BRADENTON EAST INTEGRATIVE MEDICINE

NEW PATIENT DEMOGRAPHIC FORM

Name: ______________________ Age: _______ Sex: ______________

Date of Birth: ______________ SSN: ______________ Race ______________

Phone Number: ______________ Cell Phone: ______________

Email Address: ______________________________

Street Address: ______________________________

____

Do you live alone or with others? ______________

Other Household members: ______________________________

Emergency Contact: ______________________ Relationship: ______________

Employer / Occupation: ______________________________

Work Number: ______________

Insurance Company: ______________________________

(Please provide copy of insurance card to front desk)

Preferred Pharmacy: ______________________________

How did you find us? ______________________________

Who was your previous (or current) Primary Care Physician? ______________________

BRADENTON EAST INTEGRATIVE MEDICINE

NEW PATIENT HISTORY FORM

1) When was your last Complete Physical Examination?____________________

2) Have you ever had a Colonoscopy?_______ When was the last one?_______________
   Was it normal?_________

3) When was your last Dental exam? _________

4) When was your last Eye exam?___________

5) For FEMALES ONLY:

   a) When was your last menstrual period? ____

   b) At what age did you have your first menstrual period? ______________

   c) When was your last Pap / Pelvic exam? ______________

   d) When was your last Mammogram? ___________Was it normal?_________________________

   e) Have you had laboratory tests to check your hormone levels (estrogen, progesterone, testosterone, DHEA)? ☐ Yes ☐ No

   f) Have you had laboratory tests to check your thyroid levels? ☐ Yes ☐ No

   g) Are you on any hormone replacement therapy (estrogen, progesterone, testosterone, DHEA, thyroid)? ☐ Yes ☐ No ____

6) For MALES ONLY:

   a) Do you have any of the following:

      i) ☐ low sex drive ☐ erectile dysfunction/difficulties ☐ mood problems ☐ fatigue or low energy ☐ sleep disturbances/difficulties

      ii) Have you had your Testosterone blood levels checked? ☐ Yes ☐ No

      iii) Are you on Testosterone replacement therapy? ☐ Yes ☐ No

      iv) Have you ever had a PSA test? ☐ Yes ☐ No When was the last one?_______

      Was it normal? ☐ Yes ☐ No

REVIEW OF SYSTEMS/SYMPTOMS

(Check any symptoms or findings that you have experienced recently)

CONSTITUTIONAL ☐ weight change ☐ fatigue ☐ fever ☐ night sweats ☐ general weakness

EYES ☐ vision problems ☐ double vision ☐ yellowing of the eyes

ENT ☐ hearing problems ☐ dizziness ☐ sinus trouble ☐ sore throat ☐ ringing ears ☐ bleeding gums ☐ periodontal disease

CARDIOVASC ☐ shortness of breath ☐ chest pain ☐ leg swelling ☐ increased blood pressure ☐palpitations

RESPIRATORY ☐ cough ☐ coughing up blood ☐ wheezing ☐ asthma ☐ other difficulty breathing ☐ snoring ☐ gasping for air during sleep ☐ fall asleep during the day

GASTROINTESTINAL ☐ trouble swallowing ☐ heartburn ☐ nausea ☐ vomiting ☐ diarrhea ☐ blood or black tarry stools ☐ abdominal pain ☐ gas ☐ bloating

GENITOURINARY ☐ pain with urination, blood in urine ☐ urgency ☐ incontinence ☐ increased urination ☐ sexual dysfunction ☐ nocturia (frequent urination at night)

MUSCULOSKELELTAL ☐ joint pain ☐ joint stiffness ☐ muscle cramps ☐ muscle twitching ☐ muscle weakness ☐ loss of motion ☐ tendonitis ☐ swelling of finger or other joints ☐ redness of joints

SKIN/HAIR/NAILS ☐ rash ☐ lumps/masses ☐ itchy ☐ dryness ☐ hair changes ☐ nail changes ☐ yellowing of the skin

NEUROLOGICAL ☐ fainting ☐ blackouts ☐ seizures ☐ paralysis ☐ weakness ☐ numbness ☐ memory loss ☐ numbness in a saddle distribution (inner legs and groin) ☐ headaches

PSYCHOLOGICAL ☐ nervousness ☐ tension ☐ mood changes ☐ depression ☐ anxiety

ENDOCRINE ☐ decreased libido ☐ heat or cold intolerance ☐ excessive thirst ☐ increased hunger ☐ increased craving for sweets or carbs ☐ low blood pressure ☐ hot flashes

HEMATOLOGY/ONCOLOGY ☐ easy bruising ☐ bleeding (difficulty clotting) ☐ venous thrombosis (clots) ☐ current or history of cancer

PAST MEDICAL HISTORY

Check all that apply:

☐ Abuse: ☐ Physical ☐ Emotional ☐ Sexual (Treatment: ____________________)

☐ Abnormal Heart Rhythm ☐ Fibroids ☐ Lupus

☐ Anemia ☐ Fibromyalgia ☐ Lyme disease

☐ Anxiety ☐ Food allergies or intolerances ☐Kidney Disease

☐ Asthma ☐ Headaches/Migraines ☐ Osteoarthritis ☐ Osteoporosis

☐ Autoimmune Disease ☐ Heart Attack ☐ Parkinson's Disease

☐ Bipolar Disorder ☐ Heart Disease ☐ Premenstrual Syndrome

☐ Bowel or Bladder Incontinence ☐ High Blood Pressure ☐ Prostatitis / Prostate Disease

☐ Broken Bones ____________________ ☐ High Cholesterol ☐ Pulmonary Embolism (clot in lung)

☐ Cancer (what kind/when? __________ ____________________) ☐ Psoriasis

☐ Crohn's Disease ☐ Hepatitis ☐ Rheumatoid Arthritis

☐ Deep Vein Thrombosis (clot) ☐HIV/AIDS ☐ Seizures

☐ Dementia / Memory Disorder ☐ Impotence ☐ Sleep Apnea

☐ Depression ☐ Infertility ☐ Stomach Ulcers

☐ Diabetes ☐ Insulin resistance or Borderline Diabetes ☐ Stroke

☐ Emphysema or Chronic Bronchitis (COPD) ☐ Irritable Bowel Syndrome ☐ Thyroid Disease

☐ Endometriosis ☐ Insomnia or other Sleep disturbance ☐ Ulcerative Colitis

☐ Other ____

☐ Have you ever had <u>**elevated calcium levels**</u>? If yes, then when? ☐ Yes ☐ No
Do you recall the level? How can we obtain this result?

____

Have you had laboratory tests to check your <u>**Vitamin D levels**</u>? ☐ Yes ☐ No

ARE YOU CURRENTLY ON ANY <u>BLOOD THINNERS</u>? ☐ Yes ☐ No

Have you ever taken <u>**quinolone antibiotics**</u> (Cipro, Levofloxin)? If so, when? ☐ Yes ☐ No ______

____

<u>**Chronic Musculoskeletal Pain :**</u>

☐ Shoulder ☐ Neck ☐ Knee

☐ Elbow ☐ Mid-back ☐ Ankle/foot

☐ Wrist/hand ☐ Low back ☐ other:________

SURGICAL HISTORY/HOSPITALIZATIONS

____________________________________ Date: ______________

____________________________________ Date: ______________

____________________________________ Date: ______________

____________________________________ Date: ______________

____________________________________ Date: ______________

____________________________________ Date: ______________

SOCIAL HISTORY

What is your **Marital Status**? ☐ Single ☐ Married ☐ Divorced ☐ widowed ☐ Other Long term partnership

What is your **Occupation** (if retired, from what occupation are you retired)?

____

Do you use **Tobacco** (smoke or chew)? ☐ Yes ☐ No If yes, then how much and for how long?

____

If no, then do you have a history of tobacco use? ☐ Yes ☐ No

If yes, then for many years did you smoke? ____________ How long ago did you quit? ____________

Do you use **Alcohol**? ☐ Yes ☐ No If yes, then how often and how much?

____

Do you use **Drugs**? ☐ Yes ☐ No If yes, then how often and how much?

____

Do you currently follow a **Specific Diet or Nutritional program**? ☐ Yes ☐ No

____

Do you **Cook**? ☐ Yes ☐ No

Do you **Grocery Shop**? ☐ Yes ☐ No

Do you **Read Food Labels**? ☐ Yes ☐ No

How many **Servings of Fruits/Vegetables** do you have per day (do not include fruit juice, potatoes, or processed foods)? ____

How many times per week do you **Eat Out** (include: breakfast, lunch, dinner, and dessert/snacks)?
___

Do you **Exercise**? ☐ Yes ☐ No What type and How often?
___
___

WHAT IS YOUR CURRENT LEVEL OF STRESS? ☐ none ☐ mild ☐ moderate ☐ severe

What are your **Hobbies/Interests**? ___

Do you currently have or have you had any **Environmental Exposures** to chemicals/toxins/radiation?
___

Are you **sensitive to any Environmental Chemicals** (e.g. perfumes/colognes, auto exhaust, MSG, etc)?
___

FAMILY HISTORY

Father: ☐ alive; age ___ ☐ deceased; age___ Medical problems ___
___

Mother: ☐ alive; age ___ ☐ deceased; age___ Medical problems ___
___

Brothers: Medical problems ___

Sisters: Medical problems ___

Other medical problems that run in the family? ☐ Diabetes ☐ Heart Problems ☐ Cancer ☐ Stroke ☐Hypertension ☐ High Cholesterol ☐ Thyroid problems ☐ Osteoarthritis ☐ Autoimmune Diseases (for example: Rheumatoid Arthritis, Lupus, Crohn's Disease, etc.) ☐ Emotional Disorders ☐ Alcoholism

☐Genetic Disorders / Please list:___

ALLERGIES (to medications, supplements, foods or environmental agents)

Medication: ______________________ Type of Reaction: ____________

Medication: ______________________ Type of Reaction: ____________

Medication: ______________________ Type of Reaction: ____________

Food: ______________________ _____ Type of Reaction: ____________

Food: ______________________ _____ Type of Reaction: ____________

Food: ______________________ _____ Type of Reaction: ____________

Other: ______________________ _____ Type of Reaction: ____________

MEDICATIONS/BOTANICAL HERBS/SUPPLEMENTS LIST

NAME	DOSAGE	HOW OFTEN TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

IMMUNIZATION HISTORY

Please provide the dates of the most recent vaccination for the following

(or record as n/a if you have never been vaccinated):

1. Pneumonia________________
2. DTAP____________________
3. HEPATITIS A____________________
4. HEPATITIS B ___________________
5. SHINGLES____________________
6. HPV / GUARDASIL_______________
7. MENINGITIS_________________
8. MMR______________________
9. POLIO_____________________
10. Other please list______________________________

Bradenton East Integrative Medicine

Please help us here at Bradenton East Integrative Medicine to fulfill the requirements for meaningful use of electronic medical records set forth in the health care reform bill that was passed last year. This bill requires us to collect additional demographic information. Below you will find a short questionnaire.

Circle one that applies for each category

Race

American Indian & Alaskan Native

Asian

Black or African American

Black Hispanic or Latino

Native Hawaiian & other pacific islander

White

White Hispanic or Latino

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Language Preference

English

Chinese

French

German

Italian

Japanese

Korean

NAME:______________________________

HIPPA DISCLOSURE AGREEMENT

Bradenton East Integrative Medicine, P.A

Patient Authorization for Disclosure of Information

Do we have permission to?

Leave the following information on your home answering machine or voice mail?

Appointment Information	Y	N
Medical information	Y	N
Billing information	Y	N
Contact you at work	Y	N

List family members of friends or personal care givers that you give permission to receive the following information about you:

Appointments: ____________________________

Medical or health information: ______________________

Billing/Payments: ___________________________

I understand that is the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Bradenton East Integrative Medicine in writing.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

I Have received a copy of the "Notice of Privacy Practices" to review and acknowledge that I may request a copy.

Patient signature ___________________________ Date__ /___/____

INSURANCE COMPANY: ____

NAME____

INSURANCE ID#_________________________________

GROUP#_________________________________

KNOW YOUR INSURANCE – Your insurance is a contract between you and your insurance company.

We want to inform you that your health insurance benefits may or may not cover specific services depending on your policy. These services may include but are not limited to routine physical exams, ultrasound testing, massage, acupuncture, and laboratory services.

If your coverage denies this claim, you **will** be financially responsible.

____

Signature

____

Please print name

MUSCULOSKELETAL DIVISION

1) REFERRED BY: ______________________________
2) PRIMARY CARE PHYSICIAN: ______________________ Last Visit: ______________
3) DO YOU SEE A PAIN MANAGEMENT PHYSICIAN: ☐ Yes ☐ No

NAME: ______________________ LAST VISIT: ______________

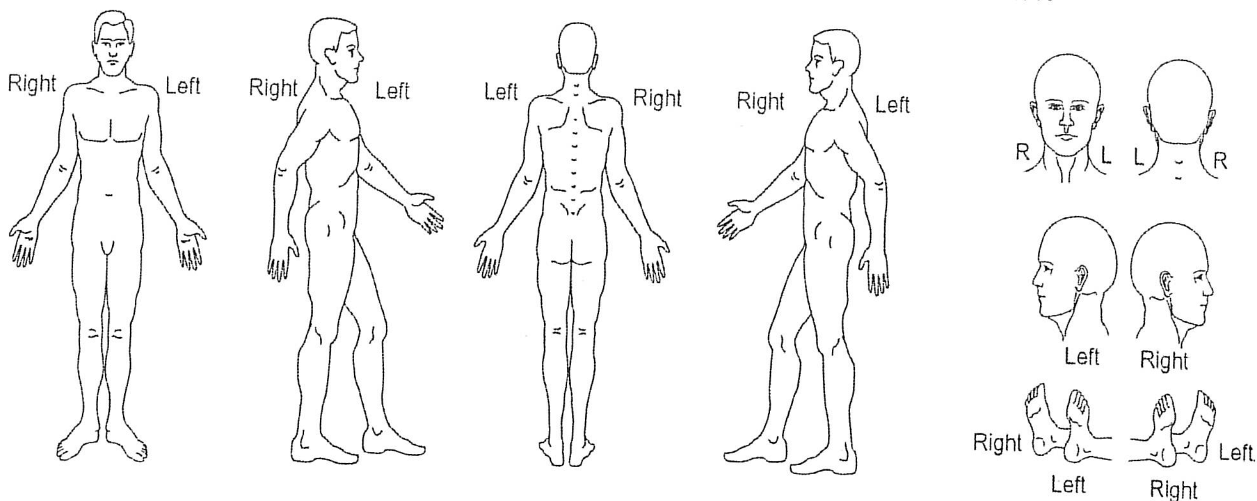
4) REASON FOR THIS VISIT:

____

____

____

PLEASE MARK THE AREAS ON THE DIAGRAM WHERE YOU ARE EXPERIENCING DIFFICULTY:



5) IS THIS THE RESULT OF AN INJURY OR ACCIDENT? IS THIS A WORKER'S COMPENSATION OR AUTOMOBILE INSURANCE RELATED CASE? (if Yes, please provide background information)

____

____

PRIMARY AREA YOU WOULD LIKE TO DISCUSS TODAY: (please check one)

☐ Neck/Upper back ☐ Mid-back/Lower Back ☐ Shoulder ☐ Elbow
☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

Comments: ______________________________

6) THE FOLLOWING QUESTIONS PERTAIN TO THE PRIMARY AREA YOU'VE CHECKED IN QUESTION 4 ABOVE :

a. When and how did this problem start?

____

____

b. How would you describe the character of your pain or complaint (check all that apply):

☐ Aching ☐ Tightness/Stiffness ☐ Numbness/Tingling ☐ Cramping ☐ Stabbing
☐ Sharp ☐ Shooting ☐ Pressure ☐ Burning ☐ Weakness

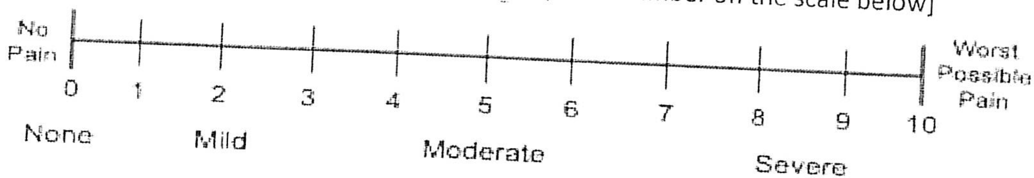
If your chief complaint today is for knee pain, then please check the following (if they apply):

☐ Knee Popping ☐ Knee Clicking ☐ Knee Catching ☐ Knee Instability

c. Does this pain/complaint radiate to any other locations? (if yes, describe the pattern)

____

d. How severe is the pain/complaint currently on a scale of 0 (no pain) to 10 (worst possible pain)? [please circle the appropriate number on the scale below]



Comments: ______________________________

What is the pain on average throughout the day on a scale of 0 – 10? __________

e. Is this pain/complaint constant? ☐ Yes ☐ No

i. How much of the day is your discomfort or pain present?

☐ Less than 1 hour ☐ 4 hours ☐ 6 hours ☐ 12 hours ☐ 18 hours ☐ 24 hours

f. How has this pain/complaint changed over time?

☐ getting better ☐ getting worse ☐ no change

g. What activities is this pain/complaint affecting?

____

____

h. What makes this pain/complaint worse?

____

i. Does it get worse with bending the area? (For neck or low back pain, is it worse with bending forward, backwards, or with turning?)

____

ii. Does it get worse with sneezing or coughing? ☐ Yes ☐ No

i. What makes this pain/complaint **better**?

____

i. Is it better at certain times of day?

____

ii. Is it better with ☐ rest or ☐ motion? Are there certain positions that ease the problem?

____

7) PRIOR TREATMENT

a. Have you taken any Medications/Botanical Herbs/Supplements for this problem?

1. Please list:

Name Dose Length of Time Taken Helpful (Not at all/Mildly/Moderately/Very)

____

____

____

____

b. **ARE YOU CURRENTLY ON ANY ONGOING STEROID THERAPY ?** ☐ Yes ☐ No

c. Have you had **Physical Therapy** for this problem? ☐ Yes ☐ No When? ____________ For how long? ____________

d. Have you had **Manual Adjustments** (e.g. Chiropractic or Osteopathic) for this problem? ☐ Yes ☐ No When? ____________ For how long? ____________

e. Have you had **Acupuncture** for this problem? ☐ Yes ☐ No When? ____________ For how long? ____________

f. Have you had **Massage** for this problem? ☐ Yes ☐ No When? ____________ For how long? ____________

g. Have you had any **Injections** for this problem? ☐ Yes ☐ No When? ____________ What kind? ____________ For how long/How many times?

____
____

h. Have you had any **other treatment interventions** for this problem? ☐ Yes ☐ No
When? ____________ For how long/How many times?
____

8) What are your **goals** for treatment?
____
____
____

9) **HAVE YOU RECEIVED ANY SPECIAL TESTING OR PROCEDURES FOR THIS PROBLEM? (PLEASE BRING COPIES OF REPORTS OR HAVE SENT TO US)**

TEST	DATE	LOCATION	RESULTS (in your own words is ok)
XRAY			
CAT SCAN (CT)			
MRI			
ULTRASOUND			
EMG/NERVE CONDUCTION			
OTHER (please specify)			

BRADENTON EAST INTEGRATIVE MEDICINE
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.

If you have any questions about this Notice please contact our Privacy Officer who is HEATHER JOHNSON

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the

health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. <u>YOUR RIGHTS</u>

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

<u>You have the right to inspect and copy your protected health information.</u> This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

<u>You have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by <u>submitting the request in writing to the privacy officer (Heather Johnson) for review with your physician.</u>

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location.</u> We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

<u>You may have the right to have your physician amend your protected health information.</u> This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will

provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Heather Johnson** at (941)727-1243 or **beim6120@gmail.com]** for further information about the complaint process.

This notice was published and becomes effective on 9/1/2013.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Bradenton East Integrative Medicine with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

______________________________ ____________
Patient's Name (print) Date

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Authorized Facility Signature Date

MISSED/CANCELLED APPOINTMENT POLICY

We require 24 hr. notice for cancellation of appointments. If you cancel your appointment on the same day or miss your scheduled appointment time you will incur a $30.00 missed appointment fee.

This is applicable for all providers.

*Please make sure to call the office to reschedule or cancel 24 hrs. prior to your appointment time to avoid this fee.

Also if you are more than 15 minutes late your appointment may need to be rescheduled.

Patient Name:____

Patient Signature:____

Date:________________________________

REQUEST TO RELEASE MEDICAL RECORDS TO:

BRADENTON EAST INTEGRATIVE MEDICINE, PA

8614 EAST STATE ROAD 70 SUITE 200 BRADENTON, FL 34202
941-727-1243
FAX: 941-751-9039

KAREN BRAINARD, MD______ **ROBIN JAMES, ARNP______**
VICTOR KIM, DO _________ **KINGA PORTER, DO ________**
DEB COUPLAND-PORTER, ARNP ________

FROM:____
NAME OF HEALTHCARE PROVIDER/PHYSICAN/FACILITY

____
STREET ADDRESS

____
CITY, STATE & ZIP

PHONE (   ) **FAX (   )**

____
PRINT PATIENT'S FULL NAME

___________/___________/___________ ___________-___________-___________
DATE OF BIRTH **SOCIAL SECURITY NUMBER**

____ ___________/_________/_________
SIGNATURE OF PATIENT OR GUARDIAN **DATE**

I HEREBY AUTHORIZE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW FOR THE PURPOSE OF CONTINUITY OF CARE

___________ **COMPLETE MEDICAL RECORDS** ___________ **LAB TESTS**
___________ **X-RAYS** ___________ **EKG/ECG/CARDIAC STUDIES**
___________ **CONSULT REPORTS**

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE OR SELF-PAID SERVICES. YOU ARE HEREBY SPECIFICALLY AUTHORIZED TO RELEASE ALL INFORMATION OR MEDICAL RECORDS RELATING TO SUCH DIAGNOSIS, TESTING, OR TREATMENT, UNLESS SPECIFICALLY EXCLUDED BELOW:

____

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNING.
THE PATIENT MAY REVOKE THIS AUTHORIZATION AT ANYTIME UPON WRITTEN REQUEST.
I ACKNOWLEDGE THAT THE DISCLOSED INFORMATION MAY NO LONGER BE PROTECTED BY THE PRIVACY PRACTICES OF THIS PRACTICE.