RESTORE
HEALTH & WELLNESS

Tabetha Smith, FNP-C
Tax ID# 45-5490235
1010 South 16th Street, Wilmington NC 28401
Phone: 910-763-1960 Fax: 910-763-1961

POST-INSERTION INSTRUCTIONS FOR MEN

• Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip and the outer layer is a waterproof dressing.

• **Do not take tub baths or get into a hot tub or swimming pool for 7 days.** You may shower, but do not remove the bandage or steri-strips for 7 days.

• No major exercises for the incision area. No heavy lifting using the legs for 7 days. This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and normal walking on a flat surface.

• 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 (25 to 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. If the redness worsens after the first 2-3 days, please contact the office.

• 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.

• We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.

REMINDERS:

• Remember to have your post-insertion blood work done 5-6 weeks after your FIRST insertion. If you are not feeling any better by 4 weeks, however, please call the office to have your labs drawn early.

• The charge for the second visit will only be for the insertion and not a consultation.

• Most men will need re-insertion of their pellets 3-4 months after their initial insertion. If you experience symptoms prior to this, please call the office.

• Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

ADDITIONAL INSTRUCTIONS:

_____

_____

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name	Signature	Today's Date

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WHAT MIGHT OCCUR AFTER A PELLET INSERTION (MALE)

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.

• INFECTION: Infection is a possibility with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.

• PELLET EXTRUSION: Pellet extrusion is uncommon and occurs in < 5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.

• ITCHING OR REDNESS: Itching or redness in the area of the incision and pellet placement is common. Some patients may also have a reaction to the tape or glue. If this occurs, apply hydrocortisone to the area 2-3 times daily. If the redness becomes firm or starts to spread, please contact the office.

• FLUID RETENTION/WEIGHT GAIN: 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, or by taking a mild diuretic, which the office can prescribe.

• BREAST TENDERNESS OR NIPPLE SENSITIVITY: These may develop with the first pellet insertion. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. Taking 2 capsules of DIM daily helps prevent excess estrogen formation. In males, this may indicate that you are a person who is an aromatizer (changes testosterone into estrogen). This is usually prevented if DIM is taken regularly but can be easily treated and will be addressed further when your labs are done, if needed.

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

• ELEVATED RED BLOOD CELL COUNT: Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased. Routine blood donation may be helpful in preventing this.

• HAIR LOSS OR ANXIETY: 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. 5-HTP may be helpful for anxiety and is available over-the-counter.

• FACIAL/BODY BREAKOUT: Acne may occur when testosterone levels are either very low or high. 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.

• AROMATIZATION: Some men will form higher-than-expected levels of estrogen from the testosterone. Using DIM 2 capsules daily as directed may prevent this. Symptoms such as nipple tenderness or feeling emotional may be observed. These will usually resolve by taking DIM, but a prescription may be needed. • HIGH OR LOW HORMONE LEVELS: The majority of times, we administer the hormone dosage that is best for each patient, however, every patient breaks down and uses hormones differently. Most patients will have the correct dosage the first insertion, but some patients may require dosage changes and blood testing. If your blood levels are low, results are not optimal and it is not too far from the original insertion, we may suggest you return so we can administer additional pellets or a “boost” (at no charge). This would require blood work to confirm. On the other hand, if your levels are high, we can treat the symptoms (if you are having any) by supplements and/or prescription medications. The dosage will be adjusted at your next insertion.

• TESTICULAR SHRINKAGE: Testicular shrinkage is expected with any type of testosterone treatment.

• LOW SPERM COUNT: Any testosterone replacement will cause significant decrease in sperm count during use. Pellet therapy may affect sperm count up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

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PELLET INSERTION CONSENT FOR MALES

My physician/practitioner has recommended testosterone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low testosterone levels. The following information has been explained to me prior to receiving the recommended testosterone therapy.

OVERVIEW Bioidentical testosterone is a form of testosterone that is biologically identical to that made in my own body. The levels of active testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced testosterone. The pellets are a delivery mechanism for testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930's. There are other formulations of testosterone replacement available, and different methods can be used to deliver the therapy. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones.

RISKS/COMPLICATIONS Risks associated with pellet insertion may include: bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents.

Some individuals may experience one or more of the following complications: acne, anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or male pattern baldness, increased growth of prostate and prostate tumors which may or may not lead to worsening of urinary symptoms, hypersexuality (overactive libido) or decreased libido, erectile dysfunction, painful ejaculation, ten to fifteen percent shrinkage in testicular size, and/or significant reduction in sperm production, increase in neck circumference, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually. Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected. All types of testosterone replacement can cause a significant decrease in sperm count during use. Pellet therapy may affect sperm count for up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

Additionally, there is some risk, even when using bioidentical hormones, that testosterone therapy may cause existing cases of prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test (PSA) is recommended for men ages 55-69 before starting hormone therapy, even if asymptomatic. Testing is also recommended for younger individuals considered high risk for prostate cancer. The test should be repeated each year thereafter. If there is any question about possible prostate cancer, a follow-up referral to a qualified specialist for further evaluation may be required.

CONSENT FOR TREATMENT: I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician or health care provider's office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits. I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered.

I understand that follow-up blood testing will be necessary six (6) weeks after my initial pellet insertion and then at least one time annually thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes.

I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets. I have read or have had this form read to me.

I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider. This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

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Testosterone Pellet Insertion Consent Form

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

Print Name | Signature | Today's Date

RISK ACKNOWLEDGEMENT WAIVER

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. Testosterone pellets should be completely out of your system in 12 months.

By beginning treatment, I accept all the risks of therapy stated herein and future risks that might be reported. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance.

Print Name | Signature | Today's Date

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MALE 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:
( ) Hemochromatosis ( ) Elevated PSA ( ) Testicular or Prostate Cancer
( ) Prostate Enlargement ( ) Hypothyroid ( ) Hashimoto's Autoimmune
( ) Live above 5000 ft ( ) Trouble passing urine or take Flomax/Avodart

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

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

Do you have parents, grandparents, brothers, or sisters have any of the following? (check all that apply)
___ Diabetes ___Heart Attack ____ Stroke ____ Cancer If so, what type? _____
___ High Cholesterol ___High Blood Pressure ___Blood Clots ___Heart Disease/Heart Surgery
___Other _____

Date of last prostate exam? _____ PSA level drawn? __Yes __ No Results: _____
Date of last sigmoidoscopy/colonoscopy: _____ Result: _____
Are you sexually active? ____ YES ____ NO With males, females, or both? _____
Have you ever had an EKG, Stress Test, or Echocardiogram? __Yes __ No Results: _____
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? _____

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Health Assessment For Men (Male Symptom Questionnaire)

Name:_____ **Date:**_____

E-Mail Address:_____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "never".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Sweating (night sweats or excessive sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Increased need for sleep or falls asleep easily after a meal					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire or in sexual performance)					
Bladder problems (difficulty in urinating, increased need to urinate)					
Erectile changes (less strong erections, loss of morning erections)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches/migraines					
Rapid hair loss or thinning					
Feel cold all the time or have cold hands or feet					
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise					
Infrequent or absent ejaculations					
Total:					

Severity	Score
Mild	1 - 20
Moderate	21 - 40
Severe	41 - 60
Very Severe	61 - 80

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HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER
(Patient Copy)

Preventative medicine and bioidentical 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, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases.

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

Understand that if you are a MEDICAID patient, Medicaid will NOT pay for any labs, prescriptions, radiology tests, etc. ordered by our providers.

This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will 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 a Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

New Patient Consult Fee ~~$300~~ *If you do your procedure on the same day as the consult, we discount the New Patient Consult fee to* ***$150***

Established Patient Consult Fee: $99

Female Hormone Pellet Insertion Fee: $400

Male Hormone Pellet Insertion Fee: $700 (regular) / $550 (modified)

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HORMONE REPLACEMENT FEE ACKNOWLEDGMENT & INSURANCE DISCLAIMER

(Office Copy)

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

Name: _____Signature:  _____ Date: _____

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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

HOW DID YOU HEAR ABOUT RESTORE HEALTH & WELLNESS CENTER? (Please check all that apply)

_____ BROCHURE	_____ SEMINAR
_____ NEWSPAPER	_____ RADIO – which station?
_____ TV – which station?	_____ PHARMACIST – which one?
_____ FRIEND/PATIENT	
Name _____	Address _____
_____ OTHER _____	

I understand that I am financially responsible for all charges. I understand that payment is due at the time services are rendered unless prior arrangements have been made. I understand and agree to give a 2 business day notice for any appointment cancellation.

*** If a 2 business day notice is not given for BioTE and Follow-Up Provider Visits, I agree to pay a $50 late cancellation fee before I can reschedule my appointment.***

SIGNATURE _____ **DATE** _____

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PATIENT COMMITMENT
- -Patient Copy - -

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. Please read the Patient handbook found on our website (www.restorehealthwellness.com), and 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.

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PATIENT COMMITMENT
- -Office Copy - -

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 found online at our website (RestoreHealthWellness.com) and that I understand and agree to the aforementioned policies and commitments.

_____ _____

Signature Date

UPDATED: 12.18.19

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BioTE Patient Awareness Consent
(Patient Copy)

Please read and initial each item below.

Patient Name: _____

_____ I understand that I am a hormone implant (ie, BioTE) patient of Restore Health & Wellness Center (RHWC).

_____ As a hormone implant patient, I understand that RHWC is primarily a bio-identical hormone replacement specialty practice and not a primary care practice.

_____ I understand that RHWC does not provide stand-alone thyroid management or stand-alone prescription drug management.

_____ I understand that if I decide in the future to discontinue my hormone implant therapy, I will need to find another medical provider to continue my medical care and to continue prescribing any medications.

_____ I understand that Restore Health and Wellness medical providers will only prescribe refills on my prescription medication/s up to 6 months from the date of my last procedure. This will allow me time to find another medical provider to take over refilling my prescriptions and caring for any medical needs I may have.

_____ I understand that if I decide in the future to discontinue being a hormone implant patient, I may still receive the following services from RHWC:

- B12 and/or MIC-B12 shots
- IV Vitamin Infusions
- Far Infrared Sauna
- Oxygen Therapy
- Cryofacial
- VI Peel Facial
- Ultrasound Treatments
- Purchase of Supplements

_____ I understand 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.

_____I understand RHWC 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 receipt showing that you paid out of pocket and with all the information you need to file insurance. WE WILL NOT, however, communicate in any way with insurance companies. The Labcorp lab in our office DOES accept insurance and will bill it for you. (I understand that if I am a MEDICAID patient, Medicaid will NOT pay for any labs, prescriptions, radiology tests, etc. ordered by our providers.)

_____ The receipt is 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 a 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.

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BioTE Patient Awareness Consent
(Office Copy)

Patient Name: _____

Patient Signature: _____

Date: _____

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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

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NOTICE OF PRIVACY PRACTICES for PERSONAL HEALTH INFORMATION (Patient Copy)

Effective Date: November 17, 2014

This notice describes how medical information about you may be used & disclosed & 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, 1010 South 16th Street, Wilmington, NC 28401.
- *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, 1010 South 16th Street, Wilmington, NC 28401. .
- *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, 1010 South 16th Street, Wilmington, NC 28401. 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,1010 South 16th Street, Wilmington, NC 28401. . 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.restorehealthwellness.com. To obtain a paper copy of this notice, call 910-761-1960.

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, 1010 South 16th Street, Wilmington, NC 28401. 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.