Wellness, Weight Loss, and Aesthetic Center

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

Patient Intake Form

Patient Name:_____ **Date:**_____

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

Cell Phone:_____ **Work Phone:**_____

DOB:_____ **Social Security #:**_____ **Gender:** ☐ **Male** ☐ **Female**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

Driver's License #:_____ **State:**_____ **Email Address:**_____

How did you hear about us? ☐ **Former Patient** ☐ **Family/Friend** ☐ **Website** ☐ **Billboard** ☐ **Driving By**

Name of family or friend that referred you: _____

Race: ☐ **African 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 YOUR DRIVER'S LICENSE/IDENTIFICATION

Chief Complaint(s) (Please Check All That Apply)	
☐ Abdominal Pain	☐ Headache
☐ Abnormal Vaginal Bleeding	☐ Hypertension
☐ Abnormal PAP Smear	☐ Insomnia
☐ Allergic Rhinitis	☐ Low Sex Drive
☐ Anemia	☐ Obesity
☐ Asthma	☐ Morbid Obesity
☐ Back Pain	☐ Pain Of The Elbow
☐ Benign Prostrate Hypertrophy	☐ Pain Of The Knee
☐ Bloody Stools	☐ Morbid Obesity
☐ Cerumen Impaction	☐ Pain Of The Shoulder
☐ Chest Pain	☐ Pain Of The Wrist
☐ Conjunctivitis	☐ Palpitations
☐ Cough	☐ Runny Nose
☐ Depression	☐ Sinusitis
☐ Diabetes	☐ Overweight
☐ Earache	☐ Upper Respiratory Infection
☐ Erectile Dysfunction	☐ Urinary Tract Infection
☐ Fever	☐ Vomiting
☐ Fracture	☐ Vertigo
☐ Goiter	☐ Wrinkles/Lines

Allergies / Sensitivities (Drug, Food, Latex, Environmental, Etc.)	
☐ **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 # _____**
Do You Exercise?	☐ **No** ☐ **Yes, I exercise 1-3 days a week** ☐ **Yes, I exercise 4-7 days a week**
Nature of Exercise?	☐ **Cardio** ☐ **Weights** ☐ **Calisthenics** ☐ **Pilates/Yoga** ☐ **Other:_____**
Do You Have Any Pets?	**Dogs #_____ Cats #_____ Other Pets #_____** **Breed/Kind:_____**
Sexual History?	☐ **Heterosexual** ☐ **Homosexual** ☐ **LGBTQ+** ☐ **Not Sexually Active** ☐ **Monogamous** ☐ **Multiple Partners** ☐ **High Risk Behaviors**
Do You Take Care Of A Disabled Person?	☐ **YES** ☐ **NO**
Are You Pregnant?	☐ **YES** ☐ **NO**
Have You Recently Given Birth?	☐ **YES / How Long Ago? _____** ☐ **NO**
Are You Currently Breast Feeding?	☐ **YES** ☐ **NO**
Do You Drink Alcohol?	☐ **YES / What Kind? _____** ☐ **NO**
Are You Concerned With The Amount You Are Drinking?	☐ **YES** ☐ **NO**
Smoking/Nicotine Use?	☐ **YES / Check All That Apply:** ☐ **Cigarretes/Cigars** ☐ **Pipe** ☐ **Dip** ☐ **Snus** ☐ **Vape** ☐ **NO**
Do You Want To Quit Smoking/Nicotine?	☐ **YES** ☐ **NO**
Do You Currently Use Recreational Drugs?	☐ **YES / Please Explain:_____** ☐ **NO**
Are You Employed?	☐ **YES** ☐ **NO**
Work Activity Level?	☐ **Sedentary** ☐ **Standing** ☐ **Light Labor** ☐ **Heavy Labor**
Exposure To Hazards At Work?	☐ **YES** ☐ **NO**
Exposure To Hazards At Home?	☐ **YES** ☐ **NO**
Duration Of Current Profession?	**_____ Years _____ Months _____ Weeks _____ Days**
Satisfied With Work?	☐ **YES** ☐ **NO**
Stress Level At Work?	☐ **High** ☐ **Medium** ☐ **Low**

Please List Any Additional Social History Details If Any:

Review of Symptoms			
Constitutional Symptoms			
Normal Appearance	YES☐ NO☐	Disability	YES☐ NO ☐
Fever	YES☐ NO☐	Chills	YES☐ NO ☐
Malaise/Fatigue	YES☐ NO☐	Night Sweats	YES☐ NO ☐
Comments:			
Sleep Problems			
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 ☐	Nightmares	YES☐ NO ☐
Comments:			
Eye Problems			
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			
Hearing Loss	YES☐ NO☐	Ear Pain	YES☐ NO☐
Sensation Of The Room Spinning	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☐	Dry Mouth	YES☐ NO☐
Comments:			

Review of Symptoms			
Respiratory Problems			
Cough	YES ☐ NO ☐	Shortness of Breath	YES ☐ NO ☐
Chest Tightness	YES ☐ NO ☐	Hemoptysis	YES ☐ NO ☐
Asthma	YES ☐ NO ☐	Wheezing	YES ☐ NO ☐
Comments:			
Gastrointestinal Problems			
Nausea/Vomiting	YES ☐ NO ☐	Change in Bowel Movement	YES ☐ NO ☐
Diarrhea	YES ☐ NO ☐	Constipation	YES ☐ NO ☐
Abdominal Pain	YES ☐ NO ☐	Difficulty Swallowing	YES ☐ NO ☐
Blood in Stools	YES ☐ NO ☐	Hemorrhoids	YES ☐ NO ☐
Comments:			
Musculoskeletal Problems			
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	YES ☐ NO ☐	Muscle Weakness	YES ☐ NO ☐
Comments:			
Integumentary Problems			
Itching	YES ☐ NO ☐	Rashes	YES ☐ NO ☐
Change In Skin Color	YES ☐ NO ☐	Change In Hair/Nails	YES ☐ NO ☐
Varicose Veins	YES ☐ NO ☐	Skin Infections	YES ☐ NO ☐
Comments:			
Hematologic			
Anemia	YES ☐ NO ☐	Easy Bruising	YES ☐ NO ☐
Night Sweats	YES ☐ NO ☐	Slow Healing Wounds	YES ☐ NO ☐
Past Blood Transfusion(s)	YES ☐ NO ☐	Vein(s) Inflammation	YES ☐ NO ☐
Comments:			

Genitourinary			
Blood In Urine	YES ☐ NO ☐	Painful Urination	YES ☐ NO ☐
Excessive Urination At Night	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 Infection	YES ☐ NO ☐	History Of Bladder Or Kidney Infection	YES ☐ NO ☐
Comments:			

Female GU			
Last Menstrual Period	Date:_____	First Menstrual Cycle	Age:_____
Regular Cycle (Anywhere Between 21-35 Days)	YES ☐ NO ☐	Irregular Cycle (Less Than 21 Days or More Than 35 Days)	YES ☐ NO ☐
Number Of Live Births	_____	Number Of Abortions	_____
Number Of Miscarriages	_____	Number Of Stillbirths	_____
Have You Had A PAP Smear?	YES ☐ NO ☐	Date Of Last PAP Smear	Date:_____
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 ☐	Are You Currently Pregnant?	YES ☐ NO ☐
Comments:			

Male GU			
Lumps/Pain In Testicles	YES ☐ NO ☐	Erection Difficulty	YES ☐ NO ☐
Ejaculation Difficulty	YES ☐ NO ☐	Abnormal Discharge From Penis	YES ☐ NO ☐
Have You Had A Prostate Exam	YES ☐ NO ☐	Date Of Last Prostate Exam	YES ☐ NO ☐
Comments:			

Review of Symptoms			
Cardiovascular Problems			
Chest Pain	YES☐ NO☐	Murmur	YES☐ NO☐
Palpitation	YES☐ NO☐	Claudication	YES☐ NO☐
Dyspnea	YES☐ NO☐	Orthopnea	YES☐ NO☐
Edema	YES☐ NO☐	Previous EKG	YES☐ NO☐
Comments:			
Neurological Problems			
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☐	Memory Loss	YES☐ NO☐
Comments:			
Psychiatric Problems			
Difficulty Concentrating	YES☐ NO☐	Insomnia	YES☐ NO☐
Suicidal Thoughts Or Attempts	YES☐ NO☐	Irritability Or Mood Changes	YES☐ NO☐
Changes In Socializing	YES☐ NO☐	Anxiety/Nervousness	YES☐ NO☐
Forgetfulness	YES☐ NO☐	Restless Sleep	YES☐ NO☐
Previous Use Of Psychotropic Medication	YES☐ NO☐	Depression	YES☐ NO☐
Comments:			
Endocrine Problems			
Excessive Urination	YES☐ NO☐	Excessive Urination	YES☐ NO☐
Changes In Hat Or Glove Size	YES☐ NO☐	Heat Or Cold Intolerance	YES☐ NO☐
Gland Problems	YES☐ NO☐	Hormone Problems	YES☐ NO☐
Excessively Dry Skin	YES☐ NO☐	Apetite Changes	YES☐ NO☐
Comments:			
Basic Activities Of Daily Living			
Bladder Incontinence	YES☐ NO☐	Bowel Incontinence	YES☐ NO☐
Using The Bathroom	YES☐ NO☐	Eating	YES☐ NO☐
Getting Dressed	YES☐ NO☐	Shower/Bathe	YES☐ NO☐
Walking	☐Self ☐Assisted	☐Wheelchair User	☐Confined to Bed
Instrumental Activities Of Daily Living			
Preparing Meals	YES☐ NO☐	Shopping	YES☐ NO☐
Medication Management	YES☐ NO☐	Money Management	YES☐ NO☐
Phone/Electronics	YES☐ NO☐	Light Work/Tasks	YES☐ NO☐
Heavy Work/Tasks	YES☐ NO☐	Transportation	YES☐ NO☐

Pharmacy

What Is Your Preferred Pharmacy? _____

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

Medical Agreement

"I Acknowledge All The Information Above Is True And Correct To The Best Of My Knowledge."

Patient's 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 healthcare, 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 the Congressional enactment of HIPAA, the Health Insurance Portability and Accountability Act. Under HIPAA, all information in your medical record, along with associated billing and payment information, as well as other related demographic data that 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 informs 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 occur than others, while others 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 our medical practice may make 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 your care. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the practice may also share medical information about you, including your records, prescriptions, requests for 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 share your healthcare information about the treatment you received at the practice to obtain payment or reimbursement for the care. We may also inform your health plan and/or referring physician about a treatment you are scheduled to receive to obtain prior approval or to determine whether your plan will cover the treatment, facilitating payment to a referring physician or similar parties.

Health Care Operations: We may use and disclose medical information about you to run our practice more efficiently and ensure that all our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, determining which additional services to offer and where, identifying which services are not needed, and assessing the effectiveness of new treatments. 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 that from other medical practices to compare our performance and identify areas for improvement in the care and services we offer. We may remove information that identifies you from this set of medical information so that others may use it to study healthcare and healthcare 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 purposes, as well as to business associates, to help us comply with our legal requirements, to auditors to verify our records, and to billing companies to assist us in this process, among other uses. 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 you to sign a "Sign In" log at the Reception Desk 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 made by phone, in writing, email, or otherwise, and may involve leaving a message via email, on an answering machine or voicemail, or may be received or intercepted by others.

Emergency Situations: Additionally, 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 related to medications, treatment protocols, and similar topics. All research projects are subject to an approval process that 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 made to someone who is 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 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 illnesses.

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 the determination of your eligibility for services. These activities may be necessary for the government to monitor the healthcare 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 healthcare 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 in capturing 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 the effective date. In addition, each time you visit the practice for treatment or healthcare 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, please contact our Compliance Officer, who will guide you through the process of filing 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 that provide services to our Practice, who may have access to our patients' 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 a review of the denial.

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 that is not kept by the practice or that 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 specify a time period of no more than six (6) years ago. 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 healthcare 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; however, 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 specific manner or at a designated time. For example, you can request that we only contact you at work or by mail, or that we refrain from leaving voicemail messages, and so on.

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 may modify the privacy practices outlined in the notice.

ACKNOWLEDGMENT THAT NOTICE OF PRIVACY PRACTICES WAS RECEIVED

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

Patient's Signature: _____ Date: _____