



WELCOME!

Thank you for trusting Integrative Medical Specialists with your health care needs. We take our commitment to you and your family very seriously. We look forward to establishing a partnership that will enhance your health and well being; now, and well into the future.

We value your time, and realize that office visits may be an interruption in an otherwise very busy schedule. For this reason, we've taken steps to assure that your time in our clinic is as focused and efficient as it can be.

Enclosed you will find new patient information forms. Before your scheduled appointment, please read and complete the attached forms. These forms are our first introduction to you, as a patient. Your detailed and thoughtful responses will help us to utilize our time in the clinic more effectively. **Please bring these completed and signed forms to your first office visit.**

Your first visit will be a thorough assessment of your health and may last up to 1 hour or more. Our fees vary based on the time and complexity of your case. This office is a cash office and payment is expected at the time of your visit. For your convenience we accept cash, check, debit cards, Visa, MasterCard, and Discover.

If you are unable to keep your scheduled appointment time, please let us know as soon as possible so that we may allow another patient to have your appointment time. We will be glad to reschedule your visit. Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge **\$25.00 for missed appointments** without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

Please remember to bring in copies of any recent lab work or medical records as well as the supplements or medications you are currently taking.

We look forward to seeing you in our clinic. Our goal is to become a trusted partner to you and your family in your health care needs.

Sincerely,

Integrative Medical Specialists



CANCELLATION/RESCHEDULE POLICY

Integrative Medical Specialists has a 24-hour cancellation/reschedule policy. If you DO NOT call within 24 hours prior to your scheduled appointment, you will be charged a \$25.00 fee for the appointment.

By signing below, I have read and understood this policy.

Name of Patient/Guardian _____

Date _____

Sign

Name of Patient/Guardian _____

Relationship _____

Print



INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the doctors of Integrative Medical Specialists to perform the following procedures to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: e.g. Laboratory bloodwork, radiology, diagnostic imaging, thermographic imaging, allergy testing, environmental testing, hormone testing, and other specialty labs.

Physical Examination: Screening Physical Exams may include any of the following: Skin & Dermatology; Head, Ear, Eyes, Nose & Sinuses & Throat; Face & Neck; Lungs & Pulmonary; Chest & Cardiovascular; Abdominal; Hands, Arms & Lower Limbs; Reflexes; Motor Skills; Back and Spine; Cranial Nerves; Male Genitalia, Prostate & Rectal Exams; Female Genitalia, Gynecological & Breast Exams; Mini-Mental Status Exams; Nutritional Exams.

Minor Office Procedures: e.g. Wound dressing, ear cleansing, and wart treatment.

Medicinal use of Nutrition: e.g. Therapeutic nutrition, and nutritional supplements.

Physical Medicine: e.g. Therapeutic ultrasound and electrical muscle stimulation, manipulative therapy, muscle stretching/massage, constitutional hydrotherapy.

Botanical Medicine: Botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.

Homeopathic Medicine: The use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing responses.

Immunization: e.g. Homeopathic immunizations.

Detoxification: e.g. Heavy metal and environmental detoxification.

Chinese Medicine: e.g. Acupuncture, cupping, electrical stimulation, TDP lamp, Chinese herbal medicine.

Lifestyle Counseling and Hygiene: e.g. Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risk: Allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes.

Potential Benefits: Restoration of health and body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease of its progression.

Notice to Women: All female patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present a risk to the pregnancy and fetus.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Integrative Medical Specialists or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand Integrative Medical Specialists will keep a record of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or my representative in writing, or unless it is required by law. I understand that I may look at my medical record and can request a copy of it by paying the appropriate fee. I understand that my medical record will not be kept more than ten years after the last day of my last treatment. I understand that any questions concerning this form can be asked of the doctor.

Name of Patient/Guardian _____ Date _____

Sign

Name of Patient/Guardian _____ Relationship _____

Print



**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE
OPERATIONS FOR PATIENTS OF INTEGRATIVE MEDICAL SPECIALISTS**

I consent to the use or disclosure of my protected health information by Integrative Medical Specialists for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for Integrative Medical Specialists. I understand that diagnosis or treatment of me by my doctor(s) at Integrative Medical Specialists may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Integrative Medical Specialists is not required to agree to the restrictions that I may request. However, if Integrative Medical Specialists agrees to the restrictions that I request, the restriction is binding on Integrative Medical Specialists and my doctor(s) at Integrative Medical Specialists.

I have the right to revoke this consent, in writing, at any time, except to the extent that my doctor(s) at Integrative Medical Specialists has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Integrative Medical Specialists Notice of Privacy Practices prior to signing this document. Integrative Medical Specialists Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Medical Specialists. This Notice of Privacy Practices also describes my rights and Integrative Medical Specialists duties with respect of my protected health information.

Integrative Medical Specialists reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised copy to be sent in the mail or asking for one at the time of my next appointment.



NOTICE OF PRIVACY PRACTICES:
ACKNOWLEDGEMENT OF RECEIPT FORM

Patient's Acknowledgement of Receipt

Integrative Medical Specialists ***Notice of Privacy Practices*** provides a thorough explanation of how we may use and disclose your protected health information, as well as your rights as a patient.

I, _____ (*print your name*), have received a copy of Integrative Medical Specialists Notice of Privacy Practices.

I choose to designate the individuals listed below as my primary contacts. Integrative Medical Specialists personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Patient's Name _____	Patient DOB _____
Contact Name _____	Contact Name _____
Relationship _____	Relationship _____
Phone _____	Phone _____

Signature _____ Date _____
(Patient, Parent, Authorized Representative)

Inability to Obtain Acknowledgement

To be completed by Integrative Medical Specialists Representative:

It was not possible to obtain the individual's acknowledgement, due to:

- Emergency Situation
- Patient physically unable to sign
- Patient Refused
- Patient left office prior to obtaining signature
- Other (explain) _____

Name of Patient _____
Comments _____

Signature of Integrative Medical Specialists Representative _____ Date _____



NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: December 8, 2004

Privacy Contact: 913-825-6111

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.

We at Integrative Medical Specialists understand that your medical/health information is personal and private. In order to provide you with quality care and to ensure compliance with certain legal requirements, we create a record of the care and services you receive in our office(s). We respect the privacy and confidentiality of medical/health information about you and that can be identified with you. This is called "protected health information". Your protected health information is contained in the medical and billing records maintained by our practice. It includes demographic information and information that relates to your present, past or future physical or mental health and related health care services.

This Notice of Privacy Practices ("Notice") describes the ways in which we may use and disclose your protected health information. It also describes your rights and our legal obligations with respect to your protected health information. This Notice applies to uses and disclosures we may make of all your protected health information, whether created by us in our practice or received by us from another health care provider.

Federal and State Laws require us to: ensure the privacy of your protected health information, which we have either created in our practice or received from another health care provider, whether it is about your past, present, or future health care condition; maintain the privacy of your protected health information regarding payment for your health care; explain the manner in which we may use and disclose your protected health information; abide by the terms of this Notice, as currently in effect; and obtain your written authorization to use or disclose your protected health information for reasons other than those listed below and permitted by law.

You may request a copy of this Notice at any time by contacting our office in writing or by phone. We reserve the right to amend this Notice at any time in the future, and make the new provisions effective for all protected health information we maintain, regardless of when it was created or received. If the Notice is amended, we will post the revised Notice, with the new effective date, in our office(s) and make copies of the revised Notice available to you upon request.

INCIDENTAL DISCLOSURES

In the process of using or disclosing your protected health information for an authorized use, we may make incidental disclosures. We will take reasonable steps to limit incidental disclosures.

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE YOU WITH TREATMENT, TO OBTAIN PAYMENT FOR SERVICES RENDERED TO YOU, AND FOR HEALTH CARE OPERATIONS.

For treatment: We may use and disclose your protected health information to provide you with medical treatment and services, and to coordinate or manage your health care and related services. We may disclose your protected health information either within our practice or an outside health care provider. We may also disclose your protected health information to providers or facilities who may be involved in your care after you leave our facility or our care.

For Payment: We may use and disclose your protected health information to an insurance company or managed care company or any other third party payer to bill and receive payment for treatment and services. We may also provide protected health information to collection departments, consumer reporting agencies or any other health care provider who requests information necessary for them to collect payment.

For Health Care Operations: We may use and disclose your protected health information for internal operations as necessary for us to operate our medical practice such as:

- General administrative activities and quality assurance programs.
- To train and educate doctors, nurses, students, volunteers or other medical staff;
- To plan for services, such as when we assess certain services that we may want to offer in the future;
- To our lawyers, consultants, accountants, and other business associates;
- In order to compare your information with that of several other patients to determine if we should offer new services or if new treatments were effective;
- To identify groups of patients who have similar health problems to give them information about treatment alternatives, programs, or new procedures;
- To organizations that assess the quality of care we provide to our patients (such as government agencies or accrediting bodies)
- To organizations that evaluate, certify or license health care providers, staff or facilities in a particular specialty;
- For procedures involving health care fraud and abuse detection and compliance

The following are situations in which we may use or disclose your protected health information without your written authorization or an opportunity for you to agree or object.

We may use or disclose your protected health information:

- When required to do so by federal, state or local law or other judicial or administrative proceedings.
- As necessary in emergency treatment situations.
- For public health activities such as reports about communicable disease, injuries or disability, births and deaths, child abuse and/or neglect, victims of abuse or neglect, and regarding the recall of products.
- *Unless you object*, we will also call your name to notify you that the practitioner is ready to see you or that we need to discuss something with you.
- *Unless you object*, we may disclose protected health information about you to a family member, relative, close personal friend or any other person you identify, including clergy, who is involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in payment for your care.
- For a health oversight agency for activities, such as audits, investigations, inspections, licensure actions or other legal proceedings.
- In response to a court or an administrative order.
- For certain law enforcement purposes, including, but not limited to reporting certain types of wounds and/or other physical injuries (i.e. gunshot wounds); reports required by law; identifying or locating a suspect or missing person, material witness or fugitive; answering requests for information concerning crimes, about the victim of crimes; reporting criminal conduct that took place on our premises; and in emergency situations to report a crime, the location of the crime or victim or the identity, description and/or location of a person involved in the crime.
- To a coroner, medical examiner for the purposes of identifying you or funeral director if necessary to allow them to carry out their duties.
- If you are an organ donor, to an organization involved in the donation of organs and tissue to enable them to carry out their lawful duties.

- For research purposes, provided that the privacy and safety aspects of the research have been reviewed and approved by an institutional review board or a privacy board.
- If we believe it is necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- If you are a member of the armed forces, we may use and disclose your protected health information as required by military command authorities.
- We may disclose protected health information to authorized federal officials conducting national security, counterintelligence, and intelligence activities authorized by law.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official to enable the correctional institution or law enforcement official to provide you with necessary health care services; to protect your own health and safety; to protect the health and safety of others; and/or for the safety and security of the correctional institution.
- To comply with laws and regulations relating to workers' compensation or similar programs established by law that provides benefits for work-related injuries and/or illnesses.
- We may use limited protected health information such as your name, address and phone number and the dates you received treatment or services, to contact you in an effort to raise money for a program developed by our practice. We may also disclose contact information for fundraising purposes to a foundation related to our organization. If you do not want to be contacted this way, you should notify us in writing by contacting Integrative Medical Specialists LLC at the telephone number listed on the first page of this Notice.
- To remind you about appointments in our organization; and appointments that we have scheduled for you with other health care organizations.
- To inform you about treatment alternatives and health-related benefits and services that may be of interest to you. This may include telling you about treatments; services; products; other health care providers; special programs; nutritional services.

Your authorization is required for all other uses and disclosures of your protected health information.

Except for those circumstances listed above, we will use and disclose your protected health information only with your written authorization. You may revoke your authorization, in writing, at any time. If you revoke an authorization, we will no longer use or disclose your protected health information for the purposes covered by that authorization, except where we have already relied on the authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION.

You have the following rights regarding your protected health information that we maintain:

1. **The Right to Access Your Protected Health Information:** Except under limited circumstances, and upon written request, you have the right to inspect and obtain a copy of your protected health information. Your protected health information is contained in our medical and billing records or any other record used by us to make decisions about your care. We may charge you for the record copy. We may deny your request to inspect or receive copies of your Protected Health Information (PHI) in the following limited circumstances:
 - The information was compiled exclusively in connection with a criminal, civil or administrative proceeding;
 - The disclosure to the patient is prohibited by the Clinical Laboratory Improvement Act (42 U.S.C. §263a);
 - You are a correctional institution inmate and the correctional administrators have provided reasons for denying access;
 - The information is for a research study not yet complete;
 - The Privacy Act (5 U.S.C. §552a) prohibits access;
 - The information was obtained by a person other than a health care provider upon our promise to keep the information confidential, and access would reveal the informant's identity;

- We determine access is likely to endanger the life or safety of the patient or others;
 - The information contains information about another person and we determine that access is likely to cause substantial harm to that person;
 - The request for access is made by the patient's personal representative and we believe access is likely to cause substantial harm to the patient or others
2. **The Right to Request Restrictions:** You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on the protected health information that we disclose about you to a family member, friend or other person involved in your care or the payment of your care. **If you wish to request such a restriction, you must submit your written request to us.** You must tell us what information you want restricted, to whom you want the information restricted, and whether you want to limit our use, disclosure or both. *We are not required to agree to such a restriction.* If we do agree to the restriction, we will honor that restriction except as needed to provide you with emergency treatment.
3. **The Right to Request Confidential Communications:** You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. **You should submit your written request for confidential communications to us.** You must tell us how and where you want to be contacted. We will accommodate your reasonable requests, *but may deny the request if you are unable to provide us with appropriate methods of contacting you.*
4. **The Right to Request an Amendment:**
You have the right to request that we amend medical or billing records, or other protected health information maintained by us, for as long as the information is kept by us. **Your request must be made in writing and must explain the reasons for the requested amendment.**

We may deny your request for amendment if the information:

- was not created by us (unless you prove the creator of the information is no longer available to amend the record);
- is not part of the records maintained by us;
- in our opinion, is not accurate and complete;
- is information to which you do not have a right of access.

We must respond to your request within 60 days of receiving the request. If we agree to the amendment, we will notify you and amend the relevant portions of your medical record. We will also make a reasonable effort to inform business associates and other individuals known to us, or identified by you, as having the protected health information being amended.

If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial and explain to you that you have the right to submit a written statement disagreeing with the denial. Your statement of disagreement will be attached to your medical record. If you should submit a statement of disagreement, we have the right to insert a rebuttal statement into the medical record. We will provide you with a copy of the rebuttal statement. If you do not wish to submit a statement of disagreement, you may request that a copy of the amendment request and a copy of our denial be included with all future disclosures.

Should we deny your request for an amendment, you have the right to pursue a complaint process by contacting Integrative Medical Specialists LLC, or you may contact the Secretary of Health and Human Services to lodge your complaint.

If you wish to request an amendment, you should submit the request to us in writing.

5. **The Right to an Accounting of Disclosures:** You have the right to request an accounting of certain disclosures of your protected health information made after December 8, 2004. You may request an accounting of disclosures made up to six (6) years before the date of your request, beginning with records created on or after December 8, 2004. An accounting is a listing of disclosures made by us or by others on our behalf, but does not include:

- disclosures made for treatment, payment and health care operations;
- disclosures made directly to you, that you authorized, or those which are made to individuals involved in your care;
- disclosure made to correctional institutions or law enforcement official about an inmate in custody;
- disclosure made for national security or intelligence purposes;
- disclosure of a limited data set; or
- an incidental disclosure.

You must submit your request for an accounting of disclosures to us in writing. You must state the time period for which you would like the accounting. We must respond to you 60 days after receipt of your request. The accounting will include the disclosure date, the name, address (if known) of the person or entity that received the information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure. If you request a listing of disclosures more than once within a 12-month period, we will charge you a reasonable fee for the accounting. The first accounting, within a 12-month period, is provided to you at no charge.

SPECIAL RULES REGARDING THE DISCLOSURE OF MENTAL HEALTH CONDITIONS, SUBSTANCE ABUSE, AND HIV-RELATED INFORMATION.

1. **Mental Health Information:** If needed for your diagnosis or treatment in a mental health program, mental health information may be disclosed as needed between your treatment team members, and very limited information may be disclosed for payment purposes. Otherwise mental health information may not be disclosed without your authorization, except as specifically permitted by state or federal law. A special authorization is required for the disclosure of psychotherapy notes, and special rules may apply which limit the information which is disclosed.
2. **HIV-related Information:** HIV-related information will not be disclosed, except under limited circumstances set forth under state or federal law, without your specific written authorization.
3. **Substance Abuse Treatment:** If you are treated in a substance abuse program, information which could identify you as alcohol or drug-dependant will not be disclosed without your specific authorization except for purposes of treatment or payment or when specifically required or allowed under state or federal law.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the federal government. You will not be retaliated against for filing a complaint.

