RESTORE
HEALTH & WELLNESS

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

Consent & Authorization for *INJECTION/INTRAVENOUS THERAPY*

Patient Name: _____ D.O.B. _____

Procedure: Basic Myers / Immune Boost Myers / Glutathione / Saline / Lactated Ringers/ and/or Oxygen

Medical Care Provider: _____

Procedure Performed By: Karla Vavra Melcher, RN BSN

1. Restore Health & Wellness Center provides personnel to assist your medical care provider in the performance of intravenous therapy. You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

    a. The procedure involves inserting a needle into your vein, tissue or muscle and injecting the formula described above.
    b. An alternative to injection/ intravenous therapy is oral supplementation and/or dietary and lifestyle changes.
    c. Risks of injection/intravenous therapy include:
        i. Discomfort, bruising and pain at the site of injection.
        ii. Inflammation of the vein used for injection, phlebitis.
        iii. Severe allergic reaction, anaphylaxis, cardiac arrest and death.
    d. Benefits of injection/intravenous therapy include:
        i. Injectables are not affected by stomach or intestinal disease.
        ii. Total amount of injection/infusion is available to the tissues.
        iii. Nutrients are forced into cells by means of a high concentration gradient.
        iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

2. You have the right to consent to or refuse the proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above.

3. I understand that this therapeutic treatment may not be considered a conventionally accepted medical treatment but that the practitioner believes may be of potential benefit to you.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing.
b. The procedure(s) set forth above has been adequately explained to you.
c. You have received all the information and explanation you desire concerning the procedure.
d. You authorize and consent to the performance of the procedure or series of procedures from the medical staff of Restore Health & Wellness Center, PLLC.

DATE: _____ TIME: _____

SIGNATURE:_____
Patient/Representative

If signed by representative, indicate relationship: _____

WITNESS:_____

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Consent & Authorization for Intravenous Vitamin C Infusion

Patient Name: _____ D.O.B._____

Medical Care Provider: _____

Procedure: High Dose Vitamin C Infusion for 25 gram, 50 gram, 75 gram, and/or 100 gram

I, _____, hereby request & consent to undergo a series Intravenous Vitamin C Infusions. It has been recommended by_____ that I receive these Infusions as treatment for _____. The initial course of treatment will consist of a series of _____ infusions, given at a rate of _____ per week though this will be modified in response to therapy.

This treatment involves the placement of a flexible catheter into a vein by a Registered Nurse (RN), then the infusion of the solution over a 1 to 3 hour period of time. This solution will consist of the following nutritional components: Magnesium Sulfate, Ascorbic Acid (Vitamin C), and Sterile Water. Methyl (B12) may also be used except for patients undergoing treatment during dental procedures to remove mercury amalgam fillings.

Usually most patients experience an improved sense of well-being, improved energy, and increased immune function, which can be due to destruction of pathogenic organisms such as viruses, bacteria, and yeast, improved hepatic detoxification function, destruction of toxins and allergenic proteins, improved metabolic functioning in cells of the body, and destruction of primitive cells that lack natural antioxidant enzymes.

Very few patients experience any complications or side effects. Occasionally patients may experience: phlebitis (irritation of the vein), dehydration, chills, fever, loose stools, nausea, headache, fatigue, lightheadedness, blurred vision, head fog, temporary alteration of blood glucose levels, allergic reaction to one or more of the components: hemolysis (destruction of red blood cells), anemia, and Vitamin C deficiency and scurvy if IV infusions are suddenly discontinued without tapering down the dosage.

I acknowledge that I have no known allergies to the components of the solution, and I will advise the RN at each treatment if I feel I have experienced any adverse effects or if I have any questions for the practitioner. I acknowledge that I have been given no guarantees or warranties, expressed or implied, regarding the outcome of this procedure. I acknowledge that I have not been asked to discontinue care provided by any specialists or my primary care physician. I understand that alternatives to this procedure include oral supplementation and/or dietary and lifestyle changes.

I understand that this therapeutic treatment may not be considered a conventionally accepted medical treatment but that the practitioner believes it may be of potential benefit to me.

I hereby request to receive this treatment or series of treatments from the medical staff of Restore Health & Wellness Center, PLLC.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing.
b. The procedures(s) set forth above has been adequately explained to you.
c. You have received all the information and explanation you desire concerning the procedure.
d. You authorize & consent to the performance of the treatment or series of treatments from the medical staff of Restore Health & Wellness Center, PLLC.

Date: _____ Time: _____ Signature:_____
Patient/Representative

If signed by representative, indicate relationship: _____

Witness: _____

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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, I agree to pay a $50 late cancellation fee before I can reschedule my appointment.

*** 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. 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 and that I understand and agree to the aforementioned policies and commitments.

_____ _____

Signature Date

UPDATED: 12.18.19

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IVMT Cancellation Policy & Payment Agreement

-- Patient Copy --

I, _____, understand and agree to the following information, and agree to make a payment in the following amount/s to Restore Health & Wellness Center for each missed IVMT appointment.

As of April 25, 2018 any patient scheduled for an IV micronutrient treatment will be charged the following prices.

Glutathione Infusion 5 ml (1000 mg or 1 gram)	89.00	High Dose "C" Infusion 25 grams	149.00
Myer's Multivitamin Infusion 12 ml (2400 mg or 2.4 grams)	119.00	High Dose "C" Infusion 50 grams	179.00
Myer's Multivitamin Infusion	119.00	High Dose "C" Infusion 75 grams	209.00
Myer's Multivitamin Infusion with 5 ml Glutathione (1 gm)	145.00	High Dose "C" Infusion 100 grams	239.00
Myer's Multivitamin Infusion w/ 12 ml Glutathione (2.4 gm)	179.00	Add Myer's to a High Dose Vit.C Infusion	+65.00
15 gram Vit C Super Myers/Immune Boost Myers (IBM)	149.00		
15 gram Vit C Super Myers/ " (IBM) w/ 5 ml Glutathione (1 gm)	175.00	Add 30 min Oxygen to any IV	+15.00
15 gram Vit C Super Myers/ " (IBM) w/ 12 ml Glut. (2.4 grams)	209.00	Add 250 cc bag of fluids to any IV	+20.00
20 gram Vit C Super Myers/Immune Boost Myers (IBM)	169.00	Add 500 cc bag of fluid to any IV	+30.00
20 gram Vit C Super Myers/ " (IBM) w/ 5 ml Glutathione (1 gm)	195.00	Add 1000cc bag of fluids to any IV	+50.00
20 gram Vit C Super Myers/ " (IBM) w/ 12 ml Glut. (2.4 gm)	229.00		
PORT ACCESS FEE	20.00		

- All IV treatments are drawn up the morning of the scheduled appointment and cannot be reused once they have been drawn up and set out for a scheduled appointment.
- Restore Health & Wellness Center acknowledges that emergencies can occur that prevent a patient from showing up for their IV treatment.
- However, because of the cost and the time that is taken to draw up each IV, we can no longer be responsible for the cost of a wasted IV treatment.
- **If you have purchased an IV package and have failed to show up for a scheduled appointment or have canceled late (after 7:30 AM), you will be charged for the IV Infusion. If you have pre-purchased an infusion package, no treatments will be added to the end of the 8 week packages for any treatment missed.**

I understand and agree that all current appointment charges that have been missed will be charged to my credit card on the date of the missed appointment.

The credit card will remain active for twelve months from the date of this agreement.

If payment is made by a Credit/Debit Card and my credit card is declined at any time I agree to pay a $25 decline fee when it goes through. I also agree that there will not be a statement sent out to me for this amount.

Established 4/29/14; Updated/Revised 4/25/2018, 4/3/2019, 12/14/19, 12/2021, 8/2023

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IVMT Cancellation Policy & Payment Agreement

-- Office Copy --

I, _____, understand and agree to the following information, and agree to make a payment in the above amount/s to Restore Health & Wellness Center for each missed IVMT appointment.

Patient Signature_____ Date_____

Witness _____ Date _____

NAME: _____ DATE _____

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

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

CARD NUMBER _____

EXPIRATION DATE _____ 3 DIGIT SECURITY CODE _____

VISA _____ MASTERCARD _____ DISCOVER _____

Established 4/29/14; Updated/Revised 4/25/2018, 4/3/2019, 12/14/19, 8/2023

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FEMALE HEALTH HISTORY

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

Living Situation: Spouse ____ Alone ____ Partner ____ Friend(s) ____ Parents ____ Children ____ Other ____

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____
_____
_____

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

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

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:
_____
_____
_____
_____

Do your parents, grandparents, brothers, or sisters have any of the following? (check all that apply)
___ Diabetes ___ Heart Attack ___ Cancer If so, what type? _____
___ Stroke ___ High Cholesterol ___ High Blood Pressure ___ Blood clots
___ Heart disease/heart surgery ___ Other_____

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: _____

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? _____

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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

Effective Date: November 17, 2014

(Patient Copy)

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.