HIPAA - SUMMARY OF PRIVACY NOTICE

Officer Name: Center, Wellness Life
Office Website: www.wellnesslifecenter.org
Office Phone Number: (229) 397-5433
Office Address: 1842 Hwy 82 West, Cairo, GA, 39827

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

07-20-2023 12:43:PM

Wellness Life Center Medical Spa

Form Name: Massage Intake Form

Registration

1. ABOUT YOU

Last Name | First Name | Middle Name or Initial

You prefer to be called | Birthdate: | Age | Social Security #: 333-22-4444

Gender (At Birth)

○ Male ○ Female ○ Prefer not to answer

Mailing Address:

City | State | ZipCode

Home Phone: | Work Phone: | Cell Phone:

E-mail Address | Whom may we thank for referring you?

Occupation? | Employer's Name/Company Name | Employer's Address

City | State | ZipCode | How long?

Status:

○ Life Partner ○ Minor ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Spouse's Name

2. INSURANCE INFORMATION

Primary Health Insurance Co. Name | Insurance Co. Address

City | State | ZipCode

Insurance Co. Phone #: | Insured's ID# | Group #: (Plan, Local, or Policy #)

Insured's Name | Relation to Patient | Insured's Date of Birth mm/dd/yyyy

Insured's Employer name and address

3. ACCOUNT INFORMATION

Person ultimately responsible for account | Relation to client?

Billing Address

City | State | ZipCode

Social Security #: 222-33-4444 | Driver's License # | Work Phone #:

I hereby authorize filing of my insurance for the services rendered. I fully understand I am solely responsible for the full balance at the time of service and that any reimbursement will be mailed to me directly through my insurance company.

Please click to acknowledge you agree with the above statement.

○ Agree ○ I do not Agree

What is your preferred payment method?

☐ Cash ☐ Check ☐ Credit Card

4. IN EVENT OF AN EMERGENCY

Whom should we contact? _____ **Relation to Client?** _____

Emerg. Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Who is your Medical Doctor? _____ **MD's Phone #:** _____

5. REASON FOR VISIT

Have you ever had a Professional Massage in the past? If so, what type?

☐ None ☐ Deep Tissue ☐ Shiatsu ☐ Swedish ☐ Other

Reason for today's visit:

○ Stress Relief ○ Emergency ○ New injury ○ Old injury ○ Chronic pain

Are you in pain?

○ No ○ Yes

Rate your pain or level of stress: 10 = severe

○ 10 ○ 9 ○ 8 ○ 7 ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Did your injury/condition occur during:

☐ Life event ☐ Auto Accident ☐ Sports/play ☐ Work ☐ Routine/Household activity

Date your condition/accident occured? _____ **Where did your injury/condition occur?** _____

Please explain what happened: _____

Is your condition getting worse?

☐ Comes and goes. ☐ Constant ☐ No ☐ Yes

Is your condition interfering with your:

☐ Daily routine? ☐ Sleep ☐ Work

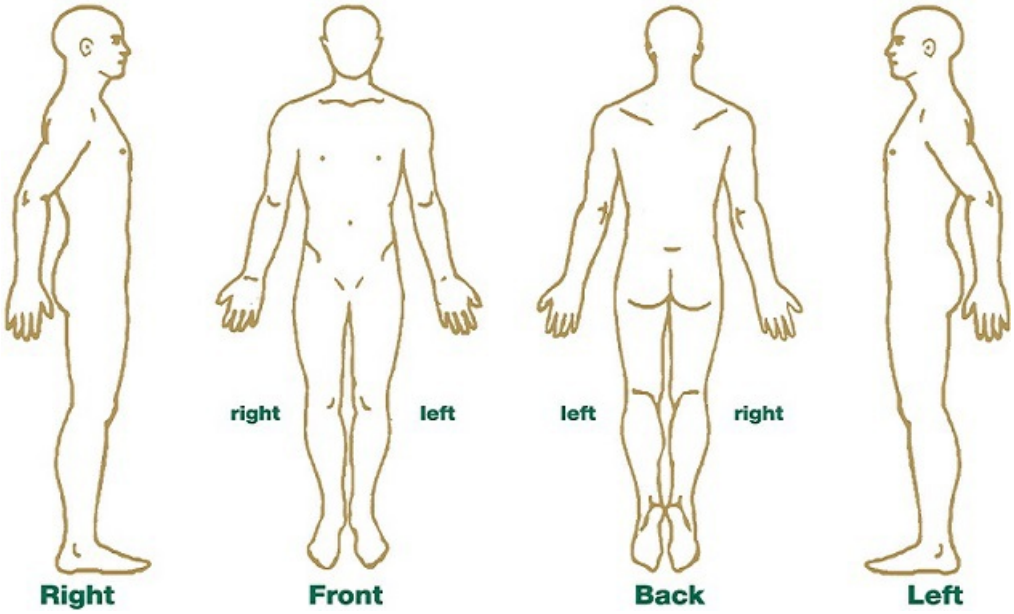
How has your condition interfered? _____

Has this or something similar happened in the past?

○ No ○ Yes

Explain: _____

Indicate any specific areas you would like the massage therapist to concentrate on during the session:



Do you have any difficulty lying on your;

☐ Left side ☐ Right side ☐ Back ☐ Front

Please explain:

What kind of music relaxes you?

What scents do you prefer?

Do you prefer?

○ Massage Oils ○ Massage Lotions
○ I don't know/Either is fine

Have you been treated by a Medical Physician for this condition?

○ No ○ Yes

Medical Physicians Contact Info

Have you ever been treated by a Chiropractor?

○ No ○ Yes

Chiropractors Contact Information

6. MEDICAL INFORMATION

Are you taking any of the following medications?

☐ Pain killer(including aspirin) ☐ Nerve Pills ☐ Stimulants ☐ Insulin ☐ Blood Thinners ☐ Muscle relaxers ☐ Other

Please list any other medications you are taking? (include over the counter)

Do you have or have you had any of the following diseases, medical conditions or procedures?

☐ Hepatitis ☐ Venereal Disease ☐ Alcohol / Drug Abuse ☐ Artificial Valves ☐ Mitral Valve Prolapse
☐ Congenital Heart Defect ☐ Heart Surg./Pacemaker ☐ Heart Attack / Stroke ☐ HIV+ / AIDS / ARC ☐ Shingles
☐ Cancer ☐ Frequent Neck Pain ☐ Glaucoma ☐ Anemia / Diabetes ☐ High/Low Blood Pressure
☐ Psychiatric Problems ☐ Rheumatic Fever ☐ Severe / Frequent Headaches ☐ Kidney Problems ☐ Ulcers / Colitisemia
☐ Fainting/Seizures/Epilepsy ☐ Sinus Problems ☐ Emphysema / Asthma ☐ Tuberculosis ☐ Difficulty Breathing
☐ Chemotherapy ☐ Lower Back Problems ☐ Artificial Bones/Joints/Implants ☐ Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

Do you have any allergies to oils, lotions, or ointments?

○ No ○ Yes

Do you have sensitive skin?

○ No ○ Yes

Are you sensitive to smells?

○ No ○ Yes

Please explain:

Do you wearing contact lenses?

☐ No ☐ Yes

Do you exercise?

○ Yes ○ No

Hours per week

Are you required to sit for long periods of time?

○ No ○ Yes

Do you perform repetitive movements in your work? (Explain)

Are you nursing?

○ No ○ Yes

Are you Pregnant?

○ No ○ Yes

If Yes, how many weeks along are you?

We invite you to discuss with us any questions regarding our services. Draping will be used during the session. Only the area being worked on will be uncovered. Clients under the age of 17 must be accompanied by a parent or legal guardian

during the entire session. Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

○ I acknowledge my digital signature below.

Print your full name and sign:

X _____ Ip Address