340 Broadway, Suite 1,
Saratoga Springs, NY, 12866

PATIENT INFORMATION

Name, First _____ MI _____ Last _____

DOB _____

Address _____ City, State Zip _____

Home phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Sex: __Male __Female __Non-binary/Other **Ethnicity:** __Hispanic/Latino __ Non hispanic/Latino

Race: __ American Indian/Alaskan Native __Black/African American __Native Hawaiian/Pacific Islander __Asian
__White __Other __Unknown

What is your primary language? _____ Other languages? _____

Marital Status: __Single __ Married __ Divorced __Widowed __Partnered

Work Status: __FT __PT __Unemployed __Retired Student status: ____Full-time ____Part-time

Primary Care Physician _____ Referring Physician _____

Do you wish to have electronic access to your records: __Yes __No

Please check all forms of correspondence you agree to: __Phone __Voicemail __Mail __e-mail

GUARANTOR(responsible party) ____check here if same as patient

Name _____

Address _____

City, State Zip _____ Phone _____

Emergency Contact Information & Pharmacy Information

Contact Name _____ Phone/Relationship _____

Pharmacy Name _____ Pharmacy Phone _____

Patient's Signature _____ Date _____
(Parent or guardian if the patient is a minor)

HEALTH HISTORY

Name_____

Date of Birth_____ Today's Date_____

Reason for today's visit_____

Medical Problems (Please list):

1._____ 4._____

2._____ 5._____

3._____ 6._____

Surgeries (Please list with date):

1._____ 3._____

2._____ 4._____

Hospitalizations/ Major Illness/Accidents/Trauma/Injuries (Please list with date):

1._____ 2._____

3._____ 4._____

Medications (Please list name, dosage and how many times a day):

1._____ 4._____

2._____ 5._____

3._____ 6._____

Over-the-counter medications/Herbs/Vitamins/Supplements (Please list name, dosage and how many times a day):

1._____ 3._____

2._____ 4._____

Allergies to Medications/Drug reactions (please list with reaction to each _____

_____

_____

Social History

Marital Status Single____ Married____ Separated____ Divorced____ Widowed____

Children [natural/adopted/mixed family]_____

Use of alcohol: Never____ Yes____ number of drinks per week, including Beer and wine)____

Use of tobacco: Never ____ Yes____ number of packs/day____ number of years smoking____

Use of drugs: Never____ Yes _____

Type/frequency _____

Number of cups of coffee, tea, and cola per day_____

Occupation_____

Family History

Circle if present in any blood relatives (including parents, grandparents, brothers, sisters, children, cousins, aunts and uncles):

Cancer _____ High Blood Pressure_____ Heart Disease(including heart attack) _____ Lung Disease _____

Tuberculosis _____ Glaucoma _____ Psychiatric Illness _____ Suicide _____ Epilepsy _____

Arthritis _____ Migraine Headaches _____ Kidney Disease _____

Diabetes _____ Blood Disease _____ Alcohol or Drug abuse _____

Asthma _____ Other inherited conditions_____

I have reviewed the above information with the patient. Physician Signature:_____ Date:_____

Review of Systems

Symptoms	Please circle NO or YES. If YES, please explain below
Fever/night sweats/weight change	NO YES
Skin rashes	NO YES
Easy bruising/bleeding	NO YES
Depressed mood	NO YES
Difficulty sleeping	NO YES
Shortness of breath	NO YES
Chest pain	NO YES
Nausea/vomiting	NO YES
Loss of bowel/bladder control	NO YES
Sexual dysfunction	NO YES
Numbness/tingling	NO YES (if yes, discuss with doctor)
Weakness	NO YES (if yes, discuss with doctor)

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FINANCIAL POLICY

Full payment is due at time of service. We accept personal checks or credit cards. There will be a $35 charge for returned checks.

INSURANCE

We are out of network providers for most insurances and have **opted-out** of Medicare. We can give you a document to submit to your insurance (other than Medicare) for possible partial reimbursement. Many insurances do cover some portion of osteopathic manipulation. Any questions regarding your benefits should be directed to your insurance carrier(s) directly.

MINORS & DEPENDENTS

Parents and guardians are responsible for *full* payment at the time of service.

MISSED APPOINTMENTS

Your appointment is time dedicated to you by your doctor. If you cannot make your appointment, we kindly ask that you cancel with at least 48-hours notice by calling or emailing us directly. Without 48-hours notice, patients who forget or miss their appointments will be charged the *full* amount. True emergencies rarely occur, but will be handled on a case-by-case basis.

TARDINESS

Anyone who arrives more than 30 minutes late for a first-time visit, may only have time for a thorough medical history to be obtained and a discussion of goals of treatment. Anyone who arrives more than 20 minutes late for a follow-up appointment, may need to be re-scheduled and will be charged for the appointment time. Please reach out to us by phone, if you know you are running late. While we understand that emergencies do occur, we respect everyone's appointment times and do not wish to delay the care of other patients.

TREATMENT/MEDICATIONS

Your treatment time includes a thorough medical and surgical history, review of any imaging, an osteopathic structural exam, and manual treatment. This office will **not** prescribe/refill any opiates/controlled substances.

I have read and agree with the above policy,

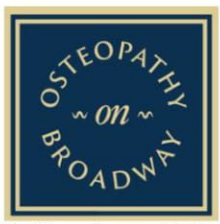
_____ _____ __/__/__

Print Patient Name **Signature** **Date**

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

_____ _____ __/__/__

Print Parent or Guardian Name **Signature** **Date**



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PRIVATE CONTRACT WITH MEDICARE BENEFICIARIES IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D

Osteopathy On Broadway, PLLC, Clara E. Somoza, D.O. has OPTED-OUT of Medicare.

This contract is entered into by and between Clara E. Somoza, D.O. (hereinafter called "physician"), whose principal medical office, Osteopathy on Broadway, PLLC, islocated at 340 Broadway, Suite 1 Saratoga Springs, NY 12866 and _____ (hereinafter called "beneficiary"), who resides at _____, and shall become effective on this **16th day of March, 2020**and shall not expire("**opted- out**"), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

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

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

The 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.

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

The physician acknowledges that she must enter into a contract for each opt-out period.

Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

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

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The 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 1 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 the 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.

The 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.

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

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

The beneficiary, or his or her legal representative, understands that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Name of physician (printed)_____Clara E. Somoza, D.O._____

Signature of physician_____ Date _____

Principal Office Address ____340 Broadway, Suite 1 Saratoga Springs, NY 12866__

Office Phone Number _(518) 290-0844_

National Provider Identifier (NPI) ____1477628618____

Name of Beneficiary (printed) or His/Her Legal Representative_____

Signature of Beneficiary or His/Her Legal Representative_____

Date_____ Home Address_____Phone_____

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HIPAA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting us.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving away my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ **Relationship to Patient:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the Patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my personal health information for treatment, payment, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____

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PATIENT COMMUNICATION CONSENT FORM

I, _____, am:
(print name)

(Please check one)

_____ a) a patient of

_____ b) the legal representative of a patient, _____
(print patient's name)

(please initial below)

_____ I agree to allow to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize to leave messages for me when I am unavailable. I understand that messages may contain confidential information.

METHOD	NUMBER/ADDRESS	MESSAGES (YES/NO)
_____ Home Phone	(_____)_____	☐ YES ☐ NO
_____ Cell Phone	(_____)_____	☐ YES ☐ NO
_____ Work Phone	(_____)_____	☐ YES ☐ NO
_____ Alternate Phone	(_____)_____	☐ YES ☐ NO
_____ Text Messages	(_____)_____	☐ YES ☐ NO
_____ Email	_____	☐ YES ☐ NO

(please initial below)

_____ I authorize staff to discuss my healthcare information (which may include history, diagnosis, labs, evaluation findings, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

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Client Consent Form for Osteopathic Manual Treatment

Osteopathic manipulative therapy (OMT), is widely recognized as one of the safest drug-free, non-invasive therapies available for the treatment of pain, neuromusculoskeletal/joint complaints, as well as for optimization of health through the balance of the structure of the human body.

Treatment will include manual therapies where the health practitioner places her hands on your body. Body and hand contact may include areas of your chest wall, pelvic floor, and pubic bones. If intraoral technique is required (work inside your mouth), disposable vinyl gloves will be worn.

Although OMT has an excellent safety record, no health treatment is completely free of adverse effects. The risks associated with OMT, however, are minimal. Many patients feel immediate relief following OMT, but some may experience mild soreness and aching, just as they do after exercise or deep tissue massage. Some may even feel an increase of their symptoms immediately after treatment as their bodies adjust and start releasing tensions. Current literature shows that minor discomfort or soreness following soft tissue therapy typically fades in 24 hours. If symptoms persist over 48 hours, please notify your Osteopath.

Certain therapies like Fascial Distortion Model (FDM) may cause redness, inflammation, and even bruising, however, this more intense therapy usually leads to quicker pain relief, when applicable.

I understand that I can refuse or stop the treatment at any time if it is uncomfortable.

If I do not fully understand a manual procedure or its risks, consequences, or alternative approaches to treatment, I have the right to question my osteopathic physician.

I, (print Name) _____, have had full opportunity to read and consider the contents of this consent form. I understand that by signing this form, I am giving consent for medical treatment.

Signature_____ Date __/__/____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Print Parent/Guardian Name_____

Signature_____ Date __/__/____