Please note that communication via email, over the Internet, is never entirely secure. While improbable, it is still possible that information you include in an email could be intercepted and read by other parties besides the person for whom it is intended.
Please fax or hand-carry completed documents to your appointment.

Lisa Mainier, D.O.
Salus Integrative Medicine, PC
2545 West 26th St., Erie, PA 16506
(Pittsburgh Clients: Please use FAX)
(P) 814-923-4025 – Erie, PA
(F) 814-746-4684

Client Demographics

Name:	
Mailing Address:	
Cell Phone:	
Home Phone:	
Email Address:	
Age:	DOB:
(circle) Gender: M F	
Appointments, reminders and some confidential messages may be left on my (circle ALL that apply) Cell voicemail / home voicemail / Text / Email	
Emergency Contact Name, Phone number and relationship to client:	
Client Signature/date:	

Employer

Employer:

PCP/Pharmacy

PCP Name:	PCP Phone:
PCP Address:	
Pharmacy Name and Address:	
Pharmacy Phone:	Pharmacy Fax:

Other Treating Physician/Services

Physician Name:	
Address:	
Phone:	Fax:
Diagnosis:	
Treatment:	

Permissions

May your PCP call me so that I may discuss lab findings and other pertinent information, if needed? Y N	
Please initial and date:	Date:

Providing Information

Salus Integrative Medicine, PC will not give anyone information about your healthcare without your permission. There are some circumstances where you may desire assistance in receiving healthcare information such as providing copies of records, labs, prescriptions to family members (i.e. spouse) or confirming appointments. Below, please list name and relationship to those who you choose to have permission to receive information regarding your health:

Please print legibly and state relationship to you:	
Name:	Date:
Client (or client's Legally Authorized Person) signature:	
Relationship to Client:	

Communication Policies

Please read and initial the policies listed below:

- ___ Dr. Mainier and client does not use email for direct communication regarding sensitive healthcare information.
- ___ Clients must call 814-923-4025 or ChARM (EMR) for confidential communication.
- ___ I agree to receive email notices of workshops or events or simple communication regarding articles of interest and other general information from Salus Integrative Medicine, PC

OR

- ___ I DO NOT wish to receive emails from Salus Integrative Medicine, PC regarding workshops and events or even articles of interest.

AGREEMENTS, AUTHORIZATIONS, ACKNOWLEDGEMENTS, NOTICE AND CONSENT

Please Initial each statement where indicated:

1. I, ________________________________, authorize Dr. Lisa Mainier*, licensed medical physician in the state of Pennsylvania, to provide medical and health care treatment for myself. I understand that I am seeking medical advice from Lisa Mainier, D.O., a licensed, board-certified medical physician. Her practice focuses on overall wellness, nutrition, and lifestyle modifications that may include functional, holistic, complementary and integrative approaches.
2. ________ **I understand that Dr. Mainier is NOT my primary care physician (PCP)** and is not responsible for the diagnosis and treatment of any particular disorder, but instead is offering medical guidance for my medical condition(s) and overall health, regarding nutrition, wellness and soundness of mind and body. **I understand that I must maintain a PCP to continue with all available conventional measures to attend to any medical condition for which I require continued monitored medical care.** I will update Dr. Mainier regarding the identity of my referring physicians or PCP using the attached PCP and Specialist Information Form. If desired, I will complete the attached Authorization Form to authorize my referring health care provider or PCP to release my medical records to Dr. Mainier at Salus Integrative Medicine, PC.
3. _________I understand that although Dr. Mainier is formally trained in medicine and is Board Certified in both Family Medicine and Integrative Medicine. Her services and recommendations may be also be based traditional and non-conventional services, often referred to as complementary, alternative, holistic or integrative medicine. This approach to healing and health may entail the use of other services that may not be offered or recognized by those physicians in the medical community who practice solely, traditional medicine. Many of these services may include, but are not limited to, nutrition, health counseling, supplements, and mind-body approaches, that may not be recognized as customary medical practices. Many of these approaches have been practiced for many years, but may be considered investigational, experimental and may not be approved by the Food and Drug Administration and other regulatory agencies.
4. _______I understand that herbs, botanical products and supplements are generally considered safe, based on their long history of use by many cultures, but many have not been tested using conventional study designs. Although rare, any product can be detrimental, particularly if I am allergic to them, and this could lead to serious consequences. Interactions, both commonly known and some unknown, between conventional drugs, other herbs or supplements, and some medical conditions, exist. This could result in reduced or increased effects of other medications or other negative effects. It is therefore vital, that **I reveal all medications, herbs and supplements that I am taking and inform all of my treating physicians, including Dr. Mainier of all of my medical conditions and treatments.**
5. __________Dr. Mainier may suggest mind–body approaches such as meditation, guided imagery, breathing techniques, biofeedback and the like, to facilitate my ability to achieve wellness, manage stress, gain a positive perspective, and perform successfully in maintaining a healthy lifestyle. I understand that this approach may be effective in reversing the influence of stress on healthful living because we now understand that stress impacts many medical conditions.

6. ________ **I understand that should I have an adverse reaction, and if it is serious, I will seek emergency care immediately.** Although Dr. Mainier is qualified, she does not treat urgent or emergent conditions as a PCP, and that I should seek help at a qualified medical facility or my own doctor. I will report to her, any and all unfavorable reactions that occur. I understand that Dr. Mainier is completely office-based and she does not admit to a hospital, is not affiliated with any hospital or insurance company, and **she does not provide emergency, on-call services.**
7. _________I understand that the services provided by Dr. Mainier may not be reimbursed by my health insurance. Many insurance companies will not pay for physician consultations regarding wellness, nutritional counseling, or other alternative services. Laboratory testing that pertain to wellness and insurance companies do usually not cover nutrition, including test kits sent to special laboratories. *Payment is due at time of service.* On the occasion that I have an outstanding balance owed Dr. Mainier, I agree to pay for all costs and expenses, including, but not limited to, court costs, attorney fees, and interest, *if it is necessary to secure such payment.*
8. __________I also understand that **Dr. Mainier does not participate in any insurance plans, including Medicare**, **her services may NOT be billed to OR submitted for reimbursement by Medicare,** and that I am responsible for payment, payable at each meeting, and may include but may not be limited to procedures, laboratory tests, even if my insurance company determines that her services are (i) not covered, (ii) excluded, (iii) unreasonable, or (iv) not medically necessary. If I DO NOT HAVE MEDICARE INSURANCE, I may request a super bill from Dr. Mainier, outlining the cost and nature of services. Regardless of whether the services are covered under my insurance, it is my responsibility, not Dr. Mainier's office staff, to submit any and all claims to my insurer.
9. _________ I understand that it is my responsibility to understand and refer to my plan benefits for appropriate information regarding reimbursement. Dr. Mainier may respond to insurance requests for information but is not obligated to take action on my behalf, against my health insurance company for collecting or negotiating my claim. I understand Dr. Mainier may charge a fee for responding to requests for claim information. By way of this Agreement, I also authorize release of information to any payer of my care, including my insurance company or managed care program, upon their specific request.
10. __________ I understand there is an Appointment Confirmation Fee of $25 that is NOT refundable and may not be re-used at a later date after appointment cancelation. *This fee must be paid prior to next appointment.* I also agree that multiple cancellations and schedule changes may incur a fee of $25 *regardless of membership status*.
11. _________ I understand that there is no "guarantee" regarding outcomes of any diagnosis or treatments rendered by Dr. Mainier, as the practice of medicine is not an exact science. I agree that I will take responsibility for my health and well-being by following my personal treatment plan suggested by Dr. Mainier. I will also discuss the advice and ideas of Dr. Mainier during my sessions. Her treatment plans are meant to further my own health, aid in healing, and do not guarantee absolute "cure". I may or may not benefit from the treatment plan designed for me. If I do follow the recommendations it is less likely that I will obtain benefit from her services. I will not hold Dr. Mainier responsible for less than satisfactory results.
12. _________ I understand that electronic medical records (EMR), secure video messaging and other forms of electronic information use, storage and communication will be utilized during my care. Although these electronic services are strongly protected and

HIPAA compliant, I realize that no matter how well the information is protected, there is always a chance of corruption, although highly unlikely. With that understanding, I give permission for the use of such electronic services.

13. _________ **If I choose not participate in EMR services (ChARM online medical record/document delivery) there will be a $10 monthly fee to cover hard-copies, Xerox, and mailing services.**
14. _________ I have read and understand the nature of the services provided by Dr. Mainier. It is my prerogative to revoke, in writing, at any time, the authorizations contained in this document. Such revocation does not affect my financial responsibility to pay for services already provided to me by Dr. Mainier and her staff.
15. _______ I have read, understood and agree to policies regarding cancellation, rescheduling, late arrivals, new encounters, completed paperwork and communication policies.

*"Dr. Lisa Mainier" refers to :Dr. Lisa Mainier ***of Salus Integrative Medicine, PC***

Receipt of Notice of Privacy Practices

Although Salus Integrative Medicine, PC is not subject to Health Insurance Portability and Accountability Act, Dr. Mainier will follow HIPAA guidelines regarding the privacy of clients. Your information will not be released without your consent unless subpoenaed by a court of law. This Notice of Privacy Practice (Notice) provides information about how we may use and disclose health information about you and how you can access this information. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy from us. If you have any questions concerning the Notice, please submit your questions in writing to Dr. Lisa Mainier at the above address. By signing this form, you acknowledge that you have received, read, understand and consent to the terms of our use and disclosure of health information about you as set forth in the Notice. If consent is not earlier revoked, it shall, without revocation, terminate 180 days after your care is completed and you are discharged from care. I acknowledge receipt of a copy of the Salus Integrative Medicine's HIPAA notice of Privacy Practices. I further acknowledge that I have read or have had read to me in a language that I understand, the notice, understand its terms and consent to the terms set forth therein.

Client (or client's Legally Authorized Person) signature:	
Printed name of Legally Authorized Person: **Relationship:**	 **Date:**

In-Office Supplement Explanation and Agreement

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or other non-pharmaceutical remedies are not classified as "drugs". Regardless, these substances can have significant effects on physiology and must be used rationally and according to instructions. In this office, individualized recommendations regarding use of these substances, is provided based on medical evaluation, counseling and monitoring. The goal is to upgrade the quality of foods in a client's diet and to supply nutrition that supports the physiologic and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

You are under no obligation to purchase nutritional supplements at Salus Integrative Medicine, PC

As a service to you, a few nutritional supplements are available in office and most through online dispensary, **Fullscript**. These products are purchased only from manufacturers who have gained the confidence through considerable research and experience. Quality is determined by considering the: (1) quality of science behind the product; (2) quality of the ingredients themselves; (3) quality of the manufacturing process; and (4) synergism among product components. The brands of supplements that are carried by Salus Integrative Medicine, PC, are those that meet high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason these products are available is to ensure quality. **You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace.** We are not suggesting that such products have no value however, given the lack of stringent testing requirements for Over The Counter (OTC) dietary supplements, product quality varies widely.

If you have any other questions, thoughts or concerns, please feel free to discuss them further with Dr. Mainier.

Client (or client's Legally Authorized Person) signature:	
Printed name of Legally Authorized Person:	
Relationship to Client:	**Date:**

Authorizations, Agreements, Consents

By signing below, I admit to receiving, reading, understanding all agreements, authorizations and consents. In addition, I have asked all questions regarding these items and have received explanations in simple, easy to understand language. (see AGREEMENTS, AUTHORIZATIONS, ACKNOWLEDGEMENTS, NOTICE AND CONSENT)

Client (or client's Legally Authorized Person) signature:	
Printed name of Legally Authorized Person:	
Relationship to Client:	**Date:**