Registration Form

Inclusive Care Group

Please complete the Nü By ICG Registration Form and sign all required pages. Incomplete or unsigned forms may delay processing.

Email admin@inclusivecaregroup.com
Phone (727) 753-7787 Fax (833)471-3023

Personal information

Last Name

First Name

Name To Use

Address

Address Line 2

City State ZIP

Phone

Notifications ☐ Yes ☐ No

Email

☐ Not Provided

Date of Birth

Social Security Number

Sex at Birth ☐ Male ☐ Female ☐ Unknown

Pronouns

Sexual Orientation Gender Identity

Marital Status Language Race Ethnicity

Emergency Contact Full Name and Relationship

Emergency Contact Phone

Where did you hear about us?

- ☐ A friend or colleague
- ☐ Creative Loafing
- ☐ Website
- ☐ Google
- ☐ Watermark
- ☐ Social Media
- ☐ Current Patient
- Other
- ☐ Winter Pride
- ☐ Events

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Allergies & Medications

Food/Allergy	Medication	Allergic reaction

Current Medication Name	Dose	Times per day

Medical History

Please select all that apply.

- ☐ None
- ☐ AICD/Pacemaker
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding/Clotting Problems
- ☐ Cancer: _____
- ☐ Celiac Disease
- ☐ Chest Pain
- ☐ Cirrhosis of Liver
- ☐ Colon Polyps
- ☐ Connective Tissue Disorder
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease/Failure
- ☐ Lactose Intolerance
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Neurologic Disorders
- ☐ Pancreatitis
- ☐ Prostate Enlargement
- ☐ Pulmonary Hypertension
- ☐ Sleep Apnea
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ TB (Tuberculosis)
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Other _____

_____

_____

_____

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Surgical/Procedural History

Please select all that apply.

		Date			Date
	None			Incisional Hernia Repair	
	Abdominoplasty/Tummy Tuck			Gallbladder Surgery	
	Appendectomy			Hemorrhoid Surgery	
	Back/Spinal Surgery			Hiatal Hernia Repair	
	Bariatric Surgery			Hysterectomy Surgery	
	Bladder Surgery			Inguinal Hernia Repair	
	Breast Surgery			Liver Biopsy	
	ERCP			Ovarian Surgery	
	Colon Resection			Prostate surgery	
	Colostomy/Ileostomy			Stomach/abdominal surgery	
	Colonoscopy			Stress Test	
	EGD			Thyroid surgery	
	Umbilical Hernia Repair			EUS	
	Pelvic Floor Surgery			Echocardiogram	
	Other:				

Additional information

Are you currently taking blood thinners or aspirin? ☐ Yes ☐ No

Are you currently on medication for weight loss? ☐ Yes ☐ No

Are you currently on medication for seizures? ☐ Yes ☐ No

Colonoscopy ☐ Yes ☐ No Date _____ Results ☐ Normal ☐ Abnormal

Mammogram ☐ Yes ☐ No Date _____ Results ☐ Normal ☐ Abnormal

Imaging studies completed _____ Imaging location _____ Date _____

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

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Privacy Practices & Patient Acknowledgment HIPAA Notice

Inclusive Care Group (ICG) is committed to protecting the privacy and confidentiality of your protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable Florida law. We may use and disclose your health information for purposes of treatment, payment, healthcare operations, care coordination, and public health reporting as required by law. Access to your information is limited to authorized personnel only. We maintain administrative, technical, and physical safeguards to protect your privacy.

Patient Rights You have the right to:

- Access and request copies of your medical records
- Request corrections to your health information
- Request restrictions on certain disclosures where permitted
- Request confidential communications
- File a complaint without fear of retaliation

Electronic & Verbal Communication By receiving care at Inclusive Care Group, you acknowledge and agree that:

- Staff may contact you via phone, voicemail, text message, patient portal, or email for care-related communication
- Messages may include appointment reminders, lab results, care coordination, or billing notifications
- Absolute confidentiality cannot be guaranteed with electronic communication

You may request communication preferences or opt out of certain communication methods at any time.

HIPAA Acknowledgment I acknowledge that I have received and reviewed the Inclusive Care Group Notice of Privacy Practices. I understand my rights regarding my protected health information and how my information may be used and disclosed as permitted by law.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

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Aesthetic Services Financial Responsibility & Payment Agreement

Thank you for choosing Inclusive Care Group for your aesthetic care. Our goal is to provide exceptional service in a transparent and professional manner. Because aesthetic services are elective and are not medically necessary, they are generally not covered by health insurance. By signing this agreement, you acknowledge your financial responsibility for all services received.

Payment is due in full at the time services are rendered unless otherwise agreed to in writing. Inclusive Care Group accepts cash, major credit cards, debit cards, Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA) when applicable, approved financing options, and other payment methods accepted by the practice.

No services will be performed without payment unless prior financial arrangements have been approved.

Insurance

Aesthetic and cosmetic services are self-pay services. Inclusive Care Group does not bill insurance for elective cosmetic procedures, consultations, products, or treatment packages. Patients are solely responsible for all charges associated with their care.

Consultations

Consultation fees, if applicable, are due at the time of the appointment. Consultation fees may be applied toward treatment when offered as part of a promotion or at the discretion of Inclusive Care Group.

Deposits

Certain appointments, treatment packages, or procedures may require a non-refundable deposit to reserve appointment time. Deposits will be applied toward the scheduled treatment. Deposits may be forfeited for cancellations or rescheduling that do not comply with the practice's cancellation policy.

Cancellation & No-Show Policy

Appointments represent dedicated time reserved exclusively for you.
We kindly request at least 24 hours' notice for cancellations or rescheduling.
Failure to provide adequate notice, failure to appear for a scheduled appointment, or repeated late cancellations may result in:

- Loss of any applicable deposit
- A cancellation or no-show fee
- Requirement for a deposit before scheduling future appointments

Patients arriving more than 15 minutes late may be rescheduled at the provider's discretion.

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Aesthetic Services Financial Responsibility & Payment Agreement *(Cont.)*

Refund Policy

Because aesthetic treatments involve professional medical services that cannot be returned once performed:

- Services rendered are non-refundable.
- Injectable products are non-refundable after administration.
- Prepaid services and treatment packages are non-refundable.
- Gift cards are non-refundable and are not redeemable for cash except where required by law.

Cosmetic Results

- I understand that aesthetic medicine is not an exact science and that no guarantees or warranties have been made regarding the outcome of any treatment or procedure.
- Individual results vary based on anatomy, lifestyle, medical history, healing response, and adherence to post-treatment instructions.
- Payment is for professional medical services rendered and not for a guaranteed cosmetic outcome.

Outstanding Balances

Patients agree to remain financially responsible for any unpaid balances. Inclusive Care Group reserves the right to suspend non-emergency services until outstanding balances have been satisfied.

Returned Payments & Chargebacks

Returned checks, rejected electronic payments, payment disputes, or chargebacks may be subject to applicable fees and collection efforts as permitted by law.

Questions

Patients are encouraged to ask questions regarding fees, payment options, or financial policies before treatment begins.

Patient Acknowledgment

By signing below, I acknowledge that I have read, understand, and agree to the Financial Responsibility & Payment Agreement of Inclusive Care Group. I understand that I am financially responsible for all aesthetic services received and agree to comply with the policies outlined above.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____

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Photography & Media Consent and Authorization

Medical Photography Consent (Required)
I authorize Inclusive Care Group to photograph and/or video record treatment areas as part of my medical record.
I understand these images may be used for:

- Clinical documentation
- Treatment planning
- Monitoring treatment progress and outcomes
- Communication between providers involved in my care
- Quality assurance and medical recordkeeping

I understand these photographs and recordings are considered Protected Health Information (PHI) and will be maintained in accordance with HIPAA and all applicable federal and Florida privacy laws.

_____ *Initials*

Marketing and Educational Authorization (Optional)
I understand that Inclusive Care Group may request permission to use photographs or videos for educational or promotional purposes. My decision is voluntary and declining authorization will not affect my care.

☐ **I DO NOT authorize** any marketing or promotional use of my photographs or videos.
☐ **I authorize** the use of photographs or videos in which I am not reasonably identifiable.

Examples may include:

- Cropped treatment areas
- Before and after treatment photographs
- Close-up images
- Images without identifying facial features

These images may be used for:

- Website and Social media
- Printedanddigital marketing materials
- Educational presentations
- Patient education materials

Video Testimonial Authorization (Optional)

☐ **Yes, I authorize** Inclusive Care Group to record and use my video testimonial for educational and marketing purposes.
☐ **No, I do not authorize** video testimonials**.**

Social Media Acknowledgment
I understand that once photographs or videos are published on websites or social media platforms, they may be copied, shared, or redistributed by third parties beyond the control of Inclusive Care Group.

_____ *Initials*

Revocation of Authorization
I understand that I may revoke this marketing authorization at any time by submitting a written request to Inclusive Care Group. Revocation will apply only to future use and will not require the removal of materials that have already been published, printed, distributed, or otherwise used before my written request is received.

No Compensation _____ *Initials*
I understand that I will not receive compensation, royalties, or other payment for the use of my photographs, videos, or testimonials.

_____ *Initials*

Patient Acknowledgment
I certify that I have read and understand this Photography & Media Consent and Authorization. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

I understand that my decision regarding marketing authorization is voluntary and will not affect my ability to receive treatment at Inclusive Care Group.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name	Signature	Date

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General Medical Aesthetics Treatment Consent

I voluntarily consent to receive medical aesthetic treatments provided by Inclusive Care Group. I understand these treatments are elective and that my treatment plan will be individualized based on my consultation and medical evaluation.

I Understand That:

- Results vary from person to person and cannot be guaranteed.
- I have disclosed my medical history, medications, allergies, and pregnancy or breastfeeding status.
- I have had the opportunity to ask questions and understand the benefits, alternatives, and potential risks of treatment.
- Possible temporary side effects may include redness, swelling, bruising, tenderness, itching, pigmentation changes, or other known treatment-related reactions.
- I agree to follow all pre-treatment and post-treatment instructions provided by Inclusive Care Group.
- Clinical photographs may be taken for my medical record. Any use for marketing or social media requires my separate written authorization.
- I understand cosmetic procedures are generally not covered by insurance and I am responsible for all applicable charges.

Consent

I certify that I have read and understand this consent, have received satisfactory answers to my questions, and voluntarily authorize Inclusive Care Group and its licensed providers to perform the recommended medical aesthetic treatment(s).

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Full Name _____ Signature _____ Date _____

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Zero Tolerance Policy

At Inclusive Care Group, we are dedicated to providing a sanctuary of healing for all of our patients. To maintain a therapeutic environment, we enforce a strict Zero Tolerance Policy regarding any form of violence, harassment, or discrimination. This policy applies to all patients, visitors, staff, and contractors on these premises. Everyone has the right to receive or provide care without fear. We maintain a Zero Tolerance culture – meaning we do not just react to incidents; we proactively prevent them through continuous education and immediate intervention.

The following behaviors are strictly prohibited and will result in immediate action, up to and including removal from the practice and termination of the patient-provider relationship:

- Verbal Abuse: Shouting, swearing, or using offensive, derogatory, or discriminatory language (including homophobia, transphobia, biphobia, racism, or xenophobia).
- Targeted Harassment: Misgendering or “deadnaming” others with malicious intent, or making unwanted comments regarding a person’s body, gender expression, or sexual orientation.
- Physical Aggression: Any form of physical contact that is threatening, harmful, or non-consensual.
- Sexual Misconduct: Inappropriate touching, sexual comments, or “boundary violations” between patients or toward staff.
- Intimidation: Making threats of harm (physical or professional) or using body language to block, corner, or intimidate others in waiting areas or exam rooms.

We are committed to a safe “shared space.” If you witness another patient being harassed or feel unsafe due to another visitor’s behavior. Report It Immediately: Notify any staff member. You do not need to intervene yourself.

Immediate Response, our staff is trained to de-escalate and, if necessary, escort the offending party from the building to protect the safety of other patients. Immediate Removal, individuals engaging in prohibited behavior will be asked to leave the premises immediately. Care Dismissal, serious or repeated violations may result in formal dismissal from the practice, in accordance with Florida medical board guidelines. We will involve local authorities if there is a threat of physical violence or illegal activity.

We believe that Safety is Healthcare. By entering this clinic, you agree to treat every person you encounter with the dignity and respect they deserve.

This Agreement may be executed electronically, and such signature – whether under a legal or preferred name – shall be legally binding to the fullest extent permitted under applicable law, including the Florida Uniform Electronic Transaction Act.

Full Name _____ Signature _____ Date _____