Restore Health and Wellness Center

Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It **must** be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **3 days**.
- We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours.
- Do not take tub baths or get into a hot tub or swimming pool for **3 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- No major exercises for the incision area for the next **3 days**, this includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

- Remember to go for your post-insertion blood work **6 weeks** after the insertion.
- Most women will need re-insertions of their pellets **3-4 months** after their initial insertion.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

Additional Instructions:

_____

_____

_____

_____

_____

_____

I acknowledge that I have received a copy and understand the instructions on this form.

_____ _____ _____

Print Name **Signature** **Today's Date**

Restore Health and Wellness Center

WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- **FLUID RETENTION:** Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

- **SWELLING OF THE HANDS & FEET:** This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

- **UTERINE SPOTTING/BLEEDING:** This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

- **MOOD SWINGS/IRRITABILITY:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

- **FACIAL BREAKOUT:** Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

- **HAIR LOSS:** Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

- **HAIR GROWTH:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

I acknowledge that I have received a copy and understand the instructions on this form.

Print Name **Signature** **Today's Date**

Restore Health and Wellness Center

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name:_____ Today's Date:_____
(Last) (First) (Middle)

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)
Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

Restore Health and Wellness Center

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

I have read the Restore Health and Wellness Center **Female Testosterone and/or Estradiol Pellet Insertion Consent Form** and understand and agree to its terms.

My birth control method is:
(please circle)

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation
Vasectomy Other

Today's Date: _____

_____ _____

Print Name Signature

Restore Health and Wellness Center

Hormone Replacement Fee Acknowledgment

Although more insurance companies are reimbursing patients for the BioTE® Medical Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure.

We will give you paperwork to send to your insurance company to file for reimbursement upon request.

New Patient Consult Fee	**$125**
Established Patient Consult Fee	**$69**
Female Hormone Pellet Insertion Fee	**$365**
Male Hormone Pellet Insertion Fee	**$650**

Restore Health and Wellness Center

Hormone Replacement Fee Acknowledgment

I have read the Restore Health and Wellness Center **Hormone Replacement Fee Acknowledgment** and understand and agree to the payment requirements.

Print Name	Signature	Today's Date

Restore Health and Wellness Center

INSURANCE DISCLAIMER

Preventative medicine and bio-identical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as Medical Doctors and RN's or NP's, insurance does not recognize it as necessary medicine BUT is considered like plastic surgery (esthetic medicine) and therefore is not covered by health insurance in most cases.

Restore Health and Wellness Center is not associated with any insurance companies, which means they are not obligated to pay for our services (blood work, consultations, insertions or pellets). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company and a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies.

The form and receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, or make any contact with your insurance company. Any follow up letters from your insurance to us will be thrown away. If we receive a check from your insurance company, we will not cash it, but instead return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company.

For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. This is the best idea for those patients who have an HSA as an option in their medical coverage.

Restore Health & Wellness Center

INSURANCE DISCLAIMER

I have read the Restore Health and Wellness Center **Insurance Disclaimer** and understand and agree to its terms.

Name: _____ Signature:  _____ Date: _____

Restore Health & Wellness

FEMALE HEALTH HISTORY – PELLET VISIT

Date: _____ **Name:** _____ **Age:** ____ **Birth Date:** _____

Living Situation: Spouse____ Alone____ Partner____ Friend(s)____ Parents____ Children____ Other____

Please list any allergies you have to food or medications: _____

_____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes, please explain: _____

Please list any medical problems that you are currently being treated for or have been treated for in the past: _____

_____

_____

Personal History of any of the following:

( ) Breast Cancer ( ) Uterine Cancer ( ) Ovarian Cancer

( ) Removal of Ovaries ( ) Hysterectomy only ( ) Hysterectomy with removal of ovaries

( ) Tubal Ligation ( ) Partner with vasectomy ( ) Currently on birth control pills

( ) PCOS ( ) Uterine fibroids ( ) Fibrocystic Breast Disease

( ) Endometrial polyps ( ) Acne ( ) Breast Tenderness

( ) Facial hair ( ) Pre-menstrual migraines ( ) Hypothyroid/Hashimoto's Autoimmune

Please list any surgeries that you have had including the date: _____

_____

_____

Please list any medications and nutritional supplements ***with dosages***, prescription or over-the-counter, that you take:

_____

_____

_____

Past Hormone Replacement Therapy: _____

Age of first period: ____ Date of last period: _____ Date of last pap smear: _____ Result: _____

Date of last mammogram: _____ Result: _____ Date of last bone density study: _____ Result: _____

Date of last sigmoidoscopy/colonoscopy: _____ Result: _____

Date of last pelvic ultrasound: _____ Result: _____

Are you sexually active? ____YES____NO With males, females, or both? _____

If you are still having a period, what is your method of contraception? _____

Do you get routine physical exercise? ___YES___NO If yes, what type & how long? _____

Do you smoke cigarettes? ___YES___NO If yes, # per day: _____ Number of years: _____

Previous smoker? ___YES___NO Stop date: _____ # per day: _____ # of years: _____

Do you drink alcohol? ___YES___NO If yes, how much per day? _____ What type? _____

Do you drink caffeine products? ___YES___NO If yes, how much per day? _____ What type? _____

Restore Health and Wellness Center

BHRT Checklist For Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Restore Health & Wellness Center

PATIENT INFORMATION FORM

NAME _____ DATE _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH __/__/____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

OCCUPATION _____ WORK PHONE _____

EMPLOYER _____ RELIGION _____

EMAIL _____ RACE _____

MARITAL STATUS _____ SPOUSE/GUARDIAN NAME _____

IN CASE OF EMERGENCY, PLEASE CONTACT _____

RELATIONSHIP _____ HOME# _____ WORK # _____

WHO IS RESPONSIBLE FOR PATIENTS ACCOUNT? _____

ADDRESS _____ HOME PHONE _____

PREFERRED METHOD OF CONTACT (check all that apply)

____ EMAIL	____ OK TO SEND DETAILED MEDICAL INFORMATION
____ CELL #	____ OK TO LEAVE DETAILED MEDICAL MESSAGE
____ HOME #	____ OK TO LEAVE DETAILED MEDICAL MESSAGE
____ WORK #	____ OK TO LEAVE DETAILED MEDICAL MESSAGE

PREFERRED PHARMACY NAME _____

ADDRESS _____ PHONE _____

HOW DID YOU HEAR ABOUT OUR OFFICE? (Please check all that apply)

____ BROCHURE	____ SEMINAR
____ NEWSPAPER	____ RADIO – which station? _____
____ TV – which station? _____	____ PHARMACIST – which one? _____
____ INTERNET SEARCH ENGINE	____ MAGAZINE - which one? _____
which one? _____	

____ FRIEND/PATIENT
Name _____ Address _____

____ OTHER _____

I understand that I am financially responsible for all charges. Unless prior arrangements have been made, I understand that all payment is due at the time that services are rendered. I understand and agree to give <u>at least</u> a 2 business day notice for any appointment cancellation. If a 2 business day notice is not given, I agree to pay the $50 late cancellation fee.

SIGNATURE _____ DATE _____

UPDATED: 01/01/18

Restore Health & Wellness Center

PATIENT COMMITMENT

No matter how much support you have, nothing is as important as your own resolve! If you're reading this document, then you're making the first step… there will be many more. We ask you to commit to the following:

1. **Own and take responsibility for your health** – It is important for you to realize that the life you live is your own, and that you have always had the control to choose to live it healthfully! The services offered at Restore Health & Wellness Center (RHWC) will aid you on your journey towards health but are not magic or get well quick schemes. Our services will only help you if you make a daily commitment to live a healthier life.
2. **Be patient** – Nutritionally based, wellness/prevention medicine is founded on principles of bringing your body back into balance and then keeping it there. In the same way that you did not become unhealthy overnight, it may take some time before you feel optimum results.
3. **Be Compliant** – The quickest way to wellness is to closely follow an experienced practitioner who can guide you there. Your compliance with recommended protocols and therapies is the best way to maximize the wellness investment that you have decided to make.
4. **Keep appointments** – Our practitioners schedule your appointments in order to closely monitor your progress, properly manage your prescriptions, discuss your lab results, and answer any questions you may have about your treatment plan. If you find that you are unable to keep your appointment as scheduled, it is imperative that you give at least a 2 business day notice to the office. Late cancellations will result in a $50 no show fee.
5. **Maintain honest, open communication** – A successful partnership requires a transparent, free-flowing line of communication. We want you to feel secure enough to let us know when a treatment or therapy isn't working for you, or if you feel that a regimen we've asked you to adopt is too difficult for you. The best avenue for communication is through the Patient Portal within your electronic medical record. Please email your concerns and requests through the Patient Portal to one of our staff. RHWC does not communicate with medical insurance companies. Our relationship is with you only and we will make your medical information available through the Patient Portal.
6. **Be understanding** - Understand that RHWC is not a primary care medical office and maintains a minimal staff to provide available services. You must acquire and maintain a relationship with a primary care provider for all of your basic health care needs. Our office provides a set list of services and will not go beyond that.
7. **Manage your paperwork** - RHWC will provide to you 1 free copy of all labs & receipts at the time of your visit. You will be charged $15 per request for any further copies.
8. **Be flexible** - RHWC has multiple medical providers. We strive to work with you and your requests for which provider you would like to see. However, we cannot guarantee that you will see the same provider each visit.
9. **Be proactive** - If you need a medication refill or supplement refill, please be proactive and plan ahead for weekends, holidays, and office closings. It is the office policy for you to call your pharmacy and have them fax or email a refill request AT LEAST 3 business days prior to needing the refill. Please do not call the office for refills.
10. **Be on time** - RHWC providers strive to honor your time by being on time for your visit. We cannot be on time if you do not arrive 15 minutes prior to your visit. Please understand that if you are not 15 minutes early or if you are indeed late, your appointment may be rescheduled.

In my resolve to partner with Restore Health & Wellness Center, I, _____ (printed name), hereby set my intention to take control of my own health & wellness. My signature below implies that I have fully reviewed the RHWC Patient Handbook and that I understand and agree to the aforementioned policies and commitments.

_____ _____

Signature Date

UPDATED: 01/01/18

Restore Health and Wellness Center

Notice of Privacy Practices ACKNOWLEDGMENT

Patient Name: _____ **DOB:**_____

I acknowledge that Restore Health & Wellness Center provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____ _____

Patient Signature Patient/Guardian Signature Date

Patient Consent for Release of Protected Health Information (PHI)

I, _____, give my consent to Restore Health & Wellness Center to release my protected health information to include, but not limited to: physical exam results, lab results or other diagnostic studies, medication information/changes, appointments, billing information, etc. to the following individuals:

_____ _____

Print Name Relationship

_____ _____

Print Name Relationship

I understand that all releases of my PHI will be in compliance with Restore Health & Wellness Center' Notice of Privacy Practices.

I consent to Restore Health & Wellness Center to (check **ALL** that apply):

☐ **Email** detailed messages regarding my appointments, services or diagnostic test results at the following email address: _____

☐ **Call AND leave detailed messages** regarding my appointments, services or diagnostic test results at the following phone number: _____

☐ **Leave a callback number only** at the following phone number: _____

This consent will expire only with written notification or updated consent from me.

_____ _____

Patient Signature Date

_____ _____

Patient/Guardian Signature Relationship to Patient

Restore Health and Wellness Center

NOTICE OF PRIVACY PRACTICES for

PERSONAL HEALTH INFORMATION

Effective Date: November 17, 2014

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.

OUR OBLIGATIONS:
We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to: Office Manager, Restore Health and Wellness Center PLLC, 3175 Wrightsville Ave, Wilmington, NC 28403. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given

to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: Office Manager, Restore Health and Wellness Center PLLC, 3175 Wrightsville Ave, Wilmington, NC 28403.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: Office Manager, Restore Health and Wellness Center PLLC, 3175 Wrightsville Ave, Wilmington, NC 28403.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: Office Manager, Restore Health and Wellness Center PLLC, 3175 Wrightsville Ave, Wilmington, NC 28403. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: Office Manager, Restore Health and Wellness Center PLLC, 3175 Wrightsville Ave, Wilmington, NC 28403. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.insightfamilyhealth.com. To obtain a paper copy of this notice, call 910-508-2802.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Office Manager in writing addressed to: Office Manager, Restore Health and Wellness Center PLLC, 3175 Wrightsville Ave, Wilmington, NC 28403. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, www.acog.org, or call (202) 863-2584.