PATIENT REGISTRATION

PLEASE READ FRONT AND BACK.

Please print clearly so that we can process your information quickly and efficiently. Thank you.

Name (First, MI, Last) _____

Date of Birth_____ Age _____ Male / Female / Trans

Marital Status: S M W D

Address _____

Race _____ Primary Phone Number _____

Email _____

Employer

_____

Employer Address

_____

Employer Phone Number _____

Pharmacy _____

How did you hear about us?

_____

Referred By _____

Insurance Information

Primary Insurance Company _____

Phone Number _____

Address _____

Group # _____ Certificate or ID #_____

Insured's Name _____ Male / Female

Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____

Phone Number _____ Social Security Number _____

Date of Birth _____

Secondary Insurance Company _____

Phone Number _____

Address_____

Group # _____ Certificate or ID # _____

Insured's Name _____ Male / Female

Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____

Phone Number _____

Employer's Address _____

Insured's Social Security # _____ Date of Birth _____

I hereby assign, transfer, and set over to Vivacity Wellness Clinic all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether they are covered by my insurance.

Patient Signature _____ Date _____

MEDICATION LIST

(Please include **ALL** Prescriptions, Over-The-Counter, and herbal medications)

Medication	Dosage	Instructions

Please list any allergies and their reactions you may have:

_____
_____
_____
_____

VIVACITY WELLNESS CLINIC

Patient Information Form

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

FINANCIAL AGREEMENT

1. Services rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
    a. You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company.
    b. For unpaid claims over 45 days, it is your responsibility to follow up with your insurance and the balance due is considered due and payable.
2. It is your responsibility to notify our front desk of any insurance or address change. You will be responsible for any changes that occur if we are not notified.
3. Please inform us, if for any reason you are not able to keep your appointment at least 24 hours in advance. In case of no show without notification, we may charge you $25 to cover for cost incurred for preparation of your visit.

PATIENT AUTHORIZATION

I authorize Vivacity Wellness Clinic to submit insurance claims using my signature on file below. I authorize the release of any medical information necessary in order to process this assignment on claim. I authorize payment of medical benefits to be paid directly to Serene Care PA d/b/a VIVACITY WELLNESS CLINIC.

X_____ _____

Patient signature (or authorized representative) Date

PHOTO RELEASE

AUTHORIZATION AND CONSENT

I authorize VIVACITY WELLNESS CLINIC and IDEAL PROTEIN OF AMERICA INC., and their respective officers, employees, agents, or affiliates (the **"IP RECIPIENTS"**) to use and/or disclose my personal information to local, state, national and international media outlets. These media outlets may include newspapers, magazines, internet, and social media sites. I specifically authorize the use and/or disclosure of the following personal health information **("Personal Information"):**

- Photographs of me, in digital or any other format, in whole or in parts; and
- My testimonial, in any form or medium.

I understand that the IP Recipients may use and/or disclose any or all of my Personal Information for marketing, publicity, communications, and other business purposes. I understand that I will receive no compensation for the use of my Personal Information.

I understand that all photographs of me, including all reproductions, negatives, videos, or films, and my personal testimony that form part of my Personal Information remain solely the property of the IP Recipients. The IP Recipients may copyright, publish, and license photographs of me and my personal testimony. I understand that I waive any right to see or approve the finished product that uses my photograph or testimonial.

I expressly release and agree to hold harmless each of the IP Recipients from all claims arising out of, or concerned with, the use of my Personal Information.

I understand that, once any of the IP Recipients use my Personal Information, media outlets and others who have seen my Personal Information may not be subject to the same federal health privacy laws and may distribute any of the above information.

I understand that the IP Recipients may not condition my access to the Ideal Protein products and/or services on whether I sign this authorization and consent. I understand that I am not required to sign this authorization and consent and that my eligibly to use and/or purchase, as applicable, Ideal Protein products and/or services will not be affected by my refusal.

I understand that this authorization and consent will remain in effect for ten (10) years. I understand that I may revoke this authorization and consent at any point in time by giving the IP Recipients a written revocation. I understand that information released between the date of this authorization and consent and the date of revocation may still be used in the public domain.

I understand that I have the right to receive a copy of this authorization and consent.

I agree that I have the right to enter this authorization and consent. I have read the authorization and consent and understand its terms and condition, and I agree to all of them.

_____

Patient Name (Printed)

_____ _____

Patient Signature Date

NO REFUNDS POLICY

I understand that Vivacity Wellness Clinic does not offer a refund policy due to the Ideal Protein contract they are under.

All sales are final and once products are opened, they can not be exchanged for a different product.

Unopened Ideal Protein products can be exchanged for different unopened Ideal Protein products.

I have read and understand the NO REFUNDS POLICY for Vivacity Wellness Clinic.

_____ _____

Signature Date

PATIENT HISTORY

Please note any active, or history of, hormone-sensitive Cancers (or ongoing Estrogen Therapy)

Such as:

- Breast Cancer
- Uterine Cancer
- Ovarian Cancer
- Testicular Cancer

_____

_____

_____

_____

_____

_____

_____