

**Life Enhancing Wellness Centers, LLC**  
Ruckersville, Virginia  
*Dr. Demetrios Kydonieus, Chiropractic Nutritionist*  
(434) 481-2012 fax (888) 363-6358

**Healthcare Office Agreement**

**Contact Information. ALL LINES MUST BE FILLED IN COMPLETELY OR WE CANNOT TREAT YOU**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

If patient is a minor Name of Legal Guardian \_\_\_\_\_

If married patient's spouse's name \_\_\_\_\_ Children: Yes : How many \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Patient's Marital Status: Single Married Separated Divorced Widowed

Social security # \_\_\_\_\_ (mandatory if not paying in full on each visit).

Who referred you to our office? \_\_\_\_\_ If internet what search or website? \_\_\_\_\_

Employer/School attending if student \_\_\_\_\_

Employer/school town, state \_\_\_\_\_

What kind of daily activities do you do at work and/or home? ( Please circle: standing for more than 1 hour, driving more than an hour at a time, loading/unloading vehicles, stockyard or warehouse work, drive heavy machinery, frequent bending, landscaping, farm work (what type of farm work? \_\_\_\_\_), child care, housework, use laptop/tablet on the sofa/chair regularly, desk work, riding lawn mower/tractor, yard work, use computer to at work for more than an hour at a time, other \_\_\_\_\_.

Please describe your average day's activities \_\_\_\_\_

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**\*\*We have PRE-PAYMENT plans for cost savings so please ask about them.**

**How will you be paying for today's charges?** Cash \_\_\_\_\_ Check \_\_\_\_\_ Major Credit Card \_\_\_\_\_

Name of nearest living relative not living with you \_\_\_\_\_ relation? \_\_\_\_\_

phone # \_\_\_\_\_ (this is for emergency contact purposes)

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**Financial/Healthcare Agreement**

1. I accept the financial responsibility for the above noted patient at the office of Life Enhancing Wellness Centers, LLC and based on all statements made in this contract I understand and agree that regardless of insurance coverage I am personally and fully responsible for all charges billed by this office. I understand that my insurance may deny coverage at some point and that I have been told this in advance and agree to pay all outstanding balances in full at the regular office rates as they were billed.
2. I understand if I have an unpaid balance owed to Life Enhancing Wellness Centers, LLC and do not make satisfactory payment arrangements; my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account and possibly including reasonable attorney's fees if so incurred during collection efforts.
3. In order for Life Enhancing wellness Centers, LLC or their designated external collection agency to service my account and where not prohibited by applicable law, I agree that Life Enhancing Wellness Centers, LLC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.
4. By signing below I further understand that if collection proceedings or referral to an outside collection agency are necessary to collect on any balance that remains unpaid for 90 days or longer that I have received notification of, that I agree to pay the an additional collection fee. If my collection case goes to court another court fee per court appearance and any and all collection/court costs will be added to my final bill if the judge rules in favor of such a collection action. Such fees will be considered additional "healthcare costs".
5. US mail service to the address I have given on page 2 shall be sufficient notice of any and all legal actions. To avoid these additional fees I can pay ALL my outstanding charges on the itemized statement I received in the mail from this office within 10 days from receipt of such a notification before any such collection action has begun. I also understand if a collection matter goes to court I may have 'other' fees such as but not limited to; investigation, travel, and legal/attorney fees of the Plaintiff that I will be responsible for **in addition** to the collection fees noted above. This contract is governed by the laws of Virginia. I knowingly accept all stated terms of financial responsibility noted in this contract and have willfully sought Dr. Kydonieus' time/advice/treatment for my complaints (or the complaints of my child).
6. **Nutritional Informed Consent** According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional/dietary advice and Nutritional Response Testing are not intended as a diagnostic procedure or primary treatment or therapy for any disease or particular bodily symptom. We do not diagnose/treat any specific disease with our nutritional services. Nutritional Response Testing, dietary counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutritional supplements are provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. No promise or guarantee of result is made regarding the results of Nutritional Response Testing and/or any laboratory work recommended by the doctor. Nutritional Response Testing is a means by which the body's natural organ responses can be used as an aid to determine the possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. The advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

**I certify that the information I have given is true and correct to the best of my knowledge.**

\_\_\_\_\_  
**Signature** of person responsible for the account

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**



## **Combined Acknowledgement and Consent (HIPPA)**

Acknowledgement or receipt of Notice and Consent to use and disclose health information

### **Read before signing**

This acknowledgement of notice and consent authorizes Life Enhancing Wellness Centers, LLC to use and disclose health information about you for treatment, payment and healthcare operation purposes.

**Notice of Privacy Practices:** A “Notice of Privacy Practices” Brochure that describes how we may disclose your private information and use it is available upon request. It further describes how you can access your protected health information and exercise other rights concerning you and your protected information. You may ask to see and have this information at any time and review it prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any changes effective for all protected health information that we maintain including information created or obtained prior to the date of the effective date of change. You may obtain a revised notice by submitting a written request to our Privacy Officer at any time.

### **How to Contact our Privacy Officer:**

Office Manager (Robin Kydonieus)  
8881 Seminole Trail  
Ruckersville, Virginia 22968  
434-481-2012

I have received the Notice of Privacy Practices for this office and authorize them to use and disclose health information for treatment, payment and healthcare operations consistent with this Notice of Privacy about:

Friend us or become a fan of the office page. [www.FaceBook.com/DrDemetri](http://www.FaceBook.com/DrDemetri)

Post cards email and text messages are used by this office for appointment reminders and other general communications like birthday cards, announcements and other non-personal information. If you do wish to us to use one or any of these technologies please let the front desk know. You must submit this request in writing so it can be dated and part of your file.

If you give us a testimonial in any form; written, photographic, recorded video or audio by signing this HIPPA statement you are also giving us your permission to use such testimonial or photo in our community outreach program which includes the internet, social media and other advertising means without compensation to you in any form. You can revoke this permission at any time but it must be written, signed and dated. It must be delivered to this office in person by you and NOT a representative or mailed via certified mail using the US Postal Service during regular business hours.

*(Email, text, phone calls or private message are not acceptable to revoke this clause of this agreement,. It must be in a written, signed dated letter, verified in person by our staff that it was you who gave it to us. If using US Mail a notarized letter from you must be received by us.)*

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(Print patient's name)

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Patient or patient's representative signature

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Personal Representative Printed Name

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Date

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relation to patient