HIPAA - SUMMARY OF PRIVACY NOTICE

Officer Name: Odum, Laura
Office Website: www.wellnesslifecenter.org
Office Phone Number: (229) 397-5433
Office Address: 1180 5th st. SE, Cairo, GA, 39828

1. OUR LEGAL DUTY

Our practice is dedicated to maintaining the privacy of current and former patients' health and financial information as required by our internal policies and applicable law. We are also required by federal law to give you this notice explaining your rights, our legal duties and privacy practices. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI(Personal Health Information) that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information contained in this Notice.

2. USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose PHI about you for treatment, payment, and healthcare operations. For example: Treatment: We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. Payment: We may use and disclose your PHI to obtain payment for services we provide to you. Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your Authorization: In addition to our use of your PHI for treatment, payment or healthcare operations, you may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this Notice. To Your Family and Friends: We must disclose your PHI to you, as described in the Patient Rights section (Block 3) of this Notice. We may disclose your PHI to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Persons Involved In Care: We may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, we will provide you with an opportunity to object to such uses or disclosures.

In the event of your incapacity or emergency circumstances, we will disclose PHI based on a determination using our professional judgment disclosing only PHI that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI. Marketing Health-Related Services: We will not use your PHI for marketing communications without your written authorization. Required by Law: We may use or disclose your PHI when we are required to do so by law. Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to the military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected PHI of inmate or patient under certain circumstances. Appointment reminders: We may use or disclose your PHI to provide you with appointment reminders (such as voice-mails, e-mails, postcards, or letters).

3. PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected PHI, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request. Requests for access to your protected PHI must be made in writing. Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. You must submit your request in writing to the contact information provided at the top of this notice. Your first request within a 12-month period is free of charge, but our practice may charge you for additional request made within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of

your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the contact information provided at the top of this notice. Your request, in a clear and concise manner should describe; the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both or to whom you want the limits to apply.

Alternative Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are still entitled to receive this Notice in written form.

4. QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the top of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

X

04-03-2023 05:38:PM

Wellness Life Center

Form Name: New Patient Form

New Patient Information

Today's Date

Patient Name

Patient Date of Birth

SSN

Gender

○ Female ○ Male

Marital Status

○ Single ○ Married ○ Divorced ○ Widow

Do you have children?

○ Yes ○ No

Children's Name + Ages.

Do you work?

○ Yes ○ No

If yes, where?

If no, are you disabled?

○ Yes ○ No

Explain Disability

Special Considerations

Religion

Are there any religious practices that would keep you from receiving certain medical care?

○ Yes ○ No

If yes, please explain.

Previous Primary Care Office

Last Primary Care Physician

Name of Practice

Mailing Address

Office Phone

Office Fax

Insurance Coverage

Insurance Provider

Policy Number

Group Number

Secondary Insurance Provider

Policy Number

Group Number

Self Pay

○ Yes ○ No

Emergency Contact

Emergency Contact

Phone Number

Address

Relationship to Patient

Secondary Emergency Contact

Phone Number

Address

Relationship to Patient

Pharmacy

Pharmacy Name

Pharmacy Phone Number

Pharmacy Address

Current Medication

Please least current medication: Name, Dosage, Frequency, Prescriber, Indication.

Medical History

Patient History (please select all that apply.)

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Lung Disease ☐ Anemia (or other blood disease)
☐ Thyroid Disease ☐ Digestive Disease ☐ Kidney Disease ☐ Bladder Disease ☐ Prostate Disease ☐ Sever headaches
☐ Seizures ☐ Stroke ☐ Blood Clots ☐ Neck Pain ☐ Sleep Apnea ☐ Diabetes ☐ Cancer
☐ Depression/Mental Illness ☐ Other

Comments and explanations.

Diabetic Questionnaire

Diabetes

○ Type 1 ○ Type 2

Date of Diabetic diagnosis (approximate).

Last A1C Vaule

Date of last A1C

Physician who ordered A1C

Date of last Diabetic eye exam?

Location of eye exam.

Name of Optometrist who preformed your exam.

Cancer Questionaire

What kind of cancer where you diagnosed with?

Date of Diagnosis

Surgeries for cancer?

Name of Physician/Oncologist/Surgeon

Location of Physician/Oncologist/Surgeon

Allergies

Medication

Severity

○ Mild ○ Moderate ○ Severe

Reaction

Medication

Severity

○ Mild ○ Moderate ○ Severe

Reaction

Medication

Severity

○ Mild ○ Moderate ○ Severe

Reaction

Medication

Severity

○ Mild ○ Moderate ○ Severe

Reaction

Comments and explanations

Surgeries

Please list any surgeries by type, year, and the surgeon.

Overnight Hospital Admission

Please list: Reason for Admission with the approximate date.

Family History

Father

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Mother

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Sister(s)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Brother(s)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Daughter(s)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Son(s)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Grandparents

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other

comments

Number of sisters:

Number of brothers:

Number of daughter:

Number of sons:

Social History

Smoking

Do you smoke cigarettes?

○ Yes ○ No

If yes, amount per day?

Number of years of use?

Do you use other forms of tobacco?

○ Yes ○ No

If yes, type of tobacco?

E-cigarette / Vape use?

○ Yes ○ No

Do you have a history of past tobacco/cigarette use?

○ Yes ○ No

If yes, type of tobacco used.

How long ago did you quit?

Comments

Alcohol

Do you drink alcohol?

○ Yes ○ No

what do you drink?

☐ Beer ☐ Wine ☐ Liquor

How often do you drink?

○ Daily ○ Weekly ○ Monthly ○ Yearly

Comments

Recreational Drugs

What recreational drugs do you use?

☐ Marijuana ☐ Other

If other, type used.

Amount per day?

Number of years of use?

Immunizations

Influenza

○ Yes ○ No

Date received

Pneumonia

○ Yes ○ No

Date received

Tetanus

○ Yes ○ No

Date received

COVID-19

○ Yes ○ No

Date received

Shingrix (Shingles vaccine)

○ Yes ○ No

Date received

Have you received any vaccines out of state?

○ Yes ○ No

If yes, what state?

Geriatric Questionnaire

Falls

Have you had any falls in the last year?

○ Yes ○ No

Did they result in an injury?

○ Yes ○ No

Please explain.

Females Over 40

Have you had a mammogram?

○ Yes ○ No

Date of your last mammogram.

Ordering Provider Name

Persons Over 50

Have you had a colonoscopy and/or Cologuard?

○ Yes ○ No

Date of colooscopy/Cologuard

Location

Ordering Physician Name

Past Medical Providers and Specialist

Primary Care Physician

Name of Physician

Name of Practice

Location of Practice

Cardiologist

Name of Physician

Name of Practice

Location of Practice

Gastroenterologist

Name of Physician

Name of Practice

Location of Practice

Hematologist

Name of Physician

Name of Practice

Location of Practice

Nephrologist

Name of Physician

Name of Practice

Location of Practice

Neurologist

Name of Physician

Name of Practice

Location of Practice

Oncologist

Name of Physician

Name of Practice

Location of Practice

Ophthalmologist / Optometrist

Name of Physician

Name of Practice

Location of Practice

Orthopedic

Name of Physician

Name of Practice

Location of Practice

Pulmonologist

Name of Physician

Name of Practice

Location of Practice

Rheumatologist

Name of Physician

Name of Practice

Location of Practice

Surgeon

Name of Physician

Name of Practice

Location of Practice

Urologist

Name of Physician

Name of Practice

Location of Practice

Physical Therapist

Name of Physician

Name of Practice

Location of Practice

Endocrinologist

Name of Physician

Name of Practice

Location of Practice

Podiatrist

Name of Physician

Name of Practice

Location of Practice

Gynecologist / Obstetrics

Name of Physician

Name of Practice

Location of Practice

Psychologist / Psychiatrist

Name of Physician

Name of Practice

Location of Practice

ENT

Name of Physician

Name of Practice

Location of Practice

Pain Management

Name of Physician

Name of Practice

Weight Loss / Obesity Medicine

Name of Physician

Name of Practice

Location of Practice

VA Clinic

Name of Physician

Name of Practice

Location of Practice

Other Specialist or Care Managers

Name of Physician

Name of Practice

Location of Practice

Additional Comments about past medical history or specialist.

Additional Information

Is there anything you need to share about your past medical history that was not covered previously? (Please not it below.)

Form Name: Patient Acknowledgment Form

Acknowledgement

Patient Acknowledgement

I understand that the patient's health information is private and confidential. I understand that Wellness Life Center, LLC worked very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Wellness Life Center, LLC may use and disclose the patient's personal health information to help provide health care to the patient, handle billing and payment, and take care of other healthcare operations.

Wellness Life Center, LLC had a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is available with the Front Office or online through Wellness Life Center website. I understand that I have the right to read the Notice of Privacy Practices before signing this acknowledgment.

Wellness Life Center, LLC may update this Acknowledgement and Notice of Privacy Practices. If I ask, Wellness Life Center, LLC, will provide me with the most current Notice of Privacy Practices.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving and accounting of disclosures as required by law; and requesting communication by specific methods of communications or alternative location.

Wellness Life Center, LLC has established procedures that help them meet their obligations to patients. These procedures may include other signature requirement, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Wellness Life Center, LLC by following these procedures if I choose to exercise any of my rights described in the Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review a current copy of Wellness Life Center, LLC's Notice of Privacy Practices.

Names of individuals (and phone numbers) we may release information to regarding you care:

Name

Phone

Name

Phone

Name

Phone

Print your full name and sign:

X

Ip Address

Form Name: Welcome Policy Form

Welcome to Wellness Life Center

Welcome Information

Welcome to Wellness Life Center, LLC, and thank you for choosing us as your provider for primary medical care. Our primary goal is to provide quality medical care which is easily accessible and responsive to you in your time of need. Our staff includes a comprehensive interdisciplinary team of professionals who will consistently strive to exceed your expectations to ensure that your experience with us is as comfortable and stress-free as possible.

As a patient-centered wellness center, our approach is to provide our patients with comprehensive health care, which is focused on all aspects of their health and overall wellbeing, including emotional, family, and social concerns. Along with your physician and other health care providers, you are the most important person in managing your health.

We Strive for Excellence

At Wellness Life Center we have set high expectations for our staff and leadership team. Our expectations are referred to as our 7 core values. These include; integrity, respect, dedication, servantship, kindness, patience, and excellence. We choose to operate with honesty and high moral conduct. We choose to be respectful to our colleagues and our patients. We choose to be dedicated to our work, each other, and our patients. We choose to serve one another including our patients and our community. We choose to operate with kindness towards others at all times. We choose to have patience in all circumstances and with all people. We choose to operate every aspect of our business with the highest quality.

How We Serve you

We strive to maintain an ongoing relationship with you and your family to manage your healthcare needs.

We have a strong and dedicated medical team that will assist you in coordinating care with other providers, specialists, and community resources if needed.

Our team will have access to all of your health information through electronic records in order to effectively manage your care.

We provide you with electronic access to your healthcare team and personal records through our Patient Portal and Healow App.

How You Can Help

Talk with your primary care provider and team about any questions you have.

Keep in touch with your team if further questions arise about your health.

Take care of your health by following the plan recommended by your team.

Schedule a complete physical exam at least once a year.

Always let us know how we're doing and how we can improve.

OFFICE HOURS

Our office is available Monday-Thursday 8:00 am to 5:00 pm and Friday 8:00 am to 12:00 pm and may be reached at (229) 397-5433. Our Providers are available "after hours" 24 hours per day/365 days per year by calling Grady General Hospital at 229-377-1150 and asking to speak with the provider on call for Wellness Life Center. If you need an appointment, prescription refill, or test results, please call during regular business hours.

APPOINTMENTS

Wellness Life Center is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact or insurance information. While we strive to schedule appointments appropriately, emergencies can and do occur. Our goal is to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

To ensure quality care, Wellness Life Center, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit). Follow-up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Wellness Life Center promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment, we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

NO SHOW POLICY

A "no show" is the term we use when a patient misses an appointment without canceling it within one (1) business day in advance. Unfortunately, "No-Shows" inconvenience those patients who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of **$75.00** will be billed to your account. You will be sent a letter, along with the billed administrative fee, alerting you to the fact that you failed to show up for a scheduled appointment and did not cancel the appointment within one (1) business day in advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) "no-shows" within one (1) calendar year will result in a temporary suspension of services. In order to reinstate services, you will be required to meet with your Primary Care Physician within 30 days of the third no-show letter to evaluate your situation. In the event you do not respond and/or schedule an appointment within 30 days, we will consider your patient status as terminated

Please Note No-Show charges are the patients' responsibility and will not be billed to your insurance company.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients:

If you are scheduled for an appointment, you will receive a message by telephone, email, or text message.

Closings will be displayed on our website and on Facebook.

INSURANCE

Wellness Life Center accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at **397-5433.** It is the patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. All patients will be asked to present their current insurance card(s) at each appointment. Failure to have your card could delay your appointment, and it will be the responsibility of the patient to provide proof of coverage.

PAYMENTS

Patients are responsible for co-pays at the time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department. Wellness Life Center accepts cash, personal checks, MasterCard, Discover, Visa, and American Express. Checks can be made out to Wellness Life Center. It is the policy of Wellness Life Center to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform Wellness Life Center of which Pharmacy you use and update us if this should change. Please allow up to three business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time if needed.

All medications must be brought to every appointment.

Please note that we do not fill Narcotic Medications or order Antibiotics over the phone.

Our Practice does not routinely order Narcotic Pain Medicine; therefore, you may be required to obtain these medications through a Pain Management specialist.

CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for the release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of **$20.00**. The law allows Medical Offices thirty (30) days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

COMPLETION OF FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Wellness Life Center will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time-consuming, please allow **7-14** days for the completion of requested forms/letters.

The charges for completion of these forms are as follows.

- If the form can be printed directly from the appointment summary checkout – no charge.

- If forms must be completed outside of a scheduled office visit, we charge a flat fee of $10.00.

- The payment is due at the time the forms are received/dropped off.

Please note that Wellness Life Center may require that patients schedule an office visit to complete certain paperwork. This will always be at the provider's discretion.

OUR PATIENT PORTAL

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the Patient Portal, which can provide a quick and easy method for scheduling appointments, entering and updating medications, etc. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

ADDITIONAL INFORMATION

If you have further questions or need additional information about our services, please feel free to call our office at 397-5433 and/or visit our website at www.wellneslifecenter.org.

Receipt Acknowledgement Form

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Wellness Life Center OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

Print your full name and sign:

X _____ Ip Address

Form Name: Rx History Form

RX History Consent Form

ePrescribing

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving quality patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribe program. These include:

Formulary and benefits transactions- Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification- This allows the prescriber to receive electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing the consent form you are agreeing that Wellness Life Center, LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Understanding all the above, I hereby provide informed consent to Wellness Life Center, LLC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Date of Birth

Relationship to Patient

Print your full name and sign:

X

Ip Address

Form Name: Medical Information Release Form

Medical Information Release Form

Authorization of Release

At Wellness Life Center we work hard to provide top-quality medical care. As we deliver these services to you, we also strive to maintain your patient privacy. We will never utilize your information in inappropriate ways. Likewise, we will not ask others outside of our office for your medical information without your permission. We may utilize your release of authorization form to obtain medical history, lab work, or images/x-rays as indicated to keep your preventive care measures up to date in your patient record here at Wellness Life Center. By signing the following release form, you are giving us permission to obtain medical information only as is appropriate to provide the highest quality medical care to you. We will place this form on file in your chart, which will allow us to work more quickly to obtain medical information essential to your medical care without having to interrupt your busy schedule. You only need to complete the necessary portions on the following form. We will complete the rest for you as indicated, with your permission.

Should you choose to not place a signed copy on file, we can contact you to come by to sign an individual form each time it is needed. Again, we will never obtain medical information outside of what is necessary to provide appropriate care for you.

Patient Name

Date of Birth

Adress

City/State/Zip

Telephone

I authorize release of medical information as indicated below:

Release From:

Practice Name

Practices Address

Release To:

Name

Adress

Record Pick-UP

I would like my records mailed to: (please indicate address)

I would like to pick up my records. Please call me at:

What to release:

Choose any/all that apply:

☐ All Medical Records ☐ Outpatient Notes ☐ Laboratory Report(s) ☐ X-Ray Report(s) ☐ X-Ray Film(s)
☐ Pathology Report(s) ☐ Immunization Records ☐ Other

Other (specify)

Special Release

I authorize the release of any/all information pertaining to:

- ☐ The diagnosis/treatment of AIDS, including results of HIV tests.
- ☐ The diagnosis/treatment of drug and/or alcohol abuse.
- ☐ The treatment and/or consultation for mental health or psychiatric disorders.

Purpose of Release

Please indicate the reason for this release

☐ For another doctor. ☐ Use in a lawsuit. ☐ Follow-up related to an injury. ☐ Personal use. ☐ To obtain disability.
☐ Worker's care. ☐ Armed forces requirement. ☐ Other

Other (please explain)

Expiration Date

Please change the expiration date to last until.

I understand this Authorization can be revoked at any time according to the Wellness Life Center LLC privacy practices. This request must be made in writing and sent to the same place as the original request. Attach a copy of this release if possible. Treatment, payment, and enrollment in any health plan is not conditioned on signing this authorization.

Once these records are released, the information is not protected by Wellness Life Center LLC and may potentially be re-disclosed by the party who received these records. Wellness Life Center LLC, its employees, officers, and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized.

Print your full name and sign:

X Ip Address

Form Name: Mental Health Questionnaire (PHQ-9)

Mental Health Questionnaire

Patient Name **Today's Date**

Select which applies to you best within the last two weeks.

Little interest or pleasure in doing things

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Trouble falling asleep, staying asleep, or sleeping too much.

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Poor appetite or overeating

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Trouble concentrating on things such as reading the newspaper or watching television

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Thoughts you would be better off dead or harming yourself in some way.

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Feeling down, depressed, or hopeless.

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Feeling tired or having little energy

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Feeling bad about yourself; that you are a failure, or have let yourself or your family down.

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

Moving or speaking so slowly other people could notice, or being so fidgety and restless that you are moving more than usual.

○ Not at all (0) ○ Several Days (1)
○ More than half of the days (2) ○ Nearly every day (3)

To Be completed by Medical Personnel:

Score Measurement

○ Minimal (1-4) ○ Mild (5-9) ○ Moderate (10-14) ○ Moderately Severe (15-19)
○ Severe (20-27)

Total Score

Form Name: Wellness Program Patient Questionnaire 2

Patient Information

First Name _____ Last Name _____

Date of Birth _____ Phone _____ E-MAIL _____

Address _____

Primary Care Physician _____

Goal Weight _____ Current Weight _____ Height _____

Allergies _____

Current Medical Problems

High Cholesterol

○ Yes ○ No

Elevated Blood Sugar

○ Yes ○ No

High Blood Pressure

☐ Yes ☐ No

Diabetes

○ Controlled with diet. ○ Controlled with oral medication. ○ Controlled with insulin.

Seizures

○ Yes ○ No

Stroke

○ Yes ○ No

High Blood Pressure

○ Chest Pain ○ Palpitations ○ Heart Attack ○ Stents In Heart ○ Pace Maker

Sleeping Problems

○ Difficulty falling asleep. ○ Difficulty staying asleep. ○ Sleep Apnea ○ Snoring ○ Insomnia ○ Daytime sleepiness.
○ Fatigue ○ Shift work

_____

How many hours per night do you sleep?

Acid Reflux/Heartburn

○ Yes ○ No

Constipation

○ Yes ○ No

Diarrhea

○ Yes ○ No

Irritable Bowel Syndrome

○ Yes ○ No

_____

Autoimmune Disease (please specify)

Mental Health (select all that apply)

☐ Anxiety ☐ Post Traumatic Stress Disorder (PTSD) ☐ Bipolar ☐ ADHD ☐ Depression ☐ Low Self Esteem ☐ Other

Drug/Alcohol use? **Specify use of drugs/alcohol.**

○ Yes ○ No

_____

Situational Stress? (please specify)

Glaucoma

○ Yes ○ No

Pancreatitis

○ Yes ○ No

Liver Problems

○ Yes ○ No

Asthma

○ Yes ○ No

Kidney Problems

☐ HX of Kidney Stones ☐ Other

Specify other kidney problems:

Cancer

Specify cancer: Type and Year

○ Yes ○ No

Do you have any other medical conditions that were not discussed previously?

Medications

List all medications: Name, Dosage, Frequency, Prescriber, Indication

Supplements/Herbal Medications: Name, Dosage, Frequency

Over the Counter Medications: Name, Frequency

Surgical History

Surgery Type, Year, and Surgeon:

Family History

Mother

Father

Sister(s)

Brother(s)

Daughter(s)

Son(s)

Maternal Grandparents

Paternal Grandparents

Women Only*

Do you still have a monthly menstrual cycle?

○ Yes ○ No

Menopause

○ Yes ○ No

What age did you go through Menopause?

Did you have a Hysterectomy?

○ Yes ○ No

If yes, please specify the reason for your Hysterectomy.

Drug Use

Do you use any illicit drugs?

If yes, please specify type and amount.

○ Yes ○ No

Do you drink alcohol?

If yes, please specify type and amount.

○ Yes ○ No

Do you use tobacco?

○ Yes ○ No

If yes, please specify type and amount.

Weight Questionnaire

Does anyone in your family suffer from being overweight or obese? (Please specify who)

○ Yes ○ No

_____

If yes, please explain.

_____

At what age did you begin to notice you were gaining weight?

Have you had any traumatic events that contributed to your weight gain?

○ Yes ○ No

If yes, please explain.

Have you tried other weight loss programs, medications, or weight loss surgery in the past?

○ Yes ○ No

If yes, please explain.

Physical Activity History

Do you exercise or participate in any type of physical activity?

If yes, please explain.

○ Yes ○ No

What types of physical activity/exercise do you enjoy?

Do you have any medical conditions that prevent you from exercising?

If yes, what?

○ Yes ○ No

Nutritional History

_____

How many time a day do you eat a meal? (Approximately what times.)

_____

How many times a day do you eat a snack? (Approximately what times.)

_____

Please list the types of foods that you eat on an average day.

_____

Do you ever binge eat? If so, when?

_____

What type of foods do you crave? (At what time of the day do you have these cravings.)

How did you hear about us?

☐ In the office ☐ Online ☐ Social Media ☐ Word of mouth ☐ Local Advertisement ☐ TV/Radio

Form Name: Wellness Program Fee Form 2

Wellness Program Fee's

Dear Patient

If you have received this information packet, it is because you have expressed desire to benefit from our Specialized Wellness Program. We are excited to offer our area's highest quality medical management in the areas of Functional Medicine and Obesity Medicine. We are trained and certified to provide advanced evaluation and treatment for multiple conditions. We look forward to assisting you in our journey to improved health. Thank you for placing your trust in us.

PLATINUM:
WellLifePro App with open access to all meal plans: $24.99 activation / $9.99 recurring
Initial Medical Consultation with provider (60 minutes) *: $199.00 cash*

Included:

Medical History/Disease Evaluation
Assistance choosing meal plans
Lifestyle Education/planning
Body Composition Analysis
Medication Management
Prescription Therapy
Electrocardiogram
Vitamin Injection
Blood work*

Not included:

Specialty Tests*, based on Provider Evaluation
Subsequent Nurse Visits: $29.00 cash*
Subsequent Office Visits (30 minutes)*:

Included
Continued Medical Evaluation
Medication Adjustments
Body Composition Analysis
Vitamin Injection
Subsequent blood work*
Specialty Tests*

***Insurance may be filed upon request**