Restorative HEALTH

ERECTILE HEALTH QUESTIONNAIRE

Patient Information:

Name:_____ Date:_____
Last First Middle

Date of Birth:_____ Age in Yrs:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Driver's License Number:_____

E-Mail Address:_____ May we contact you via E-Mail ( ) Yes ( ) No

In Case of an Emergency Contact:_____ Relationship:_____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow(er) ( ) Living with Partner ( ) Single

Spouses Name:_____ Phone:_____

Preferred Pharmacy:_____ Phone:_____

How did you hear about us? ( ) TV ( ) Radio ( ) Web ( ) Radio ( ) Web ( ) Pandora ( ) Social Media ( ) Referral

Who referred you?_____ Other:_____

Primary Care Physician Name:_____

Patient Questionnaire:

Approximate Duration of Problem in Years:_____ Onset of the problem was: Gradual Sudden (Circle One)

If sudden, was it related in onset to one of the following: (please circle) Surgery New Medication Life Event Penile Injury

Patient History

Present Sexual Function:

- Fill out the International Index of Erectile Function (IIEF) Questionnaire
- Fill out the Premature Ejaculation Diagnostic Tool (PEDT) Questionnaire
- Fill out the International Prostate Symptom Score (I-PSS) Questionnaire

Do you have an active sexual partner at this time? (Wife, Girlfriend, Other, None):_____

Can you achieve an orgasm?	Yes	No
Can you ejaculate normally?	Yes	No
Do you have premature ejaculation?	Yes	No
Do you think there is an emotional cause?	Yes	No
Do you experience any pain with erections?	Yes	No
Are your erections abnormally bent?	Yes	No

If so, which direction is it bent? (Up, Down, Left Right):_____

About how many degrees does it bend?_____

Any change in the bend over the past 6 months? Yes No

Previous Evaluation:

Have you had your testosterone level measured? Yes No
If so, what were the results? (Normal, Abnormal, Don't know): _____
Have you ever been seen by Urology? Yes No
If so, what was the diagnosis?_____
Undergone a penile blood flow study? Yes No
If so, what was the result? (Normal, Abnormal, Do not know):_____
Undergone testing of erections during sleep? Yes No
If so, what was the result? (Normal, Abnormal, Do not know) _____

Previous Treatment:

Have you ever had hormone replacement therapy with Testosterone? Yes No
Did it work well for you? Yes No
What type of therapy did you use (pellet, injection, cream/gel)? _____
When was your last treatment? _____
Have you ever had a Priapus Shot (P-Shot) Yes No
Did the P-Shot work to your satisfaction? Yes No
How many P-Shots have you had? _____
Have you ever had Penile Shock Wave Therapy? Yes No
Did the shock wave therapy work to your satisfaction? Yes No
Have you tried injection therapy (tri-mix, quad-mix etc)? Yes No
Did the injections produce a satisfactory erection? Yes No
Were you comfortable with the injections? Yes No
Have you tried Viagra, Levitra or Cialis? Yes No
Brand or Generic? _____
Did it work to your satisfaction? Yes No
Have you tried MUSE? Yes No
Did MUSE produce a satisfactory erection? Yes No
Do you like using MUSE? Yes No
Have you tried any other oral treatments (supplements)? Yes No
What have you tried? _____
_____
Have you tried the vacuum device? Yes No
Did it work well for you? Yes No
Do you like the vacuum device? Yes No
Have you tried any other treatments? Yes No
What was the treatment? _____

Risk Factors for Erectile Dysfunction:

Have you ever injured your penis? Yes No
Has your penis ever been forcibly bent while erect? Yes No
Have you had a straddle injury? Yes No
Do you ride a bicycle regularly? Yes No
Have you ever smoked cigarettes regularly? Yes No
If so, do you currently smoke? Yes No
Have you ever had problems with excessive alcohol drinking? Yes No
Have you injured your spinal cord? Yes No
Have you had your prostate removed for cancer? Yes No
Have you undergone radiation therapy for prostate cancer? Yes No
Have you had prostate surgery (TURP) for benign prostatic growth? Yes No
How many children do you have? (Number) _____
Have you ever had an undescended testicle? Yes No
Have you ever had a hernia repair? Yes No
Have you ever been diagnosed with a varicocele? Yes No
Have you ever had a vasectomy? Yes No
Have you had epididymitis? Yes No
Have you ever had a sexually transmitted disease (chlamydia, gonorrhea, trichomonas)? Yes No

Past Medical History:

Are you being treated for high blood pressure? Yes No
Are you being treated for elevated blood cholesterol level? Yes No
Have you been told that you have hardening of the arteries? Yes No
Do you have heart disease? Yes No
Have you ever had a stroke? Yes No
Are you or have you been treated for depression? Yes No
Are you being treated for diabetes? Yes No
If so, which treatment method are you using to control your sugar? Diet Pills Insulin No Trt
Do you have any lung problems? Yes No
Do you have any stomach problems? Yes No
Do you have any muscle or joint pain? Yes No
Ever had Mumps? Yes No
Ever had any thyroid problems? Yes No
Other Medical Illnesses?_____
_____
_____
_____
_____
_____

Past Surgeries:
_____
_____
_____
_____

Do you take aspirin regularly? Yes No

List any medications you are allergic to:
_____
_____
_____
_____
_____
_____

Current Medications / Supplements with Dosage (name, dose, how often you take) – example:

Lisinopril 20 mg one time per day

Family History:

Do you have a family history of:

High Blood Pressure	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
Prostate Cancer	Yes	No
Peyronie's Disease	Yes	No
Cancer	Yes	No
Sickle Cell	Yes	No
Birth Defects	Yes	No
Psychiatric Disease	Yes	No
Bleeding Disorders	Yes	No
Thyroid Disease	Yes	No

Diet and Exercise:

Type of die (Standard American Diet, More plant based with fruits, veggies, whole grains, legumes, meat sparingly, dairy sparinglyt:_____

Exercise:_____

Stress Level (on a scale of 1/10 – 10 being high stress and what is causing the stress):_____

Sleep (how many hours per night do you sleep, do you snore, hx of sleep apnea):_____

Reviewed By:_____Date:_____

Interview Notes: _____

Restorative HEALTH

MALE SYMPTOMS QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

What are your CURRENT Symptoms **(over the last 2 weeks)?**

0 means you have no symptoms of this type at all / 1 means you have very mild symptoms of this type
5 would be moderate symptoms of this type / 10 would mean you have severe symptoms of this type.

												Comments, if any
Sleep Disturbances/Changes	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Fatigue	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Depression	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Sad and/or Grumpy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Low Energy	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Decreased Enjoyment in Life	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Irritability	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Anxiety	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Low Sex Drive	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Erection Strength & Endurance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Hot Flashes	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Night Sweats	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Poor Focus	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Memory Lapse	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Loss of Muscle Tone	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
↓ Exercise Tolerance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Body Joint Pains	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Dry Skin	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

Answer the questions below that pertain to you

- Have you lost weight? YES NO
- Are you experiencing difficulty losing weight? YES NO
- Have you gained weight gradually without an obvious cause? YES NO
- Are you retaining fat in your abdomen (increased belly fat)? YES NO
- Have you been diagnosed with insulin resistance, diabetes, or metabolic syndrome? YES NO
- Do you produce less semen so your ejaculation quantity is reduced? YES NO
- Are you losing body hair, especially on the legs? YES NO
- Are you balding? YES NO
- Do you have less ability to cope with stress? YES NO
- Are you more emotional? YES NO
- Have you noticed a recent deterioration in your ability to play sports? YES NO
- Are you falling asleep after dinner? YES NO
- Has there been a recent deterioration in your work performance? YES NO

International Index of Erectile Function (IIEF) Questionnaire

PATIENT NAME:_____ DOB:_____TODAY'S DATE: _____

The first five questions refer to erectile function.

	No sexual activity	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
1. Over the last month, how often were you able to get an erection during sexual activity?	0	5	4	3	2	1
2. Over the last month, when you had erections with sexual stimulation, how often were your erections hard enough for penetration?	0	5	4	3	2	1
3. Over the last month, when you attempted intercourse, how often were you able to penetrate your partner?	0	5	4	3	2	1
4. Over the last month, during sexual intercourse, how often were you able to maintain your erection after you had penetrated your partner?	0	5	4	3	2	1
	No sexual activity	**Extremely difficult**	**Very difficult**	**Difficult**	**Slightly difficult**	**Not difficult**
5. Over the last month, during sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	0	1	2	3	4	5

The next three questions refer to satisfaction with intercourse.

	No attempts	1-2 times	3-4 times	5-6 times	7-10 times	11-20 times
6. Over the last month, how many times have you attempted sexual intercourse?	0	1	2	3	4	5
	No sexual activity	**Almost always or always**	**Most times (much more than half the time)**	**Sometimes (about half the time)**	**A few times (much less than half the time)**	**Almost never or never**
7. Over the last month, when you attempted sexual intercourse how often was it satisfactory for you?	0	5	4	3	2	1
	No intercourse	**Very highly enjoyable**	**Highly enjoyable**	**Fairly enjoyable**	**Not very enjoyable**	**No enjoyment**
8. Over the last month, how much have you enjoyed sexual intercourse?	0	5	4	3	2	1

CONTINUED

The next two questions refer to orgasmic function

	No sexual stimulation/ intercourse	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
9. Over the last month, when you had sexual stimulation or intercourse, how often did you ejaculate?	0	5	4	3	2	1
10. Over the last month, when you had sexual stimulation or intercourse, how often did you have the feeling of orgasm (with or without ejaculation)?	0	5	4	3	2	1

The next two questions ask about sexual desire. In this context, sexual desire is defined as a feeling that may include wanting to have a sexual experience (for example masturbation or sexual intercourse), thinking about having sex, or feeling frustrated due to lack of sex.

	Almost always or always	Most times (much more than half the time)	Sometimes (about half the time)	A few times (much less than half the time)	Almost never or never
11. Over the last month, how often have you felt sexual desire?	5	4	3	2	1
	Very high	**High**	**Moderate**	**Low**	**Very low or not at all**
12. Over the last month, how would you rate your level of sexual desire?	5	4	3	2	1

The next two questions refer to overall sexual satisfaction.

	Very satisfied	Moderately satisfied	About equally satisfied and dissatisfied	Moderately dissatisfied	Very dissatisfied
13. Over the last month, how satisfied have you been with your overall sex life?	5	4	3	2	1
14. Over the last month, how satisfied have you been with your sexual relationship with your partner?	5	4	3	2	1

The last question refers to erectile function.

	Very high	High	Moderate	Low	Very low
15. Over the last month, how do you rate your confidence that you can get and keep your erection?	5	4	3	2	1

ADD YOUR SCORES

All the questions break down into five specific areas, as follows. Add your scores in the appropriate column.

Area	Questions	Score Range	Maximum Score	Your Score
Erectile Function	1-5 & 15	0-5	30	
Orgasmic Function	9-10	0-5	10	
Sexual Desire	11-12	1-5	10	
Intercourse Satisfaction	6-8	0-5	15	
Overall Satisfaction	13-14	1-5	10	

SCORING

TOTAL

1-10: Severe Erectile Dysfunction 11-16: Moderate dysfunction
17-21: Mild to moderate dysfunction 22-25: Mild dysfunction 26-30: No dysfunction

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International Prostate Symptom Score (I-PSS)

PATIENT NAME:_____ DOB:_____TODAY'S DATE: _____

PATIENT INSTRUCTIONS

Each question has several possible responses. Circle the number of the response that best describes your own situation. Please be sure that you select one and only one response for each question.

In the past month:	Not at All	Less than 1 in 5 Times	Less than Half the Time	About Half the Time	More than Half the Time	Almost Always
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 Times**
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5

Add the numbers corresponding to questions 1-7. TOTAL:

SCORE **1-7** Mild **8-19** Moderate **20-35** Severe

Quality of Life Due to Urinary Symptoms	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

PREMATURE EJACULATION DIAGNOSTIC TOOL (PEDT) QUESTIONNAIRE

Definition: Ejaculation here refers to ejaculation (release of semen) after penetration (when your penis enters your partner).

1. How difficult is it for you to delay ejaculation?
   - ☐ 0 = Not difficult at all
   - ☐ 1 = Somewhat difficult
   - ☐ 2 = Moderately difficult
   - ☐ 3 = Very difficult
   - ☐ 4 = Extremely difficult

2. Do you ejaculate before you want to?
   - ☐ 0 = Almost never or never 0%
   - ☐ 1 = Less than half the time 25%
   - ☐ 2 = About half the time 50%
   - ☐ 3 = More than half the time 75%
   - ☐ 4 = Almost always or always 100%

3. Do you ejaculate with very little stimulation?
   - ☐ 0 = Almost never or never 0%
   - ☐ 1 = Less than half the time 25%
   - ☐ 2 = About half the time 50%
   - ☐ 3 = More than half the time 75%
   - ☐ 4 = Almost always or always 100%

4. Do you feel frustrated because of ejaculating before you want to?
   - ☐ 0 = Not at all
   - ☐ 1 = Slightly
   - ☐ 2 = Moderately
   - ☐ 3 = Very
   - ☐ 4 = Extremely

5. How concerned are you that your time to ejaculation leaves your partner sexually unfulfilled?
   - ☐ 0 = Not at all
   - ☐ 1 = Slightly
   - ☐ 2 = Moderately
   - ☐ 3 = Very
   - ☐ 4 = Extremely

Add totals noted above:_____

- A score of 11 or more is commonly found in men with PE; whilst this score is not, on its own, adequate to diagnose PE without a clinical assessment from of healthcare professional, it is highly suggestive of PE
- A score of 9 or 10 may be found in men with PE; it is a "borderline" score
- A score of 8 or less suggests that a man does not have PE

NOTICE OF PRIVACY PRACTICES

Effective January 2011

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully. This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of professional organizations to aid this practice in its compliance and certifications programs. We perform quality assessment and improvement activities, conduct, arrange for medical, legal, and audit reviews, including fraud and abuse detection. Business planning and development is ongoing. Customer service, resolution of internal grievances, sale or transfer of assets processes may apply. Persons participating in such processes will review billing and medical files to ensure we maintain our compliance with regulations and the law.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (births/death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. The law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or administrative decision-maker) or another appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation
We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting, (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Kansas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee. That fee is $25.00.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12- month

period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to the protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Persons for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Chris Lonsford
245 Peachtree Industrial Blvd #100
Sugar Hill, GA 30518
Phone: (816) 207-4119
Fax: (770) 831-0250
Email: chris@restorative-health.com

INFORMED CONSENT

I, _____, acknowledge that I have been presented with a copy of the RH Notice of Privacy Practices and am aware that all clinic personnel may have access to private information in order to serve patients.

I consent to the provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

We may call to remind you of your appointment or to notify you of test results. I agree, if I have an answering machine or voicemail, to allow the doctor or staff to identify themselves, as well as myself, to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine or voicemail.

I request that my protected health information be disclosed to the following persons or facility as listed below:

_____

_____

_____

_____

Patient Signature:_____ Date:_____