Wellness, Weight Loss & Aesthetic Center
5906 N. Highway 146 Suite: 100
Baytown, TX 77523

Patient Intake Form

Patient Name: _____Date: _____

Address: _____ City: _____ State: _____ Zip:_____

Cell Phone: _____ Work Phone: _____

DOB: _____ Social Sec.# : _____ Gender: ( ) Male ( ) Female

Marital Status: ( )Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Drivers License #: _____ State: _____ Email Address: _____

How did you hear about us? ( ) Former Patient ( ) Family/Friend ( ) Website ( ) Driving By

Name of family or friend that referred you: _____

Race: ( ) Afro-American ( ) Asian ( ) Caucasian ( ) Hispanic ( ) Other : _____

Employment Information

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____

Emergency Contact Information

Name: _____ Relationship: _____

Cell Phone: _____ Work Phone: _____

PLEASE PROVIDE US WITH A COPY OF YOUR DRIVER'S LICENSE

Chief Complaint (Please Check All That Apply)	
☐ Abdominal Pain	☐ Headache
☐ Abnormal vaginal bleeding	☐ Hypertension
☐ Abnormal PAP Smear	☐ Insomnia
☐ Allergic Rhinitis	☐ Low sex drive
☐ Anemia	☐ Obesity
☐ Asthma	☐ Pain of the ankle
☐ Back Pain	☐ Pain of the elbow
☐ Benign Prostrate Hypertrophy	☐ Pain of the hip
☐ Bloody Stools	☐ Pain of the knee
☐ Cerumen Impaction	☐ Pain of the shoulder
☐ Chest Pain	☐ Pain of the wrist
☐ Conjunctivitis	☐ Palpitations
☐ Cough	☐ Runny Nose
☐ Depression	☐ Sinusitis
☐ Diabetes	☐ Overweight
☐ Earache	☐ Upper Repertory Infection
☐ Erectile Dysfunction	☐ Urinary Tract Infection
☐ Fever	☐ Vomiting
☐ Fracture	☐ Vertigo
☐ Goiter	☐ Wrinkles/Lines

Drug, Food, Latex, Environmental, Etc. Allergies / Sensitivities

☐ **No Known Allergies**

Allergies	Reactions
1	
2.	
3.	
4.	

List All Medications

☐ **Not currently taking any OTC, RX, Vitamins, or Supplements**

Medication	Dosage	Reason for taking

Surgical History			
☐ **No Significant Past Surgical History**			
Surgery	**When**	**Hospital**	**Doctor**
Abdominal			
Adenoidectomy			
Ankle			
Appendectomy			
Bladder			
Brain			
Cesarean Section			
Circumcision			
Cosmetic			
Colposcopy (Women)			
Colonoscopy			
Elbow			
Eye			
Foot			
Gastric Bypass			
Gallbladder			
Genitourinary			
Heart			
Hysterectomy			
Knee			
Low Back			
Lung			
Neck			
Prostate			
Rectal (Hemorrhoids)			
Shoulder			
Sinus			
Tonsillectomy			
Throat			
Thyroid			
Vasectomy			
Please list any other surgical history:			

Past Medical History		
Medical History	**When**	**Comments**
Aids/HIV		
Anemia		
Anxiety		
Asthma		
Breathing Problems		
Cancer		
COPD		
Coronary Heart Disease		
Depression		
Diabetes		
GERD		
Gout		
Heart Murmur		
Heart Palpating		
Heart Valve Prolapse		
Hepatitis A, B, C		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Liver Disease		
Osteoporosis		
Osteoarthritis		
PCOS - Polycystic Ovarian Syndrome		
Migraines		
Rheumatoid Arthritis		
Sinusitis		
Stroke		
Systemic Lupus Erythematous		
Substance Abuse		
Thyroid Disorder		
Please list any other concerns with your medical history you may have:		

Past Family Medical History: (Cancer, Hypertension, Diabetes, Stroke, Heart Attack, Etc.)		
Mother	☐ Alive ☐ Deceased	
Father	☐ Alive ☐ Deceased	
Sister(s)	☐ Alive ☐ Deceased	
Brother(s)	☐ Alive ☐ Deceased	
Children	☐ Alive ☐ Deceased	
Grandparents	☐ Alive ☐ Deceased	

Social History

Marital Status?	**( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed**
Number Of Children?	**Boys # _____ Girls # _____**
Nature of Exercise?	**( ) I exercise at least 3 x's a week ( ) Everyday ( ) Cardio ( ) Weights**
Pets?	**Dogs #_____ Cats# _____ Other # _____** **Kind:_____**
Sexual History?	**( ) Not sexually active ( ) Monogamous ( ) Homosexual ( ) Heterosexual** **( ) Bisexual ( ) Multiple Partners ( ) High Risk Behaviors**
Do You Take Care Of Disabled Person?	**( ) YES** **( ) NO**
Are You Pregnant?	**( ) YES ( ) NO**
Have You Recently Given Birth?	**( ) YES If YES How Long Ago? _____** **( ) NO**
Are You Currently Breast Feeding?	**( ) YES** **( ) NO**
Do You drink alcohol?	**( ) YES ( ) NO** **If Yes, What Kind? _____** **Are You Concerned Of The Amount You Are Drinking? ( ) YES ( ) NO**
Smoking /Tobacco use?	**( ) Yes ____ Packs a day Do You Want To Quit Smoking? ( ) YES ( ) NO** **( ) No**
Caffeine intake?	**( ) Yes How Much?_____** **( ) No**
Do You Currently Use Recreational Drugs?	**( ) Yes, Please Explain:** **( ) No**
Employment Type?	**( ) Sedentary ( ) Standing ( ) Light Labor ( ) Heavy Labor** **( ) N/A**
Nature Of Work?	**( ) Physical ( ) Moderate ( ) Active**
Occupational Exposure?	**( ) YES ( ) NO**
Exposure To Health Hazards?	**( ) YES ( ) NO**
Health Hazards At Home?	**( ) YES ( ) NO**
Duration Of Current Profession?	**_____ Days _____ Weeks _____ Months _____Years**
Satisfaction With Work?	**( ) YES ( ) NO**
Stress Level At Work?	**( ) High ( ) Medium ( ) Low**
Surgical History?	

Please List Any Additional Social History Details If Any:

Review Of Systems			
Constitutional Symptoms		YES ( ) NO ( )	
Normal Appearance	YES ( ) NO ( )	Disability	YES ( ) NO ( )
Fever	YES ( ) NO ( )	Chills	YES ( ) NO ( )
Malaise/Fatigue	YES ( ) NO ( )	Night Sweats	YES ( ) NO ( )
Sleep Problems		YES ( ) NO ( )	
Sleep Apnea	YES ( ) NO ( )	Snoring	YES ( ) NO ( )
Tiredness during the day	YES ( ) NO ( )	Excessive day time sleeping	YES ( ) NO ( )
Insomnia	YES ( ) NO ( )	Gasping/Choking while asleep	YES ( ) NO ( )
Headaches when waking up	YES ( ) NO ( )	Poor concentration	YES ( ) NO ( )
Restless Sleep	YES ( ) NO ( )	Decreased sex drive	YES ( ) NO ( )
Comments:			
Eye Problems		YES ( ) NO ( )	
Blurred Vision	YES ( ) NO ( )	Double Vision	YES ( ) NO ( )
Photophobia	YES ( ) NO ( )	Visual Changes	YES ( ) NO ( )
Discharge	YES ( ) NO ( )	Glaucoma	YES ( ) NO ( )
Itching	YES ( ) NO ( )	Lacrimation	YES ( ) NO ( )
Pain	YES ( ) NO ( )	Redness Of Eyes	YES ( ) NO ( )
Eyeglasses	YES ( ) NO ( )	Contact Lens	YES ( ) NO ( )
Comments:			
Ears, Nose, Mouth, & Throat Problems		YES ( ) NO ( )	
Hearing Loss	YES ( ) NO ( )	Ear Pain	YES ( ) NO ( )
Sensation Of The Room Spinning Inside Your Body	YES ( ) NO ( )	Tinnitus	YES ( ) NO ( )
Nasal Congestion	YES ( ) NO ( )	Nasal Discharge	YES ( ) NO ( )
Abnormal Sneezing	YES ( ) NO ( )	Bleeding From Nose	YES ( ) NO ( )
Postnasal Drip	YES ( ) NO ( )	Oral Ulcers	YES ( ) NO ( )
Oro-Dental Problems	YES ( ) NO ( )	Sore Throat	YES ( ) NO ( )
Sensation Of A Lump In The Throat	YES ( ) NO ( )	Swollen Glands In Neck	YES ( ) NO ( )
Ulcerations		YES ( ) NO ( )	
Comments:			
Cardiovascular Problems		YES ( ) NO ( )	
Chest Pain	YES ( ) NO ( )	Murmur	YES ( ) NO ( )
Palpitation	YES ( ) NO ( )	Claudication	YES ( ) NO ( )
Dyspnea	YES ( ) NO ( )	Orthopnea	YES ( ) NO ( )
Edema	YES ( ) NO ( )	Previous EKG	Date:
Comments:			

Review Of Systems			
Respiratory Problems		YES ( ) NO ( )	
Cough	YES ( ) NO ( )	Shortness Of Breath	YES ( ) NO ( )
Chest Tightness	YES ( ) NO ( )	Hemoptysis	YES ( ) NO ( )
Asthma	YES ( ) NO ( )	Wheezing	YES ( ) NO ( )
Comments:			
Gastrointestinal Problems		YES ( ) NO ( )	
Nausea/Vomiting	YES ( ) NO ( )	Change In Bowel Habits	YES ( ) NO ( )
Diarrhea	YES ( ) NO ( )	Constipation	YES ( ) NO ( )
Abdominal Pain	YES ( ) NO ( )	Difficulty With Swallowing	YES ( ) NO ( )
Blood In Stools	YES ( ) NO ( )	Hemorrhoids	YES ( ) NO ( )
Comments:			
Genitourinary		YES ( ) NO ( )	
Blood In Urine	YES ( ) NO ( )	Painful Urination	YES ( ) NO ( )
Excessive Night-time Urination	YES ( ) NO ( )	Urinary Frequency	YES ( ) NO ( )
Hesitancy	YES ( ) NO ( )	Urinary Urgency	YES ( ) NO ( )
Dribbling	YES ( ) NO ( )	Decreased Urine Stream	YES ( ) NO ( )
Abnormal Discharge	YES ( ) NO ( )	Burning	YES ( ) NO ( )
Itching	YES ( ) NO ( )	Dyspareunia (Painful Sex)	YES ( ) NO ( )
History of Urinary Tract/Bladder/Kidney		YES ( ) NO ( )	
Comments:			
Female GU		YES ( ) NO ( )	
LMP	Date:	Age At Menarche	Age:
Average Cycle Length		Shortest Cycle Length	
Longest Cycle Length	_____	No. Of Pregnancies – Live Births	_____
No. of Abortions	_____	No. Of Miscarriages	_____
No. of Stillbirths	_____	Date Of Last PAP Smear	_____
Painful Menstruation	YES ( ) NO ( )	Heavy Periods	YES ( ) NO ( )
Menstrual Tension	YES ( ) NO ( )	PMS	YES ( ) NO ( )
Abnormal Vaginal Discharge	YES ( ) NO ( )	Prior D And C	YES ( ) NO ( )
C-Section	YES ( ) NO ( )	Hysterectomy	YES ( ) NO ( )
Abnormal PAP Smear	YES ( ) NO ( )	Pregnancy	YES ( ) NO ( )
Comments:			

Reviews Of System			
Male GU Problems		YES ( ) NO ( )	
Lumps/Pain In Testicles	YES ( ) NO ( )	Difficulty With Erection/Ejaculation	YES ( ) NO ( )
Abnormal Discharge From Penis	YES ( ) NO ( )	Date Of Last Prostate Exam	_____
Comments:			
Musculoskeletal Problems		YES ( ) NO ( )	
Joint Pain	YES ( ) NO ( )	Neck Pain	YES ( ) NO ( )
Shoulder Pain	YES ( ) NO ( )	Back Pain	YES ( ) NO ( )
Upper Extremity Pain	YES ( ) NO ( )	Lower Extremity Pain	YES ( ) NO ( )
Numbness/Tingling Sensation		YES ( ) NO ( )	
Comments:			
Integumentary Problems		YES ( ) NO ( )	
Itching	YES ( ) NO ( )	Rashes	YES ( ) NO ( )
Change in Skin Color	YES ( ) NO ( )	Change in Hair/Nails	YES ( ) NO ( )
Varicose Veins		YES ( ) NO ( )	
Comments:			
Neurological Problems		YES ( ) NO ( )	
Seizures	YES ( ) NO ( )	Headache	YES ( ) NO ( )
Numbness	YES ( ) NO ( )	Weakness	YES ( ) NO ( )
Tremors	YES ( ) NO ( )	Decrease in Cognitive Skills	YES ( ) NO ( )
Loss Of Balance	YES ( ) NO ( )	Head Injury	YES ( ) NO ( )
Paralysis		YES ( ) NO ( )	
Comments:			

Reviews Of System			
Psychiatric Problems		YES ( ) NO ( )	
Difficulty Concentrating	YES ( ) NO ( )	Insomnia	YES ( ) NO ( )
Changes In Socializing	YES ( ) NO ( )	Irritability/Mood Changes	YES ( ) NO ( )
Suicidal Thoughts/Attempts	YES ( ) NO ( )	Anxiety	YES ( ) NO ( )
Depression	YES ( ) NO ( )	Nervousness	YES ( ) NO ( )
Forgetfulness	YES ( ) NO ( )	Adequate/Sound Sleep	YES ( ) NO ( )
Pervious Use Of Psychotropic Medication		YES ( ) NO ( )	
Comments:			
Endocrine Problems		YES ( ) NO ( )	
Excessive Urination	YES ( ) NO ( )	Heat Or Cold Intolerance	YES ( ) NO ( )
Changes In Hat/Glove Size	YES ( ) NO ( )	Nocturia	YES ( ) NO ( )
Glandular/Hormonal Problem	YES ( ) NO ( )	Excessively Dry Skin	YES ( ) NO ( )
Comments:			
Hematologic Problems		YES ( ) NO ( )	
Anemia	YES ( ) NO ( )	Easy Bruising	YES ( ) NO ( )
Night Sweats	YES ( ) NO ( )	Slow Healing Wounds	YES ( ) NO ( )
Past Transfusions	YES ( ) NO ( )	Phlebitis	YES ( ) NO ( )
Comments:			
Basic ADL			
Bladder incontinence	YES ( ) NO ( )	Bowel Incontinence	YES ( ) NO ( )
Toileting	Independent ( ) Dependent ( )	Feeding	Independent ( ) Dependent ( )
Dressing	Independent ( ) Dependent ( )	Bathing	Independent ( ) Dependent ( )
Ambulation	( )Self ( ) Assisted ( ) Wheelchair-Bound ( ) Bed-Bound		
IADL			
Preparing Meals	( ) Non-Assisted ( ) Assisted	Shopping	( ) Non-Assisted ( ) Assisted
Medication Management	( ) Non-Assisted ( ) Assisted	Money Matters	( ) Non-Assisted ( ) Assisted
Telephone Usage	( ) Non-Assisted ( ) Assisted	Light Work	( ) Non-Assisted ( ) Assisted
Heavy Work	( ) Non-Assisted ( ) Assisted	Transportation	( ) Non-Assisted ( ) Assisted

What is your preferred Pharmacy? _____

Address: _____City:_____State: _____Zip:_____

Medical Agreement

I acknowledge all the above information is true and correct to the best of my knowledge.

Patients Signature: _____Date: _____

Thank You For Completing Our Form

Wellness, Weight Loss, and Aesthetic Center

5906 North Highway 146, Suite 100
Baytown, TX 77523-5612

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR RESPONSIBILITIES UNDER HIPAA

In the course of providing health care we generate, collect and share health-related information pertaining to our patients. Traditionally that information was kept confidential by ethical traditions and a patchwork of regulations that vary by State. We have certain responsibilities regarding that information due to Congressional enactment of HIPAA, the Health Insurance Portability and Accountability Act. Under HIPAA, all information in your medical record along with associated billing and payments plus other related demographic data which can be traced back to you as an individual is considered PHI (Protected health Information). This Notice explains how we use and disclose medical information about you and inform you of your rights to access and control that information.

PROTECTED HEALTH INFORMATION USES AND DISCLOSURES

The following are examples of the types of uses and disclosures of your PHI that might occur. Some are more likely to happen than others, some may never happen. These examples are neither exhaustive nor an indication of what we intend to do. They are simply examples of the types of uses and disclosures that could be made by our medical practice without your permission as allowed by HIPAA.

Medical Treatment: We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore, we may and most likely will disclose medical information about you to doctors, nurses, technicians, medical students, hospital personnel and surgery center personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including your records, prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice, this may include your family members or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent.)

Payment : We may use and disclose medical information about you for services and procedures so that they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information about treatment you received at the Practice to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment to facilitate payment of a referring physician or the like.

Health Care Operations: We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students and other personnel for review and learning purposes.

We may also combine the medical information we have with medical information from other medical practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also use or disclose information about you for internal or external utilization review and/or quality assurance to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor at all times when business associates are used to advise them of their continued obligation to maintain the privacy of your medical record.

Appointment and Patient Reminders: We may ask that you sign in writing at the Reception Desk a "Sign In" log on the day of your appointment. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, email otherwise and may involve the leaving of a message via email, on an answering machine or voice mail, or otherwise could potentially be received or intercepted by others.

Emergency Situations: In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Research: Under certain circumstances we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Research, Death & Organ Donation: We may use or disclose your PHI in limited circumstances for research purposes. When necessary, we must disclose PHI to a coroner, medical examiner, funeral director or to an organ procurement organization for them to carry out their duties.

Worker's Compensation: We may release medical information about you for Worker's Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Oversight of Health and Public Policy: We disclose PHI to federal, state and local health and government agencies that oversee activities authorized by law. These include audits, investigations, inspections, licensure and determination of your eligibility for services. These activities may be necessary for the government to monitor the health care system, public programs, its contractors and entities subject to civil rights laws. For example, we must disclose PHI to the US Department of Health and Human Services for purposes of determining whether we are in compliance with federal privacy laws.

Monitoring Public Health Risk and Safety: As required by law, we may disclose your PHI to public health authorities, the Food and Drug Administration or entities that receive information for the purposes of the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify 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.

Investigative, Government & Security Activities: We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and national security. These activities are necessary for the payer, the government and other regulatory agencies to monitor the health care system, government programs and compliance with civil rights laws.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, or other public civil or criminal proceeding, we may disclose your PHI in response to a court order, summons, warrant, administrative order, grand jury subpoena, discovery request or other lawful process to the extent requested.

Law Enforcement and Criminal Activity: We may disclose PHI to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person, or to protect against fraud and other illegal activities. We may also do so when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or who has escaped from lawful custody. In the case of inmates or other persons in lawful custody, we may disclose PHI to law enforcement officials or correctional institutions that are responsible for their care.

Changes to this Notice: We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, top-center, the date of the last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Compliance Officer who will direct you on how to file an official complaint. All complaints must be submitted in writing, and all complaints shall be investigated without repercussion to you. **You will not be penalized for filing a complaint**.

Disclosures and Uses of PHI with your Written Permission: We will not disclose your PHI for any purpose not previously referenced in this notice without first obtaining your written authorization. When we need your permission, you may grant it by signing an authorization form. You may later revoke it in writing, except to the extent an action, use or disclosure was already performed as a result of your prior authorization.

Business Associates - Companies who provide services to our Practice who may have access to our patient's PHI will be required to sign a Business Associate Agreement protecting the Practice from PHI disclosures without authorization. An example of a business associate would be a medical transcription service.

YOUR RIGHTS AS OUR PATIENT

Access to Your Health Information You have the right to inspect and obtain copies of your PHI that may be used to make decisions related to our care for you, generally within 30 days. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your PHI, you must submit your request in writing to our Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying and mailing.

We may deny your request to access and disclose in certain very limited circumstances, such as when disclosure would reasonably endanger you or another person. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend If you feel that the medical information we have about you in your records 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 Practice maintains your medical record.

To request an amendment, your request must be submitted in writing to the Compliance Officer, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we believe that the PHI is already accurate and complete, we will deny your request. We will likely deny requests for amendment to any PHI that was not created by us (unless you provide reasonable evidence that the person or entity that created the information is no longer available to make the amendment). We cannot grant requests to amend PHI, which is not kept by the practice or which is not part of the PHI that you are permitted to inspect.

As part of your access right, you have the right to authorize and later revoke in writing the use or disclosure of your PHI to anyone for any purpose with limited exceptions.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of the disclosures we made of medical information about you to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back. We will notify you of any cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received. Your request must be made in writing and (1) state what information is to be limited (2) to whom the restriction applies and (3) if the restriction applies to use, disclosure or both.

We are not required to agree to these additional restrictions, but if we do, we will comply with your request except in cases of emergency or when we are otherwise required to disclose the information by law.

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 time. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail messages, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

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.

Wellness, Weight Loss and Aesthetic Center reserves the right to modify the privacy practices outlined in the notice.

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received from Wellness, Weight Loss and Aesthetic Center a copy of the "Notice of Privacy Practices".

I understand that Wellness, Weight Loss and Aesthetic Center, may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and healthcare operations.

Wellness, Weight Loss and Aesthetic Center has the right to modify the privacy practices outlined in the notice.

Signature of Patient or Representative _____ **Date**_____