Registration and Patient Agreement

Patient Name_____ Date of Birth_____

Address_____ Home Phone_____

City, State, Zip_____ Cell Phone_____

E-mail Address_____ Social Security_____

Pharmacy (Name & Number)_____ Male ____ Female____

Ethnicity: Asian___ Black___ Latino___ Middle Eastern___ Mixed___ Native American___ White___ Other_____

Marital Status: Divorced___ Married___ Domestic Partnership___ Single___ Widowed___

Sexual Preference (Optional): Men___ Women___ Men & Women___

Profession_____ Allergies:_____

CURRENT MEDICATIONS: 1) _____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____ 7)_____

Patient Agreement: I agree that I am of sound mind and have the full ability and authority to make all decisions regarding my health, medical therapy and treatment, and personal choices. I voluntarily present myself at this Vitality Plus, PA location, for requested and/or professionally advised medical examination, therapy or treatment advice and opinion and/or knowledge from Michael Trombley MD or his associate attending physician of the same service, and assistants , as appointed and supervised by him/her. I understand that any services provided are completely voluntary, and I have the option to refuse service, at any time. Unless otherwise noted, I agree to all offered or advised medical examination, therapy, treatment and services rendered. I understand that Vitality Plus, PA reserves the right to refuse any and all service, as they choose. I understand that the risks, benefits, side effects, alternatives, intended goals and likelihood of success of all services professionally advised, offered or rendered will be explained to me prior to any advancement or actions.

I understand that Vitality Plus, PA does not bill any form of insurance directly, and that I am required to pay in full, unless a payment plan is agreed and otherwise noted by method of out-of-pocket payment for all expenses and fees incurred from my office visit and/or therapy and treatment, immediately following the conclusion of my visit. I understand that it is my responsibility to submit a claim to my insurance provider for reimbursement. I understand that Vitality Plus, PA offers its voluntary assistance in providing needed information for submission. I understand that Vitality Plus, PA reserves the right to refuse this service. I understand that my best interest regarding my health and quality of life is the best interest of my health care provider.

I agree that the above information was provided voluntarily, and I hereby agree to the terms stated in the Privacy Policy form, of which I have been provided with a copy of and made aware that it is readily available for review via hard copy at any Vitality Plus, PA location, as well as in electronic form on the Vitality Plus, PA website (www.vitalitymen.com).

By signing below, I agree that the following information is current and true to the best of my knowledge and that this document is a legally binding agreement with me and Vitality Plus, PA.

Print Name_____ Date_____

Signature of Patient_____

Witness_____ am a facility employee who is not the patient's physician or authorized healthcare provider and I have witnessed the patient or other appropriate person, voluntarily sign this form. I am acting as a representative of Vitality Plus, PA.

Vitality Representative_____ Date_____