES	NO	Name:_____
	YES	NO	Name:_____

Patient Signature:_____ Date:_____

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Credit Card Preauthorization

Dear Patient,

For your convenience, you may pay your account balance with your credit card. Please complete the information below:

Patient Name:_____ Date:_____

I authorize the health care provider shown above to charge my credit card account for my balance due for:

- ❑ Past services
- ❑ This visit only
- ❑ All visits this year
- ❑ Recurring charges for ongoing treatments:
  $_____ per _____
  Amount Week or Month

  from_____ to _____
  Date Date
- ❑ Other_____

  _____

  _____

❑ Mastercard ❑ VISA ❑ American Express

❑ Other_____

Charge Account Number_____Exp. Date_____

Cardholder Name_____

I understand that this form is valid for one year unless I cancel the authorization with written notice to the health care provider.

Cardholder Signature_____

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Patient Acknowledgement Form for

Patient Name: _____

(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the ZABRECKY INSTITUTE OF BIOMEDICNE, PLLC to leave medical information pertaining to my care or the care of my child by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes____ no____ Cell phone: yes___ no____ Work phone: yes____ no____
Voice Mail/Answering machine: yes____ no____ Pager: yes___ no____
May we fax medical records for referrals? yes____ no____
Please list names of people with whom we can discuss your medical care:
Spouse Name _____
Parent Name _____
Other Name (s) & Relationship _____

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier:_____
(last four digits of your social security number or mother's maiden last name)

I also acknowledge that I have received a copy of the ZABRECKY INSTITUTE OF BIOMEDICNE, PLLC Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient/Guardian or Personal Representative:

_____ **Date:**_____

If Personal Representative, give relationship to patient:

_____

789 E. Lancaster Ave. | Suite 230 | Villanova, PA 19085 office: 610-616-2500 fax: 610-616-2525
www.ZabreckyInstitute.com

ZABRECKY
INSTITUTE of Biomedicine

Special Note on Authorizations Related to Marketing

HIPAA established special requirements for marketing activities. The patient's authorization must be obtained for all marketing activities except:

1. Face-to-face communication by the physician or other employee of the Practice; or

2. Promotional gifts of nominal value provided to the patient by the Practice.

In addition, the authorization must indicate whether the Practice receives direct or indirect remuneration from a third party in connection with the marketing activities.

Thus, to the extent the authorization concerns marketing activities, the following should be added to the form:

Marketing

This authorization authorizes marketing activities for which the Practice

☐ will ☐ will not receive direct or indirect compensation.

"Marketing" is defined by HIPAA to include all communications that encourage the purchase or use of a product or service except communications for:

1. Treatment;

2. Case management or care coordination of the individual, or to direct or to recommend alternative treatments, therapies, health care providers or settings of care; or

3. Certain other health plan communications concerning benefits.

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