SonRidge Health & Healing Center

3750 US1 South
St. Augustine, FL 32086
904-794-2121 phone
904-794-2138 fax

the Sun of Righteousness...with healing on his wings
***Malachi 4:2*.**

WELCOME - A FEW REQUESTS

- **On the day of your appointment, please don't wear make up, cologne, skin cream, or oil, perfume, or other fragrant substance.**
- **Bring any recent medical records including blood work, x-ray or MRI reports if you have access to them.**
- **Please bring something to snack on. Your clinic visit may require up to 4 hours.**
- **If you have animals please bring in a sample of hair/fur.**
- **Pollen sample- please bring a swab that you rubbed on the outside of your car.**
- **Bring in a sample of lint from your dryer or air filter in your home.**

Guests are welcome. Please advise any visitor not to wear perfume, cologne, after-shave or any other fragrant substance, including clothing that contains fragrant laundry detergent or fabric softener. To protect chemically sensitive patients, we may have to ask anyone smelling of fragrance to leave the building.

Yours in health,
Dr. Marty Monahan D.C., N.M.D.

SonRidge Health & Healing Center

SERVICES AND FEES

INTIAL EXAMINATION:

New Patient 3 Day Visit Includes:	**$1595.00**
3 office visits and custom remedies	
Frequency-Specific Electro-Homeopathics (FSEH)	

OTHER SERVICES:

Return visit per day including custom remedies scan2 and (FSEH)	**$ 395.00**
Chiropractic Adjustment (must have a copy of current X-rays)	**50.00**
Laser Treatment per session	**50.00**
Nasal Cranial Remodeling (NCR)	**200.00**
Magnatherm	**35.00**
Hair Saliva Analysis (HSA)	**225.00**
Dental Tens unit	**185.00**
Body Electric	**125.00**
Ionic Foot Bath	**35.00**
Hyperbaric Oxygen Therapy (HBOT)	**100.00**

IV Therapies
Plasma Rich Platelets (PRP)
Advanced Regenerative Cellular Therapy (ARCT)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to you insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, closer personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of April, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice for the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 2020
(202) 619-0257 Toll Free: 1-877-696-6775

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This page is for patients who have previously been diagnosed with cancer from a licensed Medical Doctor. Please fill out and return with the rest of your paperwork. If you have not been diagnosed with cancer, please disregard this page. Thank you!

Date: _____

I, _____, confirm that I am receiving cancer treatment by a licensed medical Doctor, in addition to being seen by Dr. Marty Monahan D.C., NMD at SonRidge Health & Healing Center.

Doctor's Name: _____

Office Phone Number: _____

_____
Signature

_____
Printed Name

PATIENT CONSENT FORM

I understand that, Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and what I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: __
_____

Signature: _____

Relationship to Patient: _____

Date: _____