Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

Dear New Patient,

My staff and I are excited to meet you and assist you with your first office visit. To help you streamline your first visit please read, sign and complete the following forms to the best of your ability:

- ❑ Confidential Health Information
- ❑ Notice of Privacy Practices
- ❑ PHI Use & Disclosure Authorization
- ❑ Financial Office Policy
- ❑ Missed Appointment & Cancellation Policy

***COMPLETE AND BRING ALL FORMS WITH YOU TO YOUR FIRST OFFICE VISIT!**

When you arrive, you will be asked for your completed forms. A Patient Advocate will greet you and bring you back to the exam room. She will go over the Personal History Questionnaire with you to gain better clarity about your history, health concerns and health needs.

You will receive three diagnostic scans: 1) an Infrared Thermography, 2) a Surface EMG, and 3) a Heart Rate Variability. These scans will not cause any discomfort and will take approximately 20 minutes.

When your scans are complete, you will receive a Network Spinal Analysis (NSA) Exam. This will include a posture evaluation, breathing pattern observation and leg checks to determine the amount of stress and tension you are carrying in your spine and nervous system.

You will then receive your First Entrainment where gentle touches will be applied along the spine to release stress from the body and create more balance. Your entrainment will take approximately 10 - 15 minutes.

A brief Report of Findings will be given at the end of your first visit. Your entire first visit will take approximately 1 hour and 45 minutes.

On your second visit you will receive a detailed Report of Findings with recommendations for care and a folder that you can take home with you containing all information discussed. We will schedule additional time for your entrainment should you decide to begin care immediately. Your second visit will take approximately 60 minutes.

Tea and water are available for you in the reception area. My staff and I welcome you to a family environment that supports wellness and personal health transformation. Thank you for choosing me as your chiropractor, I look forward to assisting you in your journey towards well-being.

Sincerely,
Robyn A. Graber, D.C.

INNER SAGE
HEALING ARTS CENTER
Magic Happens Here

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center
1 Grove St. Ste. 103
Pittsford, NY 14534
(585) 383-8833
www.DrRobynGraber.com
www.InnerSageHealingArts.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before? ○ No ○ Yes

When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Age

Gender ○ Male ○ Female

Race ○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over) ○ Never A Smoker ○ Former Smoker ○ Current Every Day Smoker ○ Current Some Day Smoker ○ Heavy Smoker ○ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated

City | **State/Province** | **ZIP/Postal Code**

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work? ○ Yes ○ No

City | **State/Province** | **ZIP/Postal Code**

Preferred method of contact? ○ Home Phone ○ Cell Phone ○ Work Phone ○ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy? ○ Self ○ Spouse ○ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

CONFIDENTIAL HEALTH INFORMATION

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Other _____
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Other _____
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat

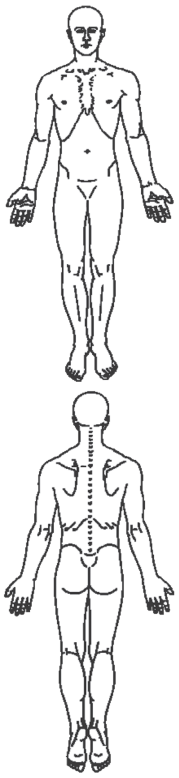
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
- ◯ An accident or injury
  - ◯ Work ◯ Auto ◯ Other _____
- ◯ A worsening long-term problem
- ◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
- ◯ Prescription medication
- ◯ Over-the-counter drugs
- ◯ Homeopathic remedies
- ◯ Physical therapy
- ◯ Surgery
- ◯ Other _____
- ◯ Acupuncture
- ◯ Chiropractic
- ◯ Massage
- ◯ Ice
- ◯ Heat

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. What else should Dr. Graber know about your current condition? _____

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

(Continued from previous page)

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		NONE ○
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness	Initials ____

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

7. Allergies

Are you allergic to any medications?

Yes	No	
○	○	If Yes please list: _____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Medications

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals):

8. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Graber about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○
_____	_____	○	○	_____	_____	○	○

10. Are there any other hereditary health issues that you know about? _____

11. Social History

Tell Dr. Graber about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much? _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

Doctor's Initials

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

12. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. What is the major stressor in your life? _____

14. How much sleep do you average per night? _____ **Hours**

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

_____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Consultation Notes

Patient name

Patient Number
(office use only)

Doctor's Initials

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

ROBYN A GRABER DC, PC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner, and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners will have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Robyn Graber, DC at (585) 383-8833 If she is unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: **_____-retaining *page 1 of 2***

Robyn A Graber, DC, PC, NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Robyn A Graber, DC, PC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me, and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name	DOB	HR#

Patient's Signature	Date

Office Personnel	Date

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Robyn A Graber, DC, PC disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Robyn A Graber, DC, PC in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Robyn A Graber, DC, PC until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative Date

Relationship to Patient: _____Driver's License Number: _____State____

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Robyn A Graber, DC, PC disclosure of my individually identifiable health information to the individuals listed:

3. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

4. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

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Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative Date

Relationship to Patient: _____Driver's License Number: _____State____

Robyn A. Graber, DC PC

1 Grove Street, Suite 103
Pittsford, NY 14534 USA

Financial Office Policy

- It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

- All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $120 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.

- For your convenience, this office accepts cash, checks, and the following credit cards: Visa, MasterCard, Discover

- Should payment be refused by your bank for any check written, this office will charge a fee equal to the amount charged by the financial institution to offset the charges we will incur as a result of the returned check.

- This office does not bill third party payers on behalf of our patients. We will provide you with a receipt sufficient to submit to your own third-party payer, if necessary.

- Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Signed: _____ Date: _____

Office Personnel: _____ Date: _____

Robyn A Graber, DC, PC
Inner Sage Healing Arts Center

Missed Appointment and Cancellation Policy

PLEASE CALL/TEXT if you will be late.

Late appointments may need to be rescheduled or they will be considered a Missed Visit and subject to a charge.

*We request 24-hour notice for cancellations so we may offer that appointment time to someone else needing care.

Chiropractic Services

There is a $60 Missed Visit charge for Cancellations, Reschedule Requests without adequate notice and Missed Visits.

We appreciate your understanding

Signature:_____ *Date*:_____

Directions to INNER SAGE HEALING ARTS CENTER
The Pickle Factory Building
1 Grove Street, Suite 103, Pittsford, NY 14534

Look for the hanging sign that says Inner Sage Healing Arts Center.
There is a separate walkway and entrance.
Please Do Not enter building through the green awning.

- If you don't have a GPS we recommend using **Google Maps**.
- **Grove Street is located off of French Road** in Pittsford, NY and it is also behind the DelMonte Spa.
- **French Road** runs between Route 96 (Main Street/East Avenue in Pittsford) and Monroe Avenue (Near Pittsford Plaza) but continues all the way to Winton Road in Brighton.
- The Parking lot is in the back of The Pickle Factory near the Loading Dock.

From North or West

1. **Take 490 East to Exit 23 (Linden Avenue) (Route 441)**
2. Bear Right off the ramp and make a **Left onto East Avenue (Route 96)**
3. **Follow Route 96 into Pittsford**. You will pass Nazareth College on your right
4. **Turn Right on French Road**. It is at a light next to a cemetery
5. Make your first **Left on Grove Street**
6. You will see The Old Pickle Factory building. **Bear right to the parking lot**
7. When pulling into the parking lot, on the left of the building if you see a **loading dock** and an **American Flag** know that is the right end of the parking lot to park.
8. Look for the hanging sign that says Inner Sage Healing Arts Center. There is a separate walkway and entrance. Please Do Not enter building through the green awning.

From Buffalo or Syracuse

1. **Take I-90 to Exit 45 (Rochester)**
2. Take 490 West to **Exit 26** (Pittsford/Route 31)
3. **Turn Right off the ramp** (West) onto Pittsford/Palmyra Road (Route 31)
4. Follow into the village of Pittsford approximately 4 minutes.
5. **Turn Right at the light onto Main Street**
6. Go over the canal bridge and past the "Del Monte Spa"
7. At your second light turn **Left on French Road**
8. Make your first **Left on Grove Street**
9. You will see The Old Pickle Factory building. **Bear right to the parking lot.**
10. When pulling into the parking lot, on the left of the building if you see a **loading dock** and an **American Flag** know that is the right end of the parking lot to park.
11. Look for the hanging sign that says Inner Sage Healing Arts Center. There is a separate walkway and entrance. Please Do Not enter building through the green awning.

Pittsford Village via Washington Road (Route 153) from Fairport and Penfield

1. Take Route 153 into Pittsford
2. Turn **Right on Main Street**
3. **Left on French Road**
4. **Left on Grove Street**
5. You will see The Old Pickle Factory building. **Bear right to the parking lot.**
6. When pulling into the parking lot, on the left of the building if you see a **loading dock** and an **American Flag** know that is the right end of the parking lot to park.
7. Look for the hanging sign that says Inner Sage Healing Arts Center. There is a separate walkway and entrance. Please Do Not enter building through the green awning.

Pittsford Village via Pittsford/Mendon Rd (Route 64) from Mendon and South

1. Follow Route 64 into the village of Pittsford
2. Go over the canal bridge and past the "Del Monte Spa"
3. At your second light turn **Left on French Road**
4. Make your first **Left on Grove Street**
5. You will see The Old Pickle Factory building. **Bear right to the parking lot.**
6. When pulling into the parking lot, on the left of the building if you see a **loading dock** and an **American Flag** know that is the right end of the parking lot to park.
7. Look for the hanging sign that says Inner Sage Healing Arts Center. There is a separate walkway and entrance. Please Do Not enter building through the green awning.

From West via Monroe Avenue (Route 31)

1. Follow Route 31 into Pittsford Plaza/Pittsford Colony area.
2. At the light, turn **Left onto French Road** and take almost to the end
3. Turn **Right on Grove Street** (located close to the end of the street)
4. You will see The Old Pickle Factory building. **Bear right to the parking lot.**
5. When pulling into the parking lot, on the left of the building if you see a **loading dock** and an **American Flag** know that is the right end of the parking lot to park.
6. Look for the hanging sign that says Inner Sage Healing Arts Center. There is a separate walkway and entrance. Please Do Not enter building through the green awning.

From East via Pittsford/Palmyra Road (Route 31)

1. Follow Route 31 into Pittsford Village
2. **Turn Right at the light onto Main Street**
3. Go over the canal bridge and past the "Del Monte Spa"
4. At your second light turn **Left on French Road**
5. Make your first **Left on Grove Street**
6. You will see The Old Pickle Factory building. **Bear right to the parking lot.**
7. When pulling into the parking lot, on the left of the building if you see a **loading dock** and an **American Flag** know that is the right end of the parking lot to park.
8. Look for the hanging sign that says Inner Sage Healing Arts Center. There is a separate walkway and entrance. Please Do Not enter building through the green awning.