WEIGHT LOSS and WELLNESS INTAKE FORM

All information contained in this questionnaire is strictly confidential, will be protected to the highest of HIPPA standards, and will become part of your Restorative Health Record

Patient Information:

Name:_____ Date:_____
Last First Middle

Date of Birth:_____ Age in Yrs:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

E-Mail Address:_____ May we contact you via E-Mail ☐ Yes ☐ No

How do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text ☐ Other_____ May we leave a voice mail? ☐ Yes ☐ No

Marital Status (check one): ☐ Married ☐ Seperated ☐ Divorced ☐ Widow(er) ☐ Living with Sig Other ☐ Single

Spouse or Sig Other Name:_____ Phone:_____

In Case of an Emergency Contact:_____ Relationship:_____

Driver's License Number:_____

Primary Care Physician Name:_____Speciality: _____

Preferred Pharmacy:_____ Phone:_____

How did you hear about us? ☐ TV ☐ Radio ☐ Web ☐ Radio ☐ Web ☐ Pandora ☐ Social Media ☐ Referral

If you were referred, who referred you? _____

Would you like to receive special offers and promotions from Restorative Health via e-mail? ☐ Yes ☐ No

What are your top 4 goals you would like to accomplish in or program (please put in order of importance)?
1.
2.
3.
4.

Have you ever had or do you have any of the following?:

- ☐ Anemia
- ☐ Abnormal Wght Loss/Gain
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar
- ☐ Bleeding Disorder
- ☐ Blood Pressure (high or low)
- ☐ Cancer
- ☐ Celiac
- ☐ Connective Tissue Disorder
- ☐ Crohn's / IBS
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Eczema☐ Epilepsy/Seizures
- ☐ Excessive Fatigue
- ☐ Excessive Stress
- ☐ GERD / Ulcers
- ☐ Genital Herpes
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ HIV or AIDS
- ☐ Implants (Breast/Other)
- ☐ Keloid Scarring
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis (A,B, C)
- ☐ Lyme Disease
- ☐ Memory Loss
- ☐ Oral Herpes or Cold Sores
- ☐ Osteoporosis / Osteopenia
- ☐ PCOS
- ☐ Pacemaker or Palpitations
- ☐ Psoriasis
- ☐ Respiratory Condition
- ☐ STD's
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ TIA's
- ☐ Transplant
- ☐ Urinary Incontinence

Please describe or explain any of the above:_____
_____
_____
_____

Other Medical Issues: _____
_____
_____
_____

Current Prescription Medication, Over the Counter Medication and Supplements			
Name of Medication / Supplement	Reason for Taking	Strength	Dosing Instruction
Example: Tylenol	Headaches	500mg	1 tab 3 times per day

Allergies to medicine, supplements, vaccines, foods, environmental or other substances	
Substance	Reaction
Example: Penicillin	Hives, Swelling, Shortness of Breath

Past Surgical and Hospitalization History	
Surgery and / or Hospitalization	Date

Family History

Illness	Mother	Father	Brothers	Sisters	Grand Mother	Grand Father
	Alive Y N	Alive Y N	How Many?_____	How Many?_____	Alive Y N	Alive Y N
			How Many Alive?_____	How Many Alive?_____		
Anxiety						
Bi-Polar						
Bleeding Disorder						
Breast Cancer						
Colon Cancer						
Depression						
Dementia / Alzheimer's						
Diabetes						
Heart Disease						
High Blood Pressure						
Lung Cancer						
Headaches (Migraine)						
Osteoporosis						
Ovarian Cancer						
Obesity						
Prostate Cancer						
Stroke						
Thyroid (hyper/hypo)						
Other:						
Staff Notes:						

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To Improve your health, how ready/willing are you to	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Weight Evaluation:

1. Present Weight: _____Height (no shoes): _____Desired Weight:_____
2. In what time frame would you like to be at your desired weight?_____
3. Birth Weight: _____Weight at 20 years of age: _____Weight one year ago:_____

4. What is the main reason for your decision to lose weight?_____

_____

5. When did you begin gaining excess weight? (Give reasons, if known):_____

_____

_____

6. What has been your maximum lifetime weight (non-pregnant) and when?_____

7. Previous diets you have followed: Give dates and results of your weight loss:_____

_____

_____

8. Is your spouse, fiancée or partner overweight? Yes No

9. By how much is he or she overweight?_____

Diet History

1. Do you follow any special diet or have diet restrictions or limitations for any reason (health, cultural, eligious or other)? Yes No If so, please describe _____

_____

2. Please list any food allergies, sensitivities or intolerances _____

_____

3. Who prepares the majority of your meals? _____ Who shops for food? _____

4. Where do you shop for food? _____

5. What percent of the foods you eat are… whole _____% organic_____% convenience _____%

6. Please indicate the materials you use for cooking and food storage:

☐ Plastic ☐ Glass _ ☐ Aluminum ☐ Styrofoam
☐ Stainless Steel ☐ Cast-iron ☐ Teflon/non-stick ☐ Ceramic

7. Do you find cooking difficult? Yes No Please describe _____

8. If you follow a special diet/nutritional program, check the following that apply:

☐ Low Fat ☐ Low Carb ☐ High Protein ☐ Low Sodium
☐ No Gluten ☐ Vegetarian ☐ Vegan ☐ Diabetic
☐ No Dairy ☐ No Wheat ☐ Ketogenic ☐ Other: Explain

_____

Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount"

Beverage Type	Daily Amt	Weekly Amt	Monthly Amt
Coffee: ☐ Reg _ ☐ Decaf _ ☐ Latte			
Water: ☐ Tap _ ☐ Filtered _ ☐ Bottled			
Tea: what type(s)?			
Juice: _ ☐ Natural _☐ Fruit drinks			
Soda: _ ☐ Regular ☐ Diet ☐ Power			
Milk: ☐ Whole ☐ 2% _ ☐ 1% _ ☐ Skim			
Milk alternative Type?			
Alcohol: ☐ Wine ☐ Beer ☐ Liquor			
Other:			
Other:			

Food Intake: Please indicate the frequency that you eat the following:

	Never	2-3 Times / Mo	1 Time / Wk	2-3 Times / Wk	1 Time / Day	2-3 Times/Day
Fast food						
Restaurant food						
Vending machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Leftovers						
Beef (hamburger, steak, etc.)						
Pork (chop, loin, ham, bacon, etc.)						
Liver or Lamb						
Poultry (chicken, turkey, etc.)						
Deli meat, type:						
Fish, type:						
Soyfoods, type:						
Beans, type:						
Crackers, type:						
Cookies, cakes, muffins						
Whole grains, type:						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
Margarine						
Dairy (Milk, yogurt, cheese, butter)						
French fries						
Fried meat (chicken, fish)						
Foods with added sweeteners/sugar, type:						
Artificial sweeteners, type:						
Meal Replacements, type:						

10. What restaurants do you frequent?_____

_____

11. Who plans meals? Cooks? Shops?_____

12. Do you use a shopping list? Yes No

13. Food(s) you crave:_____

14. Any specific time of the day or month do you crave food?_____

15. Snack Habits: What? _____How much? _____When?_____

16. When you are under a stressful situation at work or family related, do you tend to eat more? Yes No

17. Do you think you are currently undergoing a stressful situation or an emotional upset? Yes No Explain:_____

_____

Have you ever had food allergy testing? ☐ Yes ☐ No
Genetic health testing? ☐ Yes ☐ No
Nutrition testing? ☐ Yes ☐ No
Gut testing? ☐ Yes ☐ No

Eating Style: Based on how you eat on a regular basis, please check all that apply:

- ☐ Fast Eater
- ☐ Erratic eater
- ☐ Emotional eater (stressed, bored, sad, etc.)
- ☐ Late night-eater
- ☐ Time constraints
- ☐ Dislike "healthy" food
- ☐ Travel frequently
- ☐ Do not plan meals/menus
- ☐ Rely on convenience items
- ☐ Family member(s) have different tastes
- ☐ Love to eat
- ☐ Eat too much
- ☐ Eat because I have to
- ☐ Negative relationship with food
- ☐ Struggle with eating issues
- ☐ Confused about food/nutrition
- ☐ Frequently eat fast food
- ☐ Poor snack choices

Digestive History

1. Do you associate any digestive symptoms with eating certain foods? Yes No
   Please explain:_____

   _____

2. How often do you have a bowel movement? _____

3. If you take laxatives, what type/brand and how often?_____

4. Would you describe your stools are hard, soft, or loose? (circle one)

5. Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely

Stress

1. Rate your energy from 1-10: Morning _____ Noon _____ Night _____ Before Meals _____ After Meals _____

2. Rate your current overall stress level between 1-10 (1 very relaxed, 10 very stressed): _____

3. What factors most contribute to your stress: ☐ Health ☐ Work ☐ Money ☐ Spouse or Significant Other ☐ Children ☐ Other

4. What best helps you with stress?_____

5. Behavior style: (answer only one)

   You are always calm and easygoing. _____

   You are usually calm and easygoing._____

   You are sometimes calm with frequent impatience._____

   You are seldom calm and persistently driving for advancement. _____

   You are never calm and have overwhelming ambition._____

   You are hard-driving and can never relax._____

6. Have you ever had your cortisol levels checked? Yes No

Activity

7. Activity Level: (answer only one)

   Inactive □ no regular physical activity with a sit-down job.

   Light activity □ no organized physical activity during leisure time.

   Moderate activity □ occasional activities such as weekend golf, tennis, jogging, swimming or cycling.

   Heavy activity □ consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling, yoga, stretching or active sports at least three times per week..

   Vigorous activity □ Extensive physical exercise for at least 60 minutes per session 4 times per week.

   Other:_____

   _____

Sleep

Do you experience any insomnia at night? □ Yes □ No How many hours do you sleep each night? _____

If insomnic, what have you taken to help you sleep? _____

Do you wake up at night? □ Yes □ No How many times do you wake up each night? _____

Notes:

Restorative HEALTH

MALE SYMPTOMS QUESTIONNAIRE

Patient Name:_____ Date:_____

Please circle a number for each of the following categories to let us know how you have been feeling:

What are your CURRENT Symptoms Over the Past 1-4 Weeks?

0 means you have no symptoms / 1 means you have very mild symptoms

5 would be moderate symptoms / 10 would mean you have severe symptoms

												Comments, if any
Sleep Disturbances/Changes	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Fatigue	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Depression	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Sad and/or Grumpy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Low Energy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Decreased Enjoyment in Life	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Irritability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Anxiety	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Low Sex Drive	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Erection Strength & Endurance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Hot Flashes	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Night Sweats	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Poor Focus	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Memory Lapse	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Loss of Muscle Tone	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
↓ Exercise Tolerance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Body Joint Pains	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____
Dry Skin	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	_____

Answer the questions below that pertain to you

- Have you lost weight? YES NO
- Are you experiencing difficulty losing weight? YES NO
- Have you gained weight gradually without an obvious cause? YES NO
- Are you retaining fat in your abdomen (increased belly fat)? YES NO
- Have you been diagnosed with insulin resistance, diabetes, or metabolic syndrome? YES NO
- Do you produce less semen so your ejaculation quantity is reduced? YES NO
- Are you losing body hair, especially on the legs? YES NO
- Are you balding? YES NO
- Do you have less ability to cope with stress? YES NO
- Are you more emotional? YES NO
- Have you noticed a recent deterioration in your ability to play sports? YES NO
- Are you falling asleep after dinner? YES NO
- Has there been a recent deterioration in your work performance? YES NO

Restorative HEALTH

FEMALE SYMPTOMS QUESTIONNAIRE

Patient Name:_____ Date:_____

Please circle a number for each of the following categories to let us know how you have been feeling:

Current Status – What are your CURRENT Symptoms Over the Past 1-4 Weeks?

0 means you have no symptoms / 1 means you have very mild symptoms
5 would be moderate symptoms / 10 would mean you have severe symptoms

												Comments, if any
Irritability (feeling nervous, inner tension, feeling aggressive)	0	1	2	3	4	5	6	7	8	9	10	_____
Heart Discomfort (usual awareness of heart beat, heart skipping, racing, tightness)	0	1	2	3	4	5	6	7	8	9	10	_____
Sleep Problems (difficulty falling asleep, sleeping through the night, waking up early)	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety (inner restlessness, feeling panicky)	0	1	2	3	4	5	6	7	8	9	10	_____
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Depressive Mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	0	1	2	3	4	5	6	7	8	9	10	_____
Hot Flashes, Night Sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Bladder Problems (difficulty in urinating, increased need to urinate, bladder incontinence)	0	1	2	3	4	5	6	7	8	9	10	_____
Vaginal Dryness (sensation of dryness or burning, difficulty with sexual intercourse)	0	1	2	3	4	5	6	7	8	9	10	_____
Chronic Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Issues (hair loss, thinning of the hair)	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Physical & Mental Exhaustion (general decrease in perfomance)	0	1	2	3	4	5	6	7	8	9	10	_____
Joint & Muscular Discomfort (pain in the joints, rheumatoid complaints)	0	1	2	3	4	5	6	7	8	9	10	_____
Sexual problems (change in sexual desire, in sexual activity and satisfaction)	0	1	2	3	4	5	6	7	8	9	10	_____
↓ Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	_____
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	_____
Weight Control	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses (impaired memory, decrease in concentration, forgetfulness)	0	1	2	3	4	5	6	7	8	9	10	_____

Are you currently taking your progesterone? ☐ Yes ☐ No

Current Dose and Type: _____ ☐ Troche ☐ RDT (rapid dissolve tablet) ☐ Capsule

First day of your last menstrual cycle? _____

Patient Signature: _____ Date: _____

This notice describes how medical information about you may be used and disclosed and how you can get access tothis information. Please read carefully. This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of professional organizations to aid this practice in its compliance and certifications programs. We perform quality assessment and improvement activities, conduct, arrange for medical, legal, and audit reviews, including fraud and abuse detection. Business planning and development is ongoing. Customer service, resolution of internal grievances, sale or transfer of assets processes may apply. Persons participating in such processes will review billing and medical files to ensure we maintain our compliance with regulations and the law.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (births/death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Kansas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or administrative decision-maker) or another appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation
We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting, (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Kansas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee. That fee is $25.00.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12- month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to the protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Persons for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Chris Lonsford
245 Peachtree Industrial Blvd #100
Sugar Hill, GA 30518
Phone: (816) 207-4119
Fax: (770) 831-0250
Email: chris@restorative-health.com

INFORMED CONSENT

I, _____, acknowledge that I have been presented with a copy of the RH Notice of Privacy Practices and am aware that all clinic personnel may have access to private information in order to serve patients.

I consent to the provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

We may call to remind you of your appointment or to notify you of test results. I agree, if I have an answering machine or voicemail, to allow the doctor or staff to identify themselves, as well as myself, to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine or voicemail.

I request that my protected health information be disclosed to the following persons or facility as listed below:

_____

_____

_____

_____

Patient Signature:_____ Date:_____