Stillness
Inflammation & Wellness Center

New Patient Intake Form

PERSONAL INFORMATION **Today's Date:** _____

First Name: _____ Middle Initial: _____ Last Name: _____

Physical Address:

_____

City: _____ State: _____ Postal Code: _____

Mailing Address: _____

City: _____ State: _____ Postal Code: _____

Phone Home: _____ Phone Cell: _____

Email: _____

Preferred Contact Method: ____ Email _____ Phone _____Text

Date of Birth (Day/Month/Year): _____/_____/_____ Height: _____ Weight: _____

How did you hear about our clinic? _____

EMERGENCY CONTACT

Emergency Contact: _____ Phone: _____

Relationship: _____

MEDICAL INFORMATION

Do you get regular screening test by a doctor? (pap smear, physical, Bloodwork) ☐ Yes ☐ No

Reason for Visit: _____

Present of Health Concerns and Symptoms:

_____

_____

_____

_____

Allergies: (medication, food, environmental):

_____

_____

_____

Medical Conditions:

_____
_____
_____
_____
_____

Current Prescriptions & Usages:

_____
_____
_____
_____
_____

Over the Counter Products (Tylenol, Antacids, ect.) & Usages:

_____
_____
_____

Supplements, Vitamins/Minerals, Herbal Remedies & Usages:

_____
_____
_____

Surgeries & Hospitalization (include Date & Reason)

_____
_____
_____

Recent Labs and Imaging (x-ray, MRI):

_____
_____

Dental Work (filings, root canal, dentures, ect):

_____
_____

When was your last dental cleaning?_____

Do you receive regular cleanings? ☐ No ☐ Yes, How often? _____

FAMILY HISTORY

Relationship	***Age or Decreased***	***Health Condition*** *(cancer, heart disease, diabetes)*
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

CHILDHOOD MEDICAL HISTORY

Which childhood illness have you had? Check all that apply.

☐ Rubella (German Measles) ☐ Mono ☐ Mumps ☐ Chicken Pox
☐ Whooping Cough ☐ Polio ☐ Scarlet Fever ☐Asthma
☐ Other: _____

Where you vaccinated as a child/adult? _____
Are you currently taking any vaccinations? ☐ COVID ☐ FLU ☐Tetanus ☐Other: _____

ABOUT ME

Occupation:_____

Do you enjoy work? ☐ Yes ☐ No, Explain why not: _____

Describe your relationship with your co-workers:

_____

Are you currently: ☐ Single ☐ Separated ☐ Married ☐ Widow ☐ Divorced

Describe your relationship with your partner:

_____

Describe your relationship with your family:

_____

What kind a appetite do you have on a normal basis? ☐ Strong ☐ Weak

How many meals a day? _____ How many snacks a day?_____

Food You Avoid

_____

Food You Crave

_____

Typical Daily Fluid Intake: Check all that apply and how many cups per day

☐ Coffee Cups: _____ ☐ Water Cups:_____ ☐ Tea Cups: _____

☐ Juice Cups:_____ ☐ Soda Cups:_____ ☐ Other Cups: _____

Typical Dietary Intake: Create a chart on the last three days of what you ate

Day	Breakfast	Lunch	Dinner	Snacks
Today				
Yesterday				
2 Days Ago				

How frequent are your Bowel Movements? _____

Check all that apply for a typical bowel movement

☐ Loose Stool ☐ Diarrhea ☐ Hard Stools ☐ Constipation

☐ Food in Stool ☐ Gas ☐ Mucous in Stool ☐ Abdominal Pain

Do you have your gallbladder?_ ☐ Yes ☐ No Do you have your appendix? ☐ Yes ☐ No

Have you been exposed to TB? ☐ Yes ☐ No Have you ever had syphilis? ☐ Yes ☐ No

How far can you walk comfortably? _____

Do you get out of breath climbing stairs ? _____

Do climbing stairs hurt knees? ☐ Yes ☐ No

LIFESTYLE HABITS

Interests and Hobbies:

_____

_____

How often do you exercise? _____ How long? _____

What kind of exercise? _____

Alcohol Intake: ___No ____Yes, Type:_____ How often:_____ How long?____

Tabacco Intake: ___No ____Yes, Type:_____How often:_____ How long?___

Recreational Drug: ___No ____Yes, Type:_____ How often:_____ How long?___

Energy Level: rate 1 (low) to 10 (high): _____ Upon Waking

_____ Morning (about 8:00-11:00)

_____ Midday (Lunch time about 11:00-2:00)

_____ Afternoon (about 2:00-5:00)

_____ Evening (about 5:00-8:00)

_____ Bedtime (about 8:00 +)

Daily Stress Level: Rate 1 (low) to 10 (high): _____

Explain Your Stress:

_____

_____

How many hours a sleep in a typical night? _____

Do you fall asleep easy? _____ Do you stay asleep?_____

Are you sexually active? _____

If yes, click all that apply: ____ Spouse (different gender)

____ Spouse (same gender)

____ Committed Partner (different gender)

____ Committed Partner (same gender)

____ Different Partners (different gender)

____ Different Partners (same gender)

Type of Contraceptive? _____ How long?_____

Do you take hormones, (if yes what kind, how often, and what for): _____

_____

_____

Any pain, sores, discharge or complaints about reproductive issues?

_____

_____

FEMALE ONLY SECTION

When was your last menstrual cycle? _____ How many days b/w cycles? _____

How many pregnancies? _____ Number of Children: _____

Check if Apply:

☐ Hysterectomy: ☐ Have ovaries ☐ No ovaries ☐Perimenopause ☐Menopause

On your menstrual cycle, what symptoms do you experience on a regular basis?

Now	Past		Now	Past	
☐	☐	Heavy Flow	☐	☐	Light Flow
☐	☐	Bleeding b/w periods	☐	☐	Discharge
☐	☐	Pain	☐	☐	Bloating
☐	☐	Headache	☐	☐	Breast tenderness
☐	☐	Mood changes	☐	☐	Cravings

If in Menopause/Perimenopause, what symptoms do you experience on a regular basis?

Now	Past		Now	Past	
☐	☐	Hot Flashes	☐	☐	Poor memory
☐	☐	Mood changes	☐	☐	Low libido
☐	☐	Painful intercourse	☐	☐	Vaginal dryness

What symptoms do you experience on a regular basis?

Now	Past		Now	Past	
☐	☐	Lumps in breast	☐	☐	Nipple discharge
☐	☐	Breast pain	☐	☐	Pelvic pain
☐	☐	Discharge	☐	☐	Vaginal itching or burning
☐	☐	Genital sores	☐	☐	Painful sex
☐	☐	Low libido	☐	☐	Mood Changes
☐	☐	Absence of Menstrual period	OTHER:		

MALE ONLY SECTION

Click all symptoms you are experiencing:

Now	Past		Now	Past	
☐	☐	Prostate problems	☐	☐	Painful erection
☐	☐	swelling/lumps/pain in testicular	☐	☐	Discharge
☐	☐	Infertility	☐	☐	Premature ejaculation
☐	☐	Difficulty ejaculation	☐	☐	Low libido
☐	☐	Hernia	☐	☐	Painful urination

Symptoms

Possible Toxin Exposure you may have been in contact with: (mercury fillings, occupational exposure, pesticides, fertilizers)

_____

_____

Place a check mark (√) on current symptoms past symptoms that you have or have recently experienced.
Note some repeat, mark all that repeat as well.

	Symptom	**Now**	**Past**	**Symptom**	**Now**	**Past**
Pituitary	Failing memory	☐	☐	Low Blood pressure	☐	☐
	Increased sexual desire	☐	☐	Splitting headaches	☐	☐
	High/low sugar tolerance	☐	☐	Abnormal thirst	☐	☐
	Ulcers, colitis	☐	☐	Decreased sexual desire	☐	☐
	Bloating	☐	☐	Chunky hips or waist	☐	☐
Thyroid	Difficulty losing weight	☐	☐	Constipation	☐	☐
	Tired upon Waking	☐	☐	Easily Fatigued	☐	☐
	Dry or scaly skin	☐	☐	Chilly/ Sensitive to cold	☐	☐
	Mental slowness	☐	☐	Decreased appetite	☐	☐
	Nervousness	☐	☐	Heart palpitations	☐	☐
	Irritable/ restless	☐	☐	Increased appetite	☐	☐
	Underweight	☐	☐	Flush/ get hot easily	☐	☐
	Insomnia	☐	☐			
Adrenals	Easily Stressed	☐	☐	Easily / chronically fatigue	☐	☐
	Dizziness	☐	☐	Headaches	☐	☐
	Hot flashes	☐	☐	Bronzing skin	☐	☐
	Craves Salt	☐	☐	Nails weak and ridged	☐	☐
	Tendency to get hives	☐	☐	Arthritis	☐	☐
	Poor circulation	☐	☐	Increased blood pressure	☐	☐
	Weak after getting cold	☐	☐	Facial hair for women	☐	☐
Nervous:	Upset from acid foods	☐	☐	Dry eyes, nose, mouth	☐	☐
Sympathetic	Nervousness	☐	☐	Wounds that Heal slowly	☐	☐
	Gag easily	☐	☐	Very quick mentally	☐	☐
	Cold extremities	☐	☐	Light sensitive	☐	☐
	Decreased urine output	☐	☐	Heart pounds when lying	☐	☐

	Reduced appetite	☐	☐	Frequent cold sweats	☐	☐
Para	Joint stiffness on rising	☐	☐	Muscle/leg/toe cramps	☐	☐
	Butterflies in stomach	☐	☐	Digestion rapid	☐	☐
	Indigestion after eating	☐	☐	Not sweating	☐	☐
	Sweat easy or profusely	☐	☐	Frequent vomiting	☐	☐
	Alternate b/w constipation and diarrhea	☐	☐	Pulse slow	☐	☐
	Breathing irregular	☐	☐	Poor circulation	☐	☐
	Eyelids swollen/puffy	☐	☐			
CNS	Loose of balance/ fainting	☐	☐	Dizziness regular	☐	☐
	Seizures	☐	☐	Blurred/double vision	☐	☐
	Tremor	☐	☐	Paralysis	☐	☐
	Numbness/ tingling	☐	☐	Temporarily loss of sensation	☐	☐
	Lack of strength	☐	☐	Continual headache	☐	☐
Mus/skel.	One arm or leg shorter	☐	☐	Joint pain and stiffness		☐
	Joint swelling	☐	☐	Backaches	☐	☐
	Burning on soles of foot	☐	☐	Muscle cramps	☐	☐
	Unusual redness on palms	☐	☐	Coughing, sneezing or straining at stools intensifies back pain	☐	☐
Mental	Anxiety	☐	☐	Restlessness	☐	☐
	Excessive worry	☐	☐	Depression	☐	☐
	Despair	☐	☐	Suicidal thoughts	☐	☐
	Suicide attempts	☐	☐	Loneliness	☐	☐
	Mood swings	☐	☐	Prefer to be with people	☐	☐
	Prefer to be alone	☐	☐	Afraid when alone	☐	☐
	Confident and secure	☐	☐	Memory difficulties	☐	☐
	Mental confusion	☐	☐	Problems concentrating	☐	☐
	Make a lot of mistakes	☐	☐	Shy and timid	☐	☐
	Self-critical	☐	☐	Overly critical of others	☐	☐
	Lack of self confidence	☐	☐	Jealous and suspicious	☐	☐
	Organized and neat	☐	☐	Affectionate	☐	☐
	Powerful and assertive	☐	☐		☐	☐

	Symptom	**Now**	**Past**	**Symptom**	**Now**	**Past**
General	Fatigue	☐	☐	Weight Gain	☐	☐
	Change in Appetite	☐	☐	Weight Loss	☐	☐
	Change in Thirst	☐	☐	Poor Sleeping	☐	☐
	Chilly/ sensitive to cold	☐	☐	Flush/ Get hot easy	☐	☐
	Mental slowness	☐	☐	Headaches	☐	☐
	Cravings	☐	☐	Increased Sleeping	☐	☐
			OTHER:			
Skin and Hair	Dryness	☐	☐	Eczema	☐	☐
	Warts	☐	☐	Skin Pitting	☐	☐
	Rash	☐	☐	Psoriasis	☐	☐

	Hives/allergic reaction	☐	☐	Itching	☐	☐
	Hair Loss	☐	☐	Recent moles/growths	☐	☐
	Dandruff	☐	☐	Change in color	☐	☐
	OTHER:					
ENT	Eye pain	☐	☐	Sinus congestion	☐	☐
	Change in vision	☐	☐	Sinus infection	☐	☐
	Cataracts	☐	☐	Loss of smell	☐	☐
	Ear pain	☐	☐	Loss of Taste	☐	☐
	Ringing in ears	☐	☐	Nosebleeds	☐	☐
	Dizziness	☐	☐	Sore throat	☐	☐
	Facial Pain	☐	☐	Swollen Lymph Nodes	☐	☐
	Mouth Sores	☐	☐	Swollen Thyroid	☐	☐
	Headaches	☐	☐	Jaw Pain	☐	☐
	OTHER:					
Cardio	Chest pain	☐	☐	Palpitations	☐	☐
	High Blood Pressure	☐	☐	Irregular Heart Beat	☐	☐
	Low Blood Pressure	☐	☐	Fainting	☐	☐
	History Heart Attack	☐	☐	Varicose Veins	☐	☐
	Anemia	☐	☐	Cold hands/feet	☐	☐
	Shortness of Breath	☐	☐	Easy Bruising	☐	☐
	Pacemaker	☐	☐	Deep Leg Pain	☐	☐
	OTHER:					
Respiratory	Difficult Breathing	☐	☐	Emphysema	☐	☐
	Chronic Cough	☐	☐	Wheezing	☐	☐
	Bronchitis	☐	☐	Chronic Phlegm	☐	☐
	Asthma	☐	☐	Blood in Phlegm	☐	☐
	OTHER:					
Muscle, Joint, Bone	Neck pain	☐	☐	Joint immobility	☐	☐
	Back pain	☐	☐	Joint replacement	☐	☐
	Muscle pain	☐	☐	Ligament surgery	☐	☐
	Muscle weakness	☐	☐	Whiplash injury	☐	☐
	Arthritis	☐	☐	Bone fracture	☐	☐
	Bursitis	☐	☐	Osteopenia/Osteoporosis	☐	☐
	OTHER:					
Gastro.	Nausea/vomiting	☐	☐	Constipation	☐	☐
	Heartburn/reflex	☐	☐	Diarrhea	☐	☐
	Constant hunger	☐	☐	Rectal pain/burning	☐	☐
	Excessive Belching	☐	☐	Vomiting Blood	☐	☐
	Ulcer	☐	☐	Hemorrhoids	☐	☐
	Gall stones	☐	☐	Gas/bloating	☐	☐
	OTHER:					
Neuro	Anxiety	☐	☐	Seizures	☐	☐
	Depression	☐	☐	Concussion	☐	☐
	Irritability	☐	☐	Lack of coordination	☐	☐
	Emotional swings	☐	☐	Poor memory	☐	☐
	Extremity numbness	☐	☐	Extremity tingling	☐	☐

			OTHER:				
Infections	Strep throat		☐	☐	STD/STI	☐	☐
	Mononucleosis		☐	☐	HIV/AIDS	☐	☐
	Tuberculosis		☐	☐	Chronic flu/colds	☐	☐
	Poor wound healing		☐	☐	Chronic sinus infection	☐	☐
	Frequent Antibiotic Use		☐	☐			
			OTHER:				
Urinary	Frequent urination		☐	☐	Pain with urination	☐	☐
	Frequent infection		☐	☐	Wakes in the night to pee	☐	☐
	Urgency to urinate		☐	☐	UTI	☐	☐
	Incontinence		☐	☐	Blood in Urine	☐	☐
	Urine Leakage		☐	☐	Kidney Stones	☐	☐
			OTHER:				

Describe yourself and personality:

_____

_____

_____

Is this someone about yourself that you would like me to know:

_____

_____

_____

Why did you choose to come to this clinic? _____

_____

What do you know about our approach? _____

_____

Do you feel like you can't get answers from doctors or labs? ☐ Yes ☐ No How long had issues? _____

I attest that all the information provided are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

DECLARATION AND CONSENT

Thank you for choosing Stillness Inflammation & Wellness Center as your holistic health practitioner. We minimize the risk of harmful side effects by supporting the body's own ability to heal and by using the least invasive procedures whenever possible. However, even the gentlest therapies have potential for complications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. We are not a medical facility. It is very important that you inform your practitioner immediately of:

- aggravation of pre-existing symptoms
- allergic reactions to supplements or herbs

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at my medical record at any time and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my practitioner will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I will rely on the practitioner to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. Dr. Hobbs is not a medical doctor, MD, but PhD in both Holistic and Functional Medicine.

I intend this consent form to cover the entire course of educational purposes for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

l. Any service or advice provided to me as a client is not mutually exclusive from any service or advice that I may now be receiving from another licensed health care provider, or may receive in the future;

ll. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice;

lll. No employee, student or anyone else under the office's direction or control is suggesting or advising me to refrain from seeking or following the directions of any licensed health care provider;

lV. The services and therapies rendered or recommended by this office may be different than those usually offered by a medical doctor or any licensed health care provider.

V. I acknowledge that this is a holistic office and does not have a medical license, but Dr. Hobbs has a PhD, which mean this clinic does not treat, diagnose, prevent, or cure any disease or condition.

I DECLARE that I have received a full and complete explanation of the treatment of services that I may receive and hereby authorize and consent to treatment.

Full Name_____Date :_____

Signature of Client_____

Liability Disclaimer/Disclosures

The statements of supplements have not been evaluated by the Food and Drug Administration. Stillness Inflammation & Wellness Center, LLC products and services are not intended to diagnose, treat, cure or prevent any disease, but are for educational purposed only. If you are pregnant, nursing, taking medication, or have a medical condition, consult your physician before using suggested products or services. Stillness does make a profit on supplements, herbs, and other items sold at Stillness Inflammation & Wellness Center, LLC.

Disclaimer: The entire contents of the protocol plans are based upon the opinions of Stillness professionals, unless otherwise noted. Individual articles are based upon the opinions of the respective author, who retains copyright as marked. The information on this plan or advice given during an appointment are not intended to replace a one-on-one relationship with a qualified health care professional and is not intended as medical advice. It is intended as a sharing of knowledge and information from the research and experience of Stillness professionals. Stillness professionals encourage you to make your own healthcare decisions based on your research and in partnership with a qualified healthcare professional.
By reading this document, you assume all risk associated with using the advice given, with a full understand that you, solely, are responsible for anything that may occur as a result of putting this information into action in any way, and regardless of your interpretation of the advice. You further agree that Stillness, Dr. Hobbs, or affiliates can not be held responsible as a result of the information presented. It is your responsibly to conduct due diligence.

Full Name_____Date :_____

Signature of Client_____

Consent to Receive Calls, Text Messages, Emails and Telehealth

By providing the signature, I understand and agree that:

1. Stillness Inflammation & Wellness Center, and/or its business associates may contact me via phone call, text message, email, and/or telehealth through the use of electronic information and telecommunication technologies (such as audio or videoconferencing) regarding my information;

2. The calls, text messages, and/or email may be generated by Stillness or its business associates by automated dialing and may contain an artificial or prerecorded voice;

3. The texts and/or emails sent to me by Stillness will not be encrypted. This information can be read by unauthorized persons. It is my duty to keep my mobile phone safe.

I understand that Stillness inflammation & Wellness Center is not liable for the release of this information once I agree to this consent by signing below; and

I understand and acknowledge that I have received this notice.

Full Name_____Date :_____

Signature of Client_____

Client Financial Agreement

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Thank you for choosing Stillness Inflammation & Wellness Center as your holistic health practitioner. We are committed to the success of your education & system reduction plan. Payment for services provided is a part of the practitioner-client relationship with Stillness. Per the financial policy of the practice, clients and guarantors are responsible for making the necessary payments toward the services they receive.

Please initial beside each agreement:

_____ All payments are DUE before the service appointment either by advanced payment or in person at your appointment time.

_____ I understand that Stillness Inflammation & Wellness Center does NOT take insurance.

_____ All payments are by credit card or check only. No cash is accepted for services.

_____ I AGREE to pay my full account at the time of each visit, including fees for services, cost of supplements and remedies, as well as other applicable fees. I understand that there is a fee for completing letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer. Notice of 48 hours required for appointment cancellation, otherwise a $35 administrative fee will be charged.

By signing this agreement, I agree to pay for services provided by Stillness Inflammation & Wellness Center, LLC.

This payment agreement shall be considered binding after the responsible party has signed and dated the agreement and payment authorization overleaf.

I agree to the terms above:

Full Name_____Date :_____

Signature of Client_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. WE ARE NOT A MEDICAL FACILITY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this holistic practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any provider. This too can be done without your written authorization.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child 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.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Notes. I do keep "notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- For my use in creating a plan for you.
- For my use in training purposes.
- For my use in defending myself in legal proceedings instituted by you.
- For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- Required by law and the use or disclosure is limited to the requirements of such law.
- Required by law for certain health oversight activities pertaining to the originator of the notes.
- Required by a coroner who is performing duties authorized by law.
- Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a Naturopathic and Holistic Clinic, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a Naturopathic and Holistic Clinic, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.
11. We may disclose some of your health information for research purposes and publications of research without identifying you personally by name or otherwise.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone), or to send mail to a different address, and I will agree to all reasonable requests.
3. The Right to See and Get Copies of Your PHI. Other than "notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so.
4. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
5. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
6. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Full Name_____Date :_____

Signature: _____

CLIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our clients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the client's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Stillness Inflammation & Wellness Center, LLC to release my records

and any information requested to the following individuals.

1. _____ Relation to Client: _____

2. _____ Relation to Client :_____

3. _____ Relation to Client:_____

4. _____ Relation to Client:_____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding protocols, services, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

Full Name_____Date :_____

Signature_____