Welcome

Thank you for your interest in Biologic Healthcare. At this time, we are accepting new patients. Our approach to patient care offers a different perspective, focusing on Lifestyle and Functional Medicine. Recognizing that this model is not right for everyone, we have developed a brief questionnaire to ensure our providers are the most appropriate fit for your needs.

Name: Birth Date: Age: Date:

Telephone: Home: Cell: Email:

Primary Insurance ID:

1. What services do you most value at Biologic?

2. What is your most immediate health concern?

Health Concern	Current treatment?	Who is treating this?

Current Medications/Supplements*	Dose	Times/Day	Current Prescriber

**Please specify specific brand. Use additional pages if needed.*

HEALTHCARE PROVIDERS	Provider/Group Name (Current)	Last Seen (month/year)
Primary Care Practitioner		
OB/GYN		
Other/Specialist		

Prefered Provider at Biologic. Please note your choice may be limited by your insurance.

- ❒ **Samantha K. Eagle**, MS, ND • Specialty Care • No Medicare
- ❒ **Casey B. Johnson**, MD ("Doc Bayley") • Primary Care • Accepts Medicare
- ❒ **Brenton C. Murphy**, MPH, ND • Primary Care and Specialty Care • No Medicare

(continued)

Demographic Form

We cannot process your paperwork unless all required fields are completed (indicated in ***BOLD** below).

***Last Name**	***First Name**	***Prefered Name**	MI	Date
Maiden Name (previous names)		***Date of Birth**	Age	

***Assigned Sex at Birth** ❒ Female ❒ Male ❒ Intersex

***Gender** ❒ Female ❒ Male ❒ Trans/female to male ❒ Trans/male to female ❒ Non-Binary ❒ Gender fluid ❒ Other ❒ Prefer not answer

***Pronouns** ❒ She/Her ❒ He/Him ❒ They/Them

***Race** ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American ❒ Hispanic or Latino ❒ Native Hawaiian or Other Pacific Islander ❒ White ❒ Unknown ❒ Other ❒ Decline

***Ethnicity** ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Unknown ❒ Decline

***Preferred Language**

***Mailing Address**

***Street Address** if different from mailiing

***City**	***State**	***Zip**
***Telephone (Home)**	**(Work)**	**(Cell)**

***Email Address** ***May we contact you by email?** ❒ Yes ❒ No

***Where may we leave messages?** ❒ Home ❒ Work ❒ Cell

***Where do you prefer to receive your appointment reminder message?** ❒ Home ❒ Cell ❒ Email ❒ Text

Parent(s) / Guardian(s) Name / Healthcare proxy

Do you have advance directives? ❒ Yes ❒ No If yes, which state?

Relationship Status ❒ Married ❒ Partnership ❒ Separated ❒ Divorced ❒ Widowed ❒ Single

Live with ❒ Spouse ❒ Partner ❒ Parents ❒ Children ❒ Friends ❒ Alone ❒ Roommates

***Employment Status** ❒ Employed ❒ Unemployed ❒ Full time student ❒ Part time student

Occupation		Hours per week
Employer Name	Address	Telephone
***Emergency Contact** First/Last Name	***Relationship**	***Contact Phone**

***Primary Care Giver**

(continued)

Health Insurance Information

Please note that not all policies cover Naturpathic care. Contact your insurance company to better understand your specific plan. We cannot process your paperwork unless all required fields are completed (indicated in ***BOLD** below).

PRIMARY Insurance

***Insurance Verification**:	❒ Aetna ❒ BC/BS ❒ CBA ❒ Cigna ❒ Harvard Pilgrim ❒ Medicaid/VHAP (Green Mountain Care) ❒ MVP ❒ Medicare ❒ United ❒ Self-Pay
State of Verification:	

***ID/Policy #**:	***Group/Acct #**:
***Subscriber Full Name**:	***Subscriber/ Policyholder Date of birth**:
***Your Relationship to Subscriber**	
***Medicare Part D (if applicable)**	

SECONDARY Insurance (if covered))

*Insurance Company:	*State:
*ID/Policy #:	*Group/Acct #:
*Subscriber Full Name:	*Subscriber/ Policyholder Date of birth:
*Your Relationship to Subscriber	

We also need **photocopies of all insurance cards** for our records.

*CHANGES IN INSURANCE CARRIER OR POLICY CHANGES

I will notify the front desk when I arrive of any changes to my insurance carrier or any policy changes. I understand that I am responsible for knowing my insurance coverage and for notifying Biologic when changes occur. I also understand that I am responsible for any charges that are denied by my previous insurance company and denied by the new insurance due to timely filing issues.

(continued)

HEALTH HISTORY QUESTIONNAIRE

Name: Date of Birth:

HEALTH SCREENING HISTORY	Date of most recent	**HEALTH SCREENING** (cont)	Date of most recent
Mammogram		Professional Prostate Exam	
Pap Smear		Colonoscopy	
Professional Breast Exam		Lab Tests	
DEXA/Osteoporosis		Imaging (Xray, CT, MRI)/Reason	

PERSONAL/FAMILY HISTORY

* MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM (Paternal Grandmother), PGF (Paternal Grandfather), Aunt(s), Uncle(s)

	SELF	MOTHER	FATHER	SISTER(S)	BROTHER(S)	OTHER (please specify)*
Birth Date						
Age (age at death)						
Cause of death						
Check those applicable:						
Alcoholism						
Substance Misuse						
Allergies/Hay Fever						
Asthma						
Anemia						
Anxiety						
Autism Spectrum Disorder						
Bleeding Disorder						
Cancer or Tumor (Specify Type)						
Chronic Fatigue						
Diabetes (Type 1 or Type 2)						
Depression						
Epilepsy						
Glaucoma/Other Eye Disorder						
Genetic Disease						
Heart Disease						
Hepatitis						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Mental Health Disorder						
Degenerative Arthritis						
Rheumatoid Arthritis						
Stomach Ulcer						
Stroke						
Thyroid Disorder						
Tuberculosis						
Other (specify)						

(continued)

Name: Date of Birth:

CURRENT HEALTH CONCERNS

Health Concern	Current treatment?	Who is treating this?

Allergies (drug/environmental/ food)	Symptoms

Food Sensitivities	Symptoms

Current Medications	Dose	Times/Day	Current Prescriber

Preferred Pharmacy	Location

Current Herbs/Vitamins/Supplements	Dose	Times/Day

HEALTHCARE PROVIDERS	Provider/Group Name (Current)	Last Seen (month/year)
Primary Care Practitioner		
OB/GYN		
Dentist		
Eye Care		
Other/Specialist		

(continued)

Name: Date of Birth:

HOUSING

Housing type: ❒ Single family home ❒ Apartment ❒ Condo ❒ Other: _____
❒ Children (list gender/ages): _____ ❒ Biologic ❒ Foster ❒ Adopted ❒ Step
Major stresses in last 12 months: ❒ Money ❒ Job ❒ Marriage ❒ Home Life ❒ Children ❒ Housing/Food Insecurity ❒ Illness
❒ Other stressors _____
Rate your stress level 1 to 10 on average (10 worst stress): _____ Is this a change? ❒ Yes ❒ No

DIET

Check which diet(s) you currently follow: ❒ Regular Diet ❒ Vegetarian ❒ Vegan ❒ Pescatarian ❒ Keto
❒ Low Carbohydrate ❒ High Protein ❒ FODMAP ❒ SIBO ❒ Other: _____

EXERCISE

What type of exercise do you engage in currently? ❒ Aerobic ❒ Anaerobic ❒ Flexibility ❒ None
Frequency of workout: ❒ Daily ❒ 4-6 times a week ❒ 2-3 times a week ❒ Weekly ❒ Monthly
Duration of session: ❒ <30 minutes ❒ 30-45 minutes ❒ 45-60 minutes ❒ 60-90 minutes ❒ 90+ minutes

TOBACCO HISTORY

Are you a current or past tobacco user?

❒ Cigarettes: ○ Current or ○ Past
❒ E-Cigarettes: ○ Current or ○ Past
❒ Cigars: ○ Current or ○ Past
❒ Pipe Tobacco: ○ Current or ○ Past
❒ Vaping, Juuling: ○ Current or ○ Past
❒ Chew Tobacco: ○ Current or ○ Past

If yes, how long have you used tobacco? _____
How many times have you tried to quit? ❒ 1 ❒ 2 ❒ 3 ❒ 4+

SUBSTANCE ABUSE HISTORY

Do you or have you ever used any of the following to feel better, happy, or numb? ☐ Yes ☐ No
❒ Cannabis ❒ Cocaine ❒ Benzodiazepines ❒ Opioids ❒ Hallucinogens ❒ Methampetamine
❒ Prescription drugs in non-prescriptive ways ❒ Heroin ❒ Other _____ If yes, last time used: _____
Are you currently taking ❒ Suboxone: _____ mg ❒ Methadone: _____ mg

ALCOHOL HISTORY

Do you drink alcohol? ❒ Yes ❒ Never drank ❒ Former drinker
How many glasses of wine per day? _____ or per week? _____
How many glasses of beer per day? _____ or per week? _____
How many hard spirits or shots per day? _____ or per week? _____

SLEEP HISTORY

Do you currently have sleep issues? ❒ Falling asleep ❒ Staying asleep ❒ Easy waking ❒ None of these
❒ Other (sleep walking, eating, night terrors, etc.) _____
How many hours of sleep on average do you get a night? _____ hours

TRAVEL HISTORY

List all recent travel outside of the country: _____

MEDICAL DEVICE HISTORY

Do You Use or Have Any of these Devices? ❒ Brace (Neck, Back) ❒ Pacemaker ❒ IUD ❒ Artificial Limbs
❒ Artificial Heart Valve ❒ Blood Vessel Stent ❒ Joint Replacement ❒ Other Metal Implants: _____
❒ Nexplanon (birth control implant) ❒ **Name + Serial Number (if available)** _____
❒ Continuous Glucose Monitor ❒ Insulin Pump

IMMUNIZATIONS (Please provide a copy of out-of-state vaccines)

❒ Immunizations are ALL up to date ❒ Behind Schedule ❒ Never Immunized ❒ Unknown ❒ Unsure
States immunized in: ❒ VT ❒ NY ❒ NH ❒ MA ❒ CT ❒ Other
❒ COVID Vaccine: ❒ Moderna ❒ Pfizer ❒ J&J Dates: Dose 1 _____ Dose 2 _____ Dose 3 _____
List childhood illnesses: _____
List prior **ILLNESS, INJURY, HOSPITALIZATION, SURGERY, AND/OR TRAUMA (including dates):**

(continued)

Name: Date of Birth:

REVIEW OF SYSTEMS/HEALTH SCREENING HISTORY

Check the response that applies:

Y = current condition P = past condition N = a condition you've never had

GENERAL		When	
Weight		Height	
Weight 1 yr ago		Energy Level (1-10)	
Max Weight		General Daily Pain (1-10)	

CONSTITUTIONAL	Y	P	N
Chills			
Decline in Health			
Fatigue			
Fever			
Weight Gain			
Weight Loss			

HEAD	Y	P	N
Headache			
Head Injury			
Migraines			
Dizziness			

EYES	Y	P	N
Impaired Vision			
Eye Pain			
Tearing			
Dryness			
Glaucoma			
Cataracts			
Light Sensitivity			
Itchy Eyes			

EARS	Y	P	N
Impaired Hearing			
Ringing			
Earache			

NOSE/SINUSES	Y	P	N
Nose Bleeds			
Stuffiness			
Runny Nose			
Sinus Problems			

MOUTH/THROAT	Y	P	N
Frequent Sore Throat			
Gum Disease			
Hoarseness			
Teeth Grinding			
Canker Sores			

NECK	Y	P	N
Lumps			
Swollen Glands			
Goiter			
Pain or Stiffness			

RESPIRATORY	Y	P	N
Cough			
Spitting up Blood			
Wheezing			
Asthma			
Bronchitis			
Pneumonia			
Emphysema			
Pain on Breathing			
Shortness of Breath			
At Night			
Lying Down			

CARDIOVASCULAR	Y	P	N
Heart Disease			
High Blood Pressure			
Murmurs			
Chest Pain			
Swelling of Ankles			
Palpitations, Fluttering			

GASTROINTESTINAL	Y	P	N
Heartburn			
Easy fullness			
Nausea			
Vomiting			
Bowel Movements			
How Often?			
Is This a Change?			
Diarrhea			
Constipation			
Blood in Stool			
Belching or Gas			
Bloating			
Stomach Pain			
Jaundice (yellow skin)			
Liver Disease			
Hemorrhoids			

MUSCULOSKELETAL	Y	P	N
Joint Pain or Stiffness			
Arthritis			
Broken Bones			
Muscle Pain			
Muscle Spasms or Cramps			
Restless Legs			
Chronic Low Back Pain			
Motor Vehicle Accident			

BEHAVIORAL	Y	P	N
Bulimia			
Anorexia			
Addiction			
To What?			

EMOTIONAL	Y	P	N
Depression			
Anger			
Anxiety or Nervousness			
Trauma History			

SKIN	Y	P	N
Rashes			
Eczema			
Psoriasis			
Acne, Boils			
Itching			
Color Change			
Lumps			
Night Sweats			
Nails breaking			
Warts			
Fungal Infections			

NEUROLOGIC	Y	P	N
Fainting			
Seizures			
Paralysis			
Muscle Weakness			
Numbness or Tingling			
Loss of Memory			
Brain Fog			
Word Retrieval Problems			
Tremor			

ENDOCRINE	Y	P	N
Diabetes (Type 1 or 2)			
Hypothyroid/Hyperthyroid			
Heat or Cold Intolerance			
Excessive Thirst			
Excessive Hunger			
Binge Eating			
Change in Libido			
Night Sweats			

BLOOD	Y	P	N
Anemia			
Bleeding			
Bruising			

IMMUNE SYSTEM	Y	P	N
Epstein Barr			
Mono			
Shingles			
CMV			
Lupus			
Crohn's			
Chronic Infections			
Lyme			
Mold Exposure			

URINARY	Y	P	N
Pain with Urination			
Increased Frequency			
Inability to Hold Urine			
Frequent Infections			
Kidney Stones			
Urine Retention			

PERIPHERAL VASCULAR	Y	P	N
Deep Leg Pain			
Cold Hands/Feet			
Varicose Veins			

(continued)

FEMALE/MALE MEDICAL HISTORY — AND SEXUAL HISTORY

Name:

Date of Birth:

Check the response that applies: Y = current condition P = past condition N = a condition you've never had

FEMALE MEDICAL HISTORY

MENTRUAL HEALTH		Y	P	N
Age Menses Began				
Average Number of Days				
Length of Cycle				
	Y	P	N	
Bleeding Between Periods	☐	☐	☐	
Regular Cycles	☐	☐	☐	
Extended Time Without Menses	☐	☐	☐	
How Long?				
Pain During Intercourse	☐	☐	☐	
Vaginal Dryness	☐	☐	☐	
Vaginal Itchiness	☐	☐	☐	
Yeast Infections	☐	☐	☐	
Painful Menses	☐	☐	☐	
Bacterial Vaginosis	☐	☐	☐	
Endometriosis	☐	☐	☐	
PCOS (Polycystic Ovary Syndrome)	☐	☐	☐	
Excessive Flow	☐	☐	☐	
Excessive Facial Hair	☐	☐	☐	
Excessive Body Hair	☐	☐	☐	

MENOPAUSE	Y	P	N
Menopausal Symptoms	☐	☐	☐
Describe:			
Age They Began			
Age of Your Mother at Menopause			

BREAST HEALTH	Y	P	N
Do You Perform Self Exam	☐	☐	☐
Breast Lumps	☐	☐	☐
Breast Pain or Tenderness	☐	☐	☐
Nipple Discharge	☐	☐	☐

OBSTRETICS	Y	P	N
Birth Control	☐	☐	☐
What Type?			
Number of Pregnancies			
Number of Live Births			
Number of Miscarriages			
Number of Abortions			
Difficulty Conceiving	☐	☐	☐

MALE MEDICAL HISTORY

	Y	P	N
Hernias	☐	☐	☐
Testicular Masses	☐	☐	☐
Testicular Pain	☐	☐	☐
Prostate Problems	☐	☐	☐
Discharge or Sores	☐	☐	☐
Trouble Starting & Stopping Stream	☐	☐	☐
Erectile Disfunction	☐	☐	☐
Premature Ejaculation	☐	☐	☐
Scrotal Mass	☐	☐	☐
Scrotal Pain	☐	☐	☐

SEXUAL HISTORY

Sexual Orientation Identity
☐ Bisexual ☐ Gay ☐ Straight ☐ Lesbian ☐ Queer
☐ Not sure/Don't know ☐ Asexual ☐ Other

Are You Sexually Active? ☐ Yes ☐ No

Sexual Difficulties:

I have been diagnosed with and/or treated for:
☐ Bacterial Vaginosis ☐ Chlamydia ☐ Gonorrhea
☐ Herpes ☐ HPV ☐ Syphilis ☐ Trich ☐ Other:
When?

You have been tested for HIV in the past? ☐ Yes ☐ No

Are you HIV-positive? ☐ Yes ☐ No ☐ Unknown

Have you ever been ☐ diagnosed with or ☐ tested for the following?
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
When?

List additional health history which may be pertinent.

I certify that information supplied is correct to the best of my knowledge.

Printed Name _____ Date _____

Signature_____ Relationship to Patient: _____

(continued)

Consent for Treatment

I voluntarily give my permission to the healthcare providers at Biologic Healthcare LLC (BH) to provide me with medical and/or counseling services. I understand that by signing this form, I am authorizing the providers to treat me for as long as I seek care from BH or until I withdraw my consent in writing. I understand that my healthcare with BH may include acupuncture, botanical medicine, chiropractic, general family medicine, homeopathy, laboratory/ diagnostic imaging referrals, massage therapy, naturopathic medicine, nutritional assessment, physical therapy, and psychotherapy. With this knowledge, I realize no guarantees have been given to me by the providers at BH.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am legally responsible for all charges in connection with the care and treatments provided by the practitioners at BIH. I certify that I, and/or my dependent, have insurance coverage with _____ . I authorize payment directly to BIH for health insurance benefits payable to me under terms of my policy and I agree to assist in the processing of claims for benefits. I understand that my insurance carrier will not cover the cost of dietary supplements and may not approve or reimburse services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization or medical necessity. I understand that I am responsible for fees not paid in full, co-payments and policy deductibles (when applicable) and co-insurance except where my liability is limited by contract.

CHANGES IN INSURANCE CARRIER OR POLICY CHANGES

I will notify the front desk when I arrive of any changes to my insurance carrier or any policy changes. I understand that I am responsible for knowing my insurance coverage and for notifying Biologic when changes occur. I also understand that I am responsible for any charges that are denied by my previous insurance company and denied by the new insurance due to timely filing issues.

PAYMENT

Payment for all services (copays / deductibles) and supplements is due at the time of your visit. Currently BH accepts cash, check and credit/debit cards. Returned checks will be charged a service fee of $30.00, and unpaid balances over 30 days may be charged late fees. We understand that patients may experience occasional financial problems. Please speak with us before the time of service regarding any such circumstances.

CANCELLATIONS AND RESCHEDULING

If you need to reschedule or cancel an appointment, **please give at least 24 hours notification**. If you forget an appointment or cancel less than 24 hours prior you will be charged a $75.00 fee for a follow-up/acute visit OR $150.00 for a physical exam/annual preventive medicine visit/new patient appointment. A patient who is a no-show for more than three visits may be considered for dismissal from the practice.

PRESCRIPTION AND TINCTURE REFILLS

A 72 hour notice is required for refilling prescriptions and tinctures.
Do you give Biologic Healthcare consent to request your Rx history? ❒ Yes ❒ No

CONSENT FOR RELEASE OF PRIVATE HEALTH INFORMATION

I understand that a confidential record will be kept of the health services provided to me. This record will not be released to others unless directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request. A "RELEASE OF RECORDS" must be signed and kept on file prior to the release of any records.

AGREEMENT

Please sign and date below that you have read, understand and agree to the above policies. Fees and policies may change and patients will be notified of any such changes.

Print Name: _____

Signature: _____ Relationship to patient: _____ Date: _____

(patient/client, or authorized representative, parent/legal guardian)

(continued)

Non-Covered Service Waiver

Private insurance will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If your insurance company determines that a particular service or treatment is "not reasonable and necessary" they will deny payment for that service or treatment unless explicitly stated the service or treatment would be otherwise covered. Under these circumstances, a bill is not submitted to your insurance company and these charges are your responsibility.

NON COVERED PROCEDURES AND TREATMENTS:

- Most functional medicine laboratory studies, including Food Allergy Testing, IgE, and IgG. Check with your insurance company. We can provide you with the relevant code information if you would like to submit for reimbursement.
- Intramuscular injections of minerals, vitamins and/or botanicals such as B12 (J3420), B Complex(J3420).
- Nutritional supplements and Botanical products.
- Other: _____

PATIENT AGREEMENT
I understand that the services listed above are not covered by insurance. I agree to be personally and fully responsible for any charges related to the services listed above regardless of my insurance company's determination of benefits.

Print Name:

Signature: Relationship to patient: Date:

(patient/client, or authorized representative, parent/legal guardian)

Acknowledge of Receipt

of the Notice of Privacy Practice

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices (available at biologichealthcare.com or in the office).

Acknowledgment of Receipt of the Notice of Privacy Practices

Print Name:

Signature: Relationship to patient: Date:

(patient/client, or authorized representative, parent/legal guardian)

(continued)

Telemedicine Informed Consent

Patient Name: Date of Birth:

LOCATION OF PATIENT: Vermont
*You must be in Vermont for all telemedicine visits.

Samantha K. Eagle MS, ND Vermont State License Number 099.0000215
Doc Bayley, MD Vermont State License Number 042.0015682
Brenton Murphy, ND Vermont State License Number 099.0133057

Physical office location: 205 Main St Brattleboro, VT 05301

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to the providers of Biologic Healthcare providing health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or co-insurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Biologic Healthcare at 802-275-4732. As long as this consent is in force (has not been revoked) the providers of Biologic Healthcare may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient):

Signature: Date:

If authorized signer, relationship to patient:

I have been offered a copy of this consent form (patient's initials):

(continued)

New Patient Authorization to Release Personal Healthcare Information

Please fill out a separate form for each office.

Patient Name | Date of Birth

Also or previously known as (other names used)

I authorize the disclosure and use of my health information as described below:

To be RELEASED by:

Phone: Fax:

To be RECEIVED by:
Biologic Healthcare
205 Main Street
Brattleboro, VT 05301
802.275.4732 Fax: 802.275.4738

Please mail records that are over 10 pages long. Less than 10 pages may be faxed.

For the purpose of: ❒ Adjunctive/Concurrent Care ❒ Transfer of Care ❒ Other:

I specifically authorize the release of the following information:

❒ Last two progress notes, most recent labs/imaging reports, immunization records, medication/supplement lists and problem list.

❒ Other:

Unless specifically excluded, this authorization includes the release of specially protected information: referral, diagnostic and treatment information related to substance abuse, mental health/psychotherapy, and HIV/AIDS.

Check the accompanying box(s) below to EXCLUDE the information from authorization:

❒ Substance abuse ❒ Mental health/psychotherapy ❒ HIV/AIDS

I understand the conditions of this authorization:

1. Unless canceled by me, this authorization is valid for 12 months from the date of signing.
2. I may cancel this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document.
3. If the person/organization receiving the health information is not a health plan or health care provider, the release information may no longer be protected by state and Federal privacy regulations.
4. Not agreeing to or canceling this authorization may result in improper diagnosis or treatment, or denial of health benefits or other insurance coverage, but is not a condition for receiving medical treatment.
5. I am entitled to a copy of this authorization form at the time of signing.

Patient Name (PRINT) | Signature of Patient | Date

Patient's Guardian/Representative (PRINT) | Signature of Guardian/Representative | Date

biologic HEALTHCARE

sensible approaches to your well-being

205 Main Street • Brattleboro, VT 05301 • 802.275.4732 • FAX 802.275.4738
www.biologichealthcare.com