15 Hospital Center Commons, Suite 100E,
Hilton Head Island, SC 29926
3770 Richmond Ave Staten Island, NY

(718) 605-4093

www.gullowellness.com

4 Key Questions

Name: _____ Date:_____

1. Why do you eat?

2. If you wanted to lose body fat, what should you change about your eating?

3. Do you crave certain foods? If so, which ones?

4. What is the best way to eat for health?

Dr. Nicole Gullo, PC
Phone: (718) 605-4093
www. gullowellness.com

Credit Card on File Agreement

Much like many other businesses such as a hotel or car rental agency, medical practices, attorneys, etc, Nicole Gullo, DC has a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your account.

All Patients
All balances are due at the time of service. The card on file will be charged accordingly the day of your visit/procedure.

New Patient Appointment Deposit
Our office requires a deposit for holding new patient appointment time slots. The deposit will be applied towards your initial visit. These deposits are completely refundable if you cancel your new patient appointment up to 48 hours before your appointment. For existing patients there is a $50 cancelation fee if you cancel your appointment less than 48 hours in advance. For new patients, the charge for the deposit is $100. If you fail to cancel your appointment within 48 hours of your new patient appointment, you will not be refunded your $100 deposit as it will be applied as a late cancellation fee.

By signing below, I authorize Nicole Gullo, DC to keep my signature and my credit card securely on file in my account. I authorize Nicole Gullo, DC to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Nicole Gullo, DC a new, valid credit card which I allow them to charge over the telephone. I agree that the new card may be used with the same authorization as the original credit card I presented. I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction responds to the terms indicated in this form. Should you wish to revoke this authorization at any time please send written notice to the office.

☐VISA ☐MASTERCARD ☐DISCOVER ☐AMERICAN EXPRESS

Patient Name (Print):_____DOB: _____

Name on Card (Print): _____

Credit Card # _____Exp Date: _____Security Code: _____

Please fill out the information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____DOB: _____

Patient Full Name (Print): _____DOB: _____

Patient Full Name (Print): _____DOB: _____

Card Holder's Signature:_____ **Date:**_____

Frequently Asked Questions

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry.The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The amount that will be taken from your account depends on your individual appointment and what you may owe for that service. For the nutritional program, the New Patient appointment is $350, the Report of Findings appointment is $150 for 45 minutes and $50 for each additional 15 minutes. After the New Patient appointment and the Report of Findings appointment, you will be charged $50 for every 15-minute appointment. For chiropractic services, the New Patient appointment is $175 and follow up chiropractic appointments are $60 for 15 minute chiropractic adjustments and $120 for 30 minute chiropractic adjustments. This charge will be processed following the appointment.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions only.

What are the benefits?
It saves you time and eliminates the need to call the patient and ask for their credit card information after each visit. It also drives our administrative costs down because our staff spends less time taking credit card information over the phone and entering it manually into our system.

I always pay my bills on time.
Why do I have to do this? The entire billing process is time consuming and wasteful. Reducing unnecessary costs are essential to allowing us to continue to be your provider. Nothing is changing about how much you pay.

What if there is a payment discrepancy or I have other payment questions?
Please contact our office directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute or question a charge.

Can I still receive a receipt?
Yes. If requested, you can receive a paid receipt for each transaction by email.

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Patient HIPPA Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, health care operations and obtain payment.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, health care operations or payment to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to use or disclosure of your personal health information but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You many not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Office.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

HIPPA COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience , aggravation and money. We want you to know that all our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

I waive my HIPPA rights in the event of any financial disputes involving third party payers (i.e. credit/ debit card companies, banks) so that information can be provided to resolve the dispute.

It is our policy to properly determine appropriate uses of PHI in accordance with the government rules and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly-valued patients.

_____	_____	_____
print name	signature	date

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Please be advised that in order to best address your specific health and nutritional needs, it may be necessary for Dr. Gullo to order specific and advanced functional blood work to best assist her in offering you the most comprehensive care for your condition. The blood work will be sent to a lab that accepts your health insurance. This blood work is often extremely detailed and very time consuming to analyze and report to you. Due to the time it takes to go over such blood work, extended visits are often needed. Should this be true of your particular case, there is an additional $50 fee for every 15 minutes spent on extended office visits. We highly recommend coming to this appointment prepared with questions that you might have so as to have time for the doctor to answer them. If you are bringing someone with you to the extended visit please advise them of the time constraints should they have questions as well. Please understand that once the visit goes over the 15 minute extension you will be charged an additional $50 for the next 15 minutes, providing that Dr. Gullo has the opening in her schedule. If another patient is scheduled for the appointment time after your extended visit, we will be happy to accommodate you with an appointment at another time should you find that you still have questions that need to be answered. This type of testing will not apply to every patient, however if it should, you will be given the option of declining the advanced testing or the reporting of such testing.

I have read the above and understand the additional fee for reporting of advanced testing and my right to refuse Dr. Gullo's recommendation of such testing.

_____ _____

Patient's Name Date

_____ _____

Patient's Signature Witness' Signature

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Please be advised that in order to best address your specific health and nutritional needs, it may be necessary for you to book an extended visit with Dr. Gullo on occasion. These visits may include, but are not limited to, blood work, menu customization or to address health concerns that either you or Dr. Gullo might want addressed. These types of visits are usually very detailed and time consuming. Should this be true of your particular case, there is an additional $50 fee for every 15 minutes spent on extended office visits. We highly recommend coming to this appointment prepared with questions that you might have so as to have time for the doctor to answer them. If you are bringing someone with you to the extended visit please advise them of the time constraints, should they have questions as well. Please understand that once the visit goes over the 15 minute extension you will be charged an additional $50 for the next 15 minutes, providing that Dr. Gullo has the time allotted in her schedule. If another patient is scheduled for the appointment time after your extended visit, we will be happy to accommodate you with an appointment at another time should you find that you still have questions that need to be answered. Extended visits do not apply to every patient, however if it should apply to you, you are aware of the additional charges for such visits.

I have read the above and understand the additional fee for reporting of advanced testing and my right to refuse Dr. Gullo's recommendation of such testing.

_____	_____
Patient's Name	Date
_____	_____
Patient's Signature	Witness' Signature

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To Our Valued Patients,

As our practice is growing and changing some of our office policies have changed as well. To avoid lack of communication and misunderstanding of these policies, this seems like the perfect time to update all patients on new office policies and remind you of the already existing policies.

If you have been a patient of our practice in the past and have been out of the office for a period of 6 months-1 year, a re-evaluation will be necessary. At this time your health history will be updated, new blood scripts will be given and your body composition analysis will be performed. This visit will require more than the 15 minute visit allotted for your standard visit and therefore a fee will be quoted at the time of booking the appointment. Existing patients who have been inactive in the office for one year or greater will require a complete consultation and that fee will be quoted at the time of booking the appointment as well. As always, if blood work is ordered there is a need for an extended visit to consult with you about the results of your blood work. The fee for this extended visit is $150. In the weeks to come you will be asked to sign a form explaining this policy. If you have already signed it in the past we will ask that you sign it again in order to update your file.

We have always had a 48 hour cancellation policy. This notice is given to you with your new patient packet, it is posted throughout the office and you are asked to sign a sheet that you understand the policy. Failure to adhere to the 48 hour cancellation policy will result in a $50 cancellation fee. While we have been liberal with the policy in the past, it is necessary for us to strictly adhere to and enforce this policy. It is becoming increasingly common for patients to either not cancel their appointment or wait for the day of or the day before their scheduled appointment to cancel. This is not the policy and we can no longer be as liberal with this policy as we have in the past. Many patients are waiting for appointments to open up and we would like to be able to offer these patients the appointment that you are not intending on keeping. Please be courteous to others and to our office.

It has been brought to our attention that some patients are using Facebook Instant Messenger to communicate with the office. We ask that you do not send messages through Instant Messenger as it is an unreliable source in which to communicate with our office. Please do not instant message Dr. Gullo or any of her staff members with office related matters as these accounts may not get checked on a daily basis. Your questions and concerns are important to us and we would like to address these matters as quickly as possible. To ensure that your emails are answered in a timely and professional manner, please call the office at 718-605-4093, text at 347-882-9926, or email us at **gullowellness@gmail.com**. These are the only reliable means of communication with our office. Any other phone numbers, including Dr. Gullo's cell number, are not monitored consistently throughout the day and might get overlooked. Please only use the above mention means of communication when contacting our office.

Please understand that these policies are set in place in order to improve the efficiency of the office and the service that we can provide to you. Thank you in advance for cooperation in this matter and for your continued support.

Warmest Regards,

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Please be advised that all scheduled office visits with Dr. Nicole Gullo must be cancelled at least 48 hours prior to the appointment date to avoid a cancellation fee. Failure to give 48 hours notice will result in a **$50.00 cancellation fee**.

I, _____ am aware that I am required to notify Dr. Nicole Gullo of appointment cancellations within **at least 48 hours prior to my scheduled appointment**. Failure to do so will result in a $50 cancellation fee that I will be required to pay.

_____
Patient Name (please print)

_____
Signature Date

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HEALTH HISTORY

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home#: _____ Cell#: _____ Work#: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Email: _____

Who referred you to our office? _____

Are you on Facebook, Instagram, or Twitter? _____

Please provide usernames:

_____

_____

_____

3 DAY DIET RECALL

Record everything that you eat and drink. Please be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating. (i.e. Watching TV, driving, standing, talking, etc.)

This must be filled out prior to first appointment.

DAY 1

BREAKFAST

_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DAY 2

BREAKFAST

_____
_____
_____
_____

MID-MORNING SNACK

_____
_____ _
_____ _

LUNCH

_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DAY 3

BREAKFAST

_____
_____
_____
_____

MID-MORNING SNACK

_____
_____
_____

LUNCH

_____
_____
_____
_____

AFTERNOON SNACK

_____
_____

DINNER

_____

_____

_____

_____

AFTER DINNER SNACK

_____

_____

_____

DINNER

_____

_____

_____

_____

AFTER DINNER SNACK

_____

_____ _

_____ _

DINNER

_____

_____

_____

_____

AFTER DINNER SNACK

_____

_____

_____

Do you smoke?

☐ Yes

☐ No

How much_____ How long _____

If you quit, when did you quit? _____

Do you drink alcohol? _____

How much/how often? _____

Do you use recreational drugs? _____ Which ones? _____

How much/how often? _____

Do you have food allergies, restrictions, or sensitivities?

_____

_____

Describe your daily energy levels:

_____

Do you get noticeable irritable, light-headed, or weak if you haven't eaten for a while?

_____

Do you crave any of the following?

☐ Sugar ☐ Meat ☐ Fat ☐ Chocolate ☐ Fish ☐ Alcohol

☐ Desserts ☐ Milk ☐ Bread ☐ Fried Foods ☐ Other, please list below

_____

Do you take any nutritional supplements or vitamins? _____ If so, which ones? Be specific.

_____

_____

_____

_____

_____

Which prescription and over the counter medications do you take regularly? Please include present and past chemotherapeutic agents and/or immunotherapy and if you have undergone any fertility treatment and dates.

_____
_____
_____
_____
_____
_____

Which oils do you use/consume?

- ☐ Butter
- ☐ Peanut Oil
- ☐ Canola
- ☐ Margarine
- ☐ Corn Oil
- ☐ Sun/Safflower
- ☐ Olive Oil
- ☐ Crisco
- ☐ Mayonnaise
- ☐ Coconut Oil
- ☐ Vegetable Oil
- ☐ Flaxseed Oil
- ☐ Soybean Oil
- ☐ Other _____

How is your dental health?

_____

Have you ever had a filling removed or replaced?

- ☐ Yes (date) _____
- ☐ No

If yes, how many? _____ When? _____

How many bowel movements do you have a day? _____

Do you have any abnormal bowel movements such as loose stool, diarrhea, blood in your stool or impacted feces? _____

Gastroenterologist _____

Colonoscopy:

- [ ] Yes (date) _____
- [ ] No

Endoscopy:

- [ ] Yes (date) _____
- [ ] No

Rank your skin condition without lotion:

- [ ] Very Dry
- [ ] Dry
- [ ] Normal
- [ ] Oily
- [ ] Combination

Please check off any of the following that pertain to you now or in the past.

(Please mark PRESENT conditions with a P next to it):

- [ ] Acne
- [ ] Addiction (alcohol, drugs)
- [ ] Anemia
- [ ] Anorexia/Bulimia (circle one)
- [ ] Anxiety or nervousness
- [ ] Arthritis (Rheumatoid or Osteo)
- [ ] Asthma
- [ ] Attention/Focus Disorder
- [ ] Autoimmune Disease _____
- [ ] Bladder infections (Cystitis)
- [ ] Bloating, gas, or indigestion
- [ ] Blood Disorder _____
- [ ] Blood Sugar problems
- [ ] Bronchitis
- [ ] Cancer _____
- [ ] Colds or flu (frequent)
- [ ] Cold Sores
- [ ] Chronic Fatigue
- [ ] Chronic Pain
- [ ] Constipation
- [ ] Dandruff
- [ ] Depression
- [ ] Diabetes I (insulin dependent)

- [ ] Diabetes II (adult onset)
- [ ] Difficulty losing weight
- [ ] Difficulty gaining weight
- [ ] Emotional problems (instability or sensitivity)
- [ ] Emphysema
- [ ] Epstein Barr Virus (EBV)
- [ ] Fainting
- [ ] Gall Bladder Problems
- [ ] Gout
- [ ] Hair loss or poor hair growth
- [ ] Headaches
- [ ] Heart disease or problems
- [ ] Hemorrhoids
- [ ] Herpes simplex or type II
- [ ] Hiatal Hernia
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] HIV
- [ ] Hot flashes
- [ ] Hypoglycemia
- [ ] Infections _____
- [ ] Infertility _____
- [ ] Insomnia
- [ ] Intestinal problems
- [ ] Kidney stones
- [ ] Learning Disabilities
- [ ] Liver problems
- [ ] Lyme's Disease
- [ ] Memory loss or confusion
- [ ] Nails, poor growth
- [ ] Panic attacks
- [ ] Parasites
- [ ] PCOS
- [ ] Pregnant or nursing
- [ ] Reflux/Heart burn
- [ ] Respiratory problems
- [ ] Ringing in ears
- [ ] Seizures (current or past)
- [ ] Severe mood swings
- [ ] Skin conditions
- [ ] Stroke
- [ ] Suicidal Tendencies
- [ ] Thyroid conditions
- [ ] Ulcer
- [ ] Yeast Infections

Primary Care Physician: _____

Oncologist (if applicable): _____

Surgeon (if applicable): _____

Please list any hospitalizations with dates and events:

_____
_____
_____
_____

Women: Please check all that pertain:

- ☐ Last menstrual period _____
- ☐ PMS
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Loss of periods
- ☐ Hormone Replacement Therapy
- ☐ Birth control pills
- ☐ Menopause: _____
- ☐ Painful intercourse
- ☐ Number of pregnancies: _____
- ☐ Children (give ages and sex) _____
- ☐ Vaginal or c-section delivery _____
- ☐ Hysterectomy
- ☐ Miscarriages
- ☐ Are you currently trying to become pregnant? _____
- ☐ How long have you been trying to become pregnant? _____
- ☐ Ob/Gyn _____ Fertility Specialist _____

Men: Please check all that pertain:

- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Difficulty with erection
- ☐ Loss of libido
- ☐ Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____
_____
_____
_____
_____
_____

Please rate the following:

Daily energy level: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Energy level after exercise: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Daily stress level: ☐ Very High ☐ High ☐ Moderate ☐ Low

Do you have a good support system of family and friends? _____

General enjoyment of life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How many hours do you sleep? _____ Do you sleep throughout the night? _____ Do you wake up without an alarm? _____ Do you wake up feeling rested? _____ Do you fall asleep within 15 minutes? _____

How many nights a week do you sleep through the night? _____

Do you have any concerns with your weight? _____

Please check one: underweight ☐ overweight ☐

How many diets have you been on in order to lose weight? _____

Which ones? _____

What were your results? _____

What are your challenges when trying to lose weight? _____

_____

Have you ever taken weight loss supplements or "diet pills"? _____

If so, which ones? _____

When did you take weight loss supplements or medication? _____

How many diets have you been on in order to gain weight? _____

What are your challenges when trying to gain weight? _____

_____

Have you ever taken supplements or medication to gain weight? _____

If so, which ones? _____

When did you take supplements or medication to gain weight? _____

What do you feel triggered your initial weight gain? (Check One)

☐ HEREDITAY ☐ EATING HABITS ☐ STRESS ☐ HORMONES

☐ BOREDOM ☐ SMOKING CESSATION ☐ OTHER _____

Was your weight gain: (Check One)

☐ SUDDEN ☐ GRADUAL ☐ PROBLEM SINCE CHILDHOOD

Exercise:

Do you exercise? If so, what kind? _____

How often/since when? _____

_____

Please describe any health concerns you think are important:

_____

_____

_____

_____

_____

What are your nutritional goals?

_____
_____
_____
_____
_____

By signing below, I acknowledge that any dietary or supplemental suggestions made by this office are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. I also acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that I make. I understand that insurance is not accepted for this service, there are no diagnostic codes or forms available for this procedure, and no insurance claim forms will be filled out for this service. I further understand that there are no refunds for this service.

Date: _____

Name: _____

Signature: _____