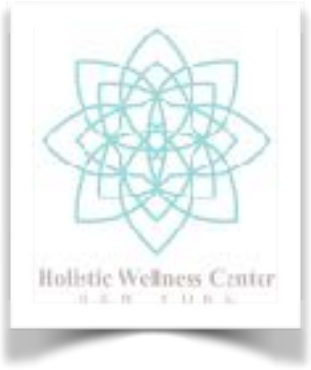



**75 Maiden Lane**
**Suite 902**
**NY, NY 10038**
**Ph: (212) 547-9907**
**Fx: (917) 591-6244**
**Tax ID: 27-3128336**

**PATIENT IDENTIFICATION FORM**

Today's Date_____

**Patient Name**:_____

Current Address: _____
Street City State Zip Code

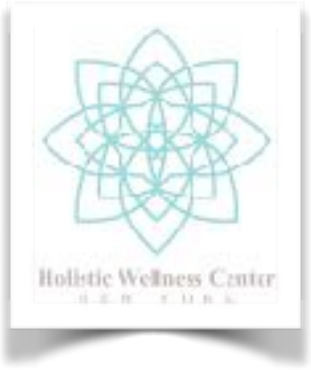
Permanent Address:_____
Street City State Zip Code

Telephone: (M)_____ (H) _____Email:_____

Reason for Referral:_____ Referred By:_____

Sex: ()Male ()Female () Non-Binary
Marital Status: ()Single ()Married/Partnered ()Separated ()Divorced () Widowed

Date of Birth:_____ Age:_____
Place of Birth:_____
Citizenship: _____
Patient'sOccupation:_____
Social Security #:_____/_____/_____
Drivers's License Number:_____ State Issued: _____
Height: _____
Weight:_____
Medical Problems:_____(If female) Pregnant? Yes / No
Medications:_____
Allergies to Medications:_____




**HIPAA PRIVACY POLICY ACKNOWLEDGEMENT/AGREEMENT**

This notice describes how your health information, as a patient of **Holistic Wellness Center New York** may be used and disclosed, as well as how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **"Health Insurance Portability and Accountability Act" of 1996 (HIPAA).** Our Commitment to your privacy: Your Clinician is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

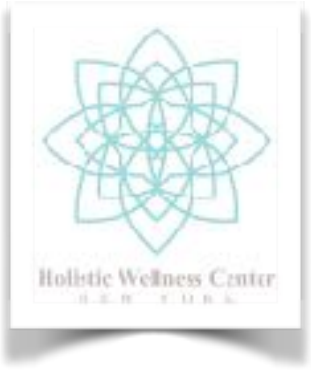
Use and disclosure of your health information in certain special circumstances: (The following circumstances may require your clinician to use or disclose your health information.)

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. IF required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat and protect from harm.
5. If you are a member of the U.S. or a foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
8. For Workers Compensations and similar programs.

Your rights regarding your health information:

1. Communications: You can request that your clinician communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or information to only certain individuals involved in your care, the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical record and billing records, but not including psychotherapy notes. You must submit your request in writing to your clinician at: **Holistic Wellness Center NY, 75 Maiden Lane Suite 902, NY NY 10038**
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept for your clinician. To request an amendment, your request must be made in writing and submitted to your clinician at: **Holistic Wellness Center NY, 75 Maiden Lane Suite 902, NY NY 10038**
5. Filing a Grievance: You have the right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with your clinician or with the Secretary of the Department of Health and Human Services. To file a complaint with your clinician, please submit in writing to your clinician at: **Holistic Wellness Center NY, 75 Maiden Lane Suite 902, NY NY 10038** Please note, you will not be penalized for filing a complaint.
6. Right to a copy of this notice at any time: You are entitled to receive a copy of this Notice of Privacy Policies. You may ask us to give you a copy at any time. To obtain a copy of this notice, contact your clinician's front reception desk.
7. Right to provide an authorization for other uses and disclosures: Your clinician will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our Health Information Privacy Policies, please contact you clinician at **(212) 547-9907.** Please, sign the second page of this Privacy Policy to acknowledge your receipt of this information.
**Thank you, Affiliates of Holistic Wellness Center New York.**




***ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY (HIPAA) AGREEMENT:***

I, _____, acknowledge that I have received a copy of the Holistic Wellness Center NY, "HIPAA Privacy Policy Acknowledgement Agreement" form.

This notice describes how Holistic Wellness Center NY may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Patient Signature Date

_____ _____
Patient Representative (Relationship to Patient) Date

***EMERGENCY AGREEMENT:***

None of us ever wish to be faced with times of emergency, but if we must endure such a time, then it is good to be prepared.

In case of an emergency please call 911. You may rightfully attempt to reach your clinician as well in this difficult time, but please do so AFTER calling 911, as your safety is of utmost importance.

As well, when contacting your clinician, please do so by phone to ensure timely and confidential delivery of the information.

Having a proper emergency plan, and knowing the actions necessary to carry out the plan, will most certainly ensure a safe and successful outcome.

We thank you for your understanding,
Holistic Wellness Center NY

Patient Signature_____Date_____

***PATIENT CANCELLATION POLICY:***

Welcome to our practice and thank you for choosing us! We appreciate your confidence and goodwill. When you have confirmed an appointment with us, please mark this important date on your calendar, as we look forward to seeing you at that mutually agreed upon time, as this time has been reserved especially for you.

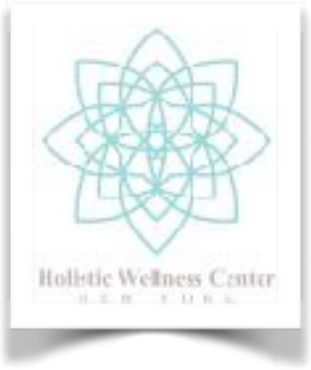
It, however, is understood that some cancellations may be inevitable. So, should such a situation arise for you, please take the time to call and cancel your appointment no less than 48 hours in advance of your previously scheduled appointment time. Doing so allows us to schedule other patients, such as yourselves in the future, who may be in need of an urgent appointment.

Should you not be able to cancel your appointment within 48 hours of your designated appointment time, you are subject to your clinician's full fee charge since they held the time specifically for you.

With a little mindfulness and mutual respect for each others time, last minute cancellations and any fees that may apply can be easily avoided.

We thank you for your understanding
Holistic Wellness Center NY

Patient Signature_____Date_____




**OFFICE POLICIES AND CONSENT TO TREATMENT**

Welcome to Holistic Wellness Center NY. This sheet contains important information about our professional services, office policies, and our work together. Please read it carefully, and discuss any concerns you may have with your clinician.

RISKS AND BENEFITS

Psychiatric/Psychological treatment with medications or psychotherapy has both risks and benefits. Risks include experiencing levels of emotional distress including sadness, guilt, anxiety, anger and frustration. Medications themselves each carry individual risks and benefits. Treatment has also shown to have benefits for people who undertake it, leading to relief of feelings of distress, better relationships and resolution of specific problems. There is an expectation but no guarantee that you will benefit from treatment. Medications all carry individual risks, and it is your clinician's obligation to discuss in detail these specific risks with you if this is to be part of your treatment.

CONFIDENTIALITY

What we discuss in sessions is confidential and may not be revealed to anyone without your permission except where disclosure is required by law. Disclosure may be required if there is a reasonable concern of 1)abuse or neglect of a child, dependent or elder adult 2) danger of harm to yourself or others 3) grave disability 4) pursuant to legal proceedings. Your clinician will not disclose information to your insurance carrier beyond a diagnosis code and a procedure code that is required for your reimbursement. He/she may ask you to sign a release to coordinate with your other health professionals. He/she may find it helpful to consult other specialist professionals about your care, in which case no identifying information about you will be revealed without discussing with you first. To protect your privacy, He/she will discuss with you how you wish to be contacted, what information may be left on voicemails and how you wish to be greeted if we see each other in public.

FEES

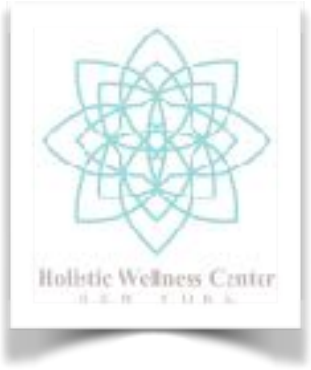
Payment is expected at the time of service. You will receive an invoice reflecting your sessions. This will be in a form suitable for insurance reimbursement or deductions from Health Care Savings Accounts. For your convenience we accept credit cards and cash. If your insurance carrier will pay for a part of your treatment, you are still responsible to pay for services first. You may submit your monthly invoice to your insurance company for them to reimburse you as their policy allows.

CANCELLATION POLICY

The scheduling of an appointment is your reservation of time specifically for us. You will be billed for all scheduled sessions. If you need to cancel an appointment, we require 48 hours advance notice or full fee is billed ($250). We will do our best to reschedule a missed session with you within what our schedules allow. In general, we are not able to conduct a session over the telephone. Your clinician cannot treat you adequately without your full attendance at scheduled sessions.

RECORDS

We keep records of your treatment that include times we met, your treatment plan and goals, indications for medication use and your response, in addition to some content of sessions. Any extensive therapy notes belong to Holistic Wellness Center NY and are generally not privy to the procuring of medical records. We do not give testimony in court. In the unfortunate circumstance that you bring suit against Holistic Wellness Center NY, you waive confidentiality and your clinicians are allowed to present our understanding of your case without explicit consent.




VACATIONS
Your clinician will tell you their vacation schedule well in advance and will provide you with a clinician to contact with emergency issues or matters while they are away.

REACHING YOUR CLINICIAN
We do our best to be available by telephone. While we are generally in the office throughout the week, we do not answer the phone if we are with a client. If you need to leave a non-urgent message about scheduling, please leave a message on the phone number given to you and we will do our best to contact you during the day, generally during business hours. If you need to reach your clinician urgently, you may call them or have them paged and they will return your call immediately. Please reserve this for truly urgent matters or emergencies, as it often involves interrupting the session of another client. There will be no charge for phone calls unless they are unusually lengthy (greater than 10 mins) or frequent. In the event routine phone contact is needed, fees will apply. We use email for professional communication and sometimes patients prefer text messaging, but we must inform you it is not a totally secure form of communication.

ENDING TREATMENT
Usually you and your clinician decide mutually when to end treatment. However if you decide to leave treatment on your own, you are free to discontinue at any time, but we ask that you please inform your clinician in a timely fashion so that they may open your appointment to someone else. Under the unfortunate circumstance of your non-compliance with scheduled appointment times or non-compliance with agreed upon treatment plans, these too can be grounds for discontinuation of the clinician/patient treatment relationship. Should this happen, you will be notified in writing of your discharge from this practice and given options for continued treatment; either in the form of a list of recommended clinicians outside of the practice and/or other mental health agencies, such as NY states 1-800-LIFENET, which can aid you in finding continued mental health care services that fit your needs.

LIMITS OF SERVICE
In the event of a life threatening emergency, please call 911 or go to the nearest emergency room. Call your clinician as soon as practical. We do not provide disability, workers compensation or insurance company evaluations. In the event you intend to apply for disability or workers compensation coverage, please discuss this with your clinician first. Medical doctors are licensed and regulated by the medical board of New York http://www.health.ny.gov/professionals/doctors/conduct/ or 1-800-663-6114. Clinical Psychologists are licensed and regulated by the NY state office of professions, so to are Acupuncturists and Nutritionists http://www.op.nysed.gov/prof/psych/

We may revise this agreement as needed to support our work together.

CONSENT
My decision to undergo treatment is voluntary. I have read and understand the above information and agree to comply with office policies.

_____
Name (Print)

_____
Signature Date

**Holistic Wellness Center NY Verbal/Written/Electronic Communication Disclosure Authorization**

I do hereby request and authorize **Holistic Wellness Center NY,** health care staff, clinician(s), and physician(s) to be able to contact the following people or organizations for the purpose of: “Facilitation of Treatment”

Names and relationships of who may be contacted are:

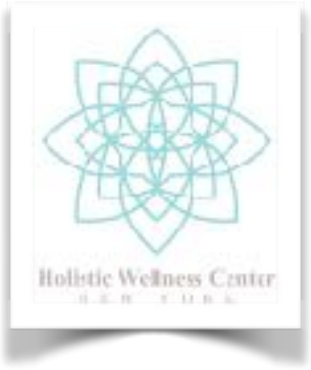
| | | | | |
|---|---|---|---|---|
| Physician | Phone | Email | Date | Client Initials |
| Psychologist/Therapist | Phone | Email | Date | Client Initials |
| Family/Significant Other | Phone | Email | Date | Client Initials |
| Other | Phone | Email | Date | Client Initials |

**Holistic Wellness Center NY Verbal/Written/Electronic Communication Disclosure Authorization**

**I understand that the Verbal/Written/Electronic exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use, emotional and physical illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. This consent will remain in effect for the duration of my treatment or until I choose to revoke my rights to further share my information.**

**The information disclosed to the authorized parties is from treatment which confidentiality is protected by Federal Law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.**

| | | |
|---|---|---|
| Patient Signature | Date | Initials |




**Authorization for Release of Health Information (Including Alcohol/Drug Treatment NEW YORK STATE DEPARTMENT OF HEALTH and Mental Health Information) and Confidential HIV/AIDS-related Information**

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.

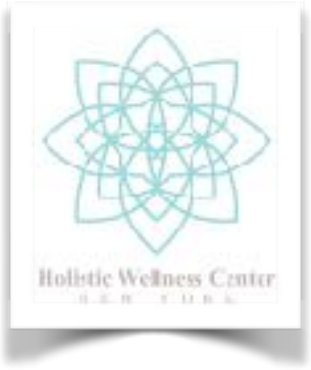
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

Signature Patient Name: _____ DOB: _____

Address: _____




5. Name and Address of Provider or Entity to Release this Information: "_____ *HOLISTIC WELLNESS CENTER NEW YORK, 75 MAIDEN LANE SUITE 902 NY NY 10038. MAY RELEASE INFORMATION ORALLY OR IN WRITTEN FORM VIA EMAIL:*_____*Or TEXT/PHONE* _____ "

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

_____

_____

7. Purpose for Release of Information: _____

8. Unless previously revoked by me, the specific information below may be disclosed from: All health information (written and oral), except: _____

**For the following to be included, indicate the specific information to be disclosed and initial below.**

-Records from alcohol/drug treatment programs Clinical records from mental health programs* HIV/AIDS-related Information INSERT START DATE_____ until INSERT EXPIRATION DATE OR EVENT _____

Information to be Disclosed ( please initial each line)

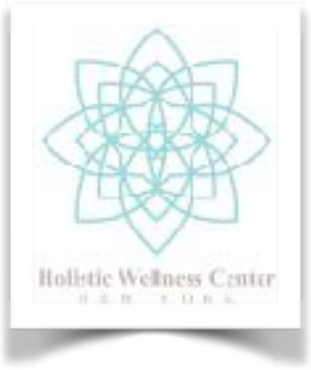
_____

_____

_____

9. If not the patient, name of person signing form: _____

10. Authority to sign on behalf of patient: _____




All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form ( if requested).

_____

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW and the DATE SIGNED

**Witness Statement/Signature:** I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative upon their request.

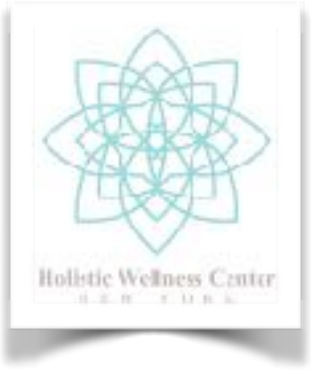
STAFF PERSON'S NAME AND TITLE _____

SIGNATURE/ DATE _____

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5032 (4/11)




Release of Liability

I understand Bill Farr is not a medical doctor or any other type of certified health care professional, and his opinion is not a substitute for professional medical prevention, diagnosis, or treatment. Please consult with your doctor or your other health care providers concerning your symptoms and medical requirements before following any of the remedies or other suggestions Bill offers. His opinion is based on his own research and is to be used for education and as another utility for improved health only. Bill Farr's wellness plans are meant to be used in conjunction with standard allopathic or osteopathic medical treatment and care. Bill asks that you continue to seek out your regular/annual medical check-ups with your primary care doctor, inform your doctor of your new wellness practices and inform him if your doctor believes that there needs to be a change made to your wellness plan. Bill is always welcome and open to collaborate with your physician for your greatest well being.

Signature of client _____

Date _____