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

MALE 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____

Date of last prostate exam: ___________ PSA level drawn? _____ Yes ______ No Result: _______________

Date of last sigmoidoscopy/colonoscopy: _________ Result: _________

Are you sexually active? ____ YES ____ NO With males, females, or both? ____________________________

Have you ever had a testosterone blood level done? _____ Yes ______ No When? ____ Result: __________

Have you ever had an EKG, Stress Test, or Echocardiogram? _____ Yes ______ No Result: ______________

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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CURRENT SYMPTOM QUESTIONNAIRE

Name: ____________________ **DOB:** ______________ **Date:** ___________

Please "X" ALL symptoms that you have now:

	HEALTH QUADRANT I		HEALTH QUADRANT II		HEALTH QUADRANT III
	Fatigue		Yellow Eyes/Skin		Dry Mouth
	Sugar Cravings		Diarrhea		Fatigue
	Allergies		Heartburn/Indigestion		Dry Skin/Mouth
	Chemical Sensitivities		Rectal Bleeding/Itching		Headache
	Stress		Nausea		Constipation
	Low Blood Sugar		Decreased Appetite		Lightheadedness
	Cold Body Temperature		Constipation		Muscle Cramps
	Irritable		Bloating/Belching		Anxiety
	Arthritis		Excess Gas		Heart Palpitations
	Heart Palpitations		History Diverticulosis		Insomnia
	Aches/Pains		History Colitis		Memory Lapses/Forgetful
	Sleep Disturbances		History Stomach Ulcers		Hair Loss
	Bone Loss		History Crohn's Disease		Diarrhea
	Weight Gain Waist		History of Cancer		Frequent Skin Rashes
	Loss of Muscle Mass		Frequent Skin Rashes		Delayed Wound Healing
	Thinning Skin		Acne		Weight Gain
	Elevated Triglycerides		Frequent Yeast Infections		Slow Metabolism
	History of Cancer		Fatigue		Depressed Mood
	Anxious		Aches/Pains		Thin/Brittle Nails
	Memory Lapse/Forgetful		History of Celiac Disease		Dry Eyes
	Headaches		Food Sensitivities		Dandruff
	Low Libido		Food Allergies		Cracked Skin on Heels
	Hair Loss		Iron Deficiency		Trouble Concentrating
	Increased Facial Hair		B12 Deficiency		Anemia
	Increased Body Hair		Undigested Food in Stool		Frequent Infections
	Acne		Persistent mucous in throat		Pale Skin
	Nervous		Weak, peeling,cracked nails		Discolored Skin/Nails
	Elevated Blood Pressure		Always eat in a rush		Muscle Weakness
	Elevated Cholesterol		Do not chew food properly		Cold Hands/Feet
	Elevated Triglycerides		Frequent Antibiotic Use		Tingling Feeling in Legs
	Elevated Blood Sugar		Feel "Sick All Over"		Swollen/Thick Tongue
	Waist Larger Than Hips		Abdominal Pain		Easy Bruising
	Elevated Insulin		Gallbladder Removed		Bleeding Gums
	Swelling in Hands/Feet		Itchy Skin		Weight Loss

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

____ ___________________
Signature Date

UPDATED: 12.18.19

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INSURANCE DISCLAIMER

(Patient Copy)

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 use to complete your insurance company's forms and 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.

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

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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INSURANCE DISCLAIMER

(Office Copy)

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

Name: ________________________________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

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.