Date: ________________

☐ **MORRISTOWN**
1843 West Morris Blvd
(423) 581-7976

☐ **SEVIERVILLE**
1360 Dolly Parton Pky
(865) 429-0921

☐ **ROGERSVILLE**
1101 E. McKinney Ave
(423) 272-1900

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Name:	Date of Birth:
Street: Primary Phone:	Occupation:
City: State: Zip Code:	Email:
Alternate Phone: Contact me by: ☐ Text ☐ Cell ☐ Email	Marital Status:
Hobbies/Interests:	Emergency Contact Name:
How did you hear about us?	Emergency Contact Phone:

General Health:

Primary Care Physician:

Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1 Average hours of sleep nightly?

Do you feel content in life? ☐ Yes ☐ No At work? ☐ Yes ☐ No With family? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If yes, what type and how often?

Do you wear contact lenses? ☐ Yes ☐ No

Do you smoke or use tobacco? ☐ Yes ☐ No How many cigarettes per day? How many years?

Do you drink alcohol? ☐ Yes ☐ No Type: ☐ Beer ☐ Liquor ☐ Wine Drinks per day: Drinks per week:

Do you have any metal implants, a pacemaker, or body piercings?

Do you pass out or get dizzy / lightheaded with needles (labs, shots, etc)? ☐ Yes ☐ No

Please list any previous surgeries:

Medications: Please list all prescription and OTC medications and supplements you use. Include those you use on an as needed basis if they are used at least weekly. This includes vitamins, herbs, nasal sprays, and inhalers.

Medication Name	Dose	How Often	Purpose	How Long Used?

Allergies: Please list any food, medication, or environmental allergies and your reactions.

Illnesses/Chronic Conditions: Please mark all that apply.

☐ Vision problems	☐ Tuberculosis	☐ Anemia	☐ Hepatitis	☐ Fibromyalgia
☐ Glaucoma	☐ High Blood Pressure	☐ Easy bleeding / bruising	☐ Stomach Ulcers	☐ Chronic Pain Syndrome
☐ Cataracts	☐ High Cholesterol	☐ Blood clots	☐ Colitis / Diverticulitis	☐ Multiple Sclerosis
☐ Hearing problems	☐ Heart Failure	☐ Autoimmune Disease	☐ Irritable Bowel Syndrome	☐ Headaches
☐ Ear Infections	☐ Heart Attack	☐ Diabetes	☐ Bladder / Kidney Infections	☐ Seizures
☐ Asthma	☐ Heart Murmur	☐ Thyroid Disease	☐ Kidney Stones	☐ Neuropathy
☐ Allergies	☐ Heart Valve Disease	☐ Genetic Disorders	☐ Urinary problems	☐ Depression / Anxiety
☐ Sinus problems	☐ Irregular Heartbeat	☐ Acid Reflux	☐ Urinary Incontinence	☐ Bipolar Disorder
☐ Bronchitis	☐ Stroke	☐ Pancreatitis	☐ Jaw Pain / TMJ	☐ Drug Abuse / Alcoholism
☐ COPD / Emphysema	☐ Varicose Veins	☐ Gallbladder Disease / Stones	☐ Arthritis	☐ Eating Disorder
☐ Pneumonia	☐ Rheumatic Fever	☐ Liver Disease	☐ Bulging / Degenerative Disks	☐ Herpes / Shingles / Cold Sores

☐ Cancer (Type: ___________________________________) ☐ Other: ____

Family Medical History:

Do any of the following conditions run in your family? Please mark all that apply and indicate who has the condition.

☐ High blood pressure ________________________	☐ Diabetes ____________________________	☐ Lung disease ________________________________
☐ High cholesterol ___________________________	☐ Obesity _____________________________	☐ Liver disease ________________________________
☐ Heart disease _____________________________	☐ Thyroid disease _____________________	☐ Stomach disease _____________________________
☐ Heart attack ______________________________	☐ Arthritis ____________________________	☐ Genetic diseases _____________________________
☐ Stroke __________________________________	☐ Cancer _____________________________	☐ Other: _____________________________________

Diet & Nutrition:

Highest adult weight: Age:	Lowest adult weight: Age:	Avg. adult weight:

How many oz. of water do you drink daily? How many soft drinks do you drink daily? Other caffeine?

How many times per week do you eat out?

Have you tried multiple diets in past? ☐ Yes ☐ No

Are you currently on a special diet? ☐ Yes ☐ No If yes, what type?

Diet & Nutrition (continued):

Have you tried any of the following diet programs in the past? (Mark all that apply.)

□ Low fat	□ Zone	□ Ornish	□ Medifast / Optifast
□ Atkins	□ Paleo	□ DASH	□ Weight Watchers
□ South Beach	□ Keto / ketogenic	□ Mediterranean	□ Other: ___________________

Please list what and what time you typically eat for each of the following:

Breakfast: ____

Lunch: ____

Dinner: ____

Snack: ____

Skin Care:

Are you under the care of a dermatologist? □ Yes □ No

Do you use: □ Acutane □ Retin A □ Renova □ Adapalene □ Other prescription skin products

Have you had: □ Botox □ Dermal fillers □ Chemical Peels □ Microdermabrasion □ Other treatments__________________________

Are you currently using any products that contain: □ Glycolic Acid □ Lactic Acid □ Hydroxy Acid □ Vitamin A

Do you have any skin sensitivities or irritants: □ Yes □ No Reaction: ______________________________________

Skin Maintenance:

Products You Use: □ Cleanser □ Toner □ Moisturizer □ Exfoliator □ Masque

Skin Type: □ Oily/Congested □ Dry/Dehydrated □ Sensitive/Redness □ Acne □ Sunburned

How often do you go tanning or are exposed to the sun? □ Daily □ Weekly □ Monthly □ Rarely

What are your skin care goals?

For Women Only:

Are you currently sexually active?	□ Yes □ No	Sexual Orientation:	
Are you currently pregnant or nursing?	□ Yes □ No		
Number of pregnancies:	Number of children born:	# Vaginal Deliveries:	# C-Sections:
Last menstrual cycle:	Avg cycle length:	Age of onset:	
Current method of birth control:		Last pelvic exam:	Last mammogram:
Have you had a hysterectomy?	Do you still have ovaries?		Age of menopause:

For Women Only (continued):

Do you suffer from any of the following female related symptoms / conditions?

☐ Irregular periods	☐ Cravings	☐ PCOS / Ovarian cysts
☐ Heavy periods	☐ Irritability	☐ Yeast infections
☐ Spotting	☐ Fatigue	☐ Bacterial vaginosis
☐ Cramps	☐ Breast tenderness	☐ Hot flashes
☐ Fluid retention	☐ Infertility	☐ Mood swings
☐ Low sex drive	☐ Endometriosis	☐ STDs

For Men Only:

Are you currently sexually active? ☐ Yes ☐ No Sexual Orientation:

Do you suffer from any of the following male related symptoms / conditions?

☐ Impotence	☐ Weak erection	☐ Premature ejaculation
☐ Low sex drive	☐ Increased sex drive	☐ Prostate Problems
☐ Testicle Pain/Lump	☐ Penis discharge	☐ Infertility
☐ Moods Swings	☐ Fatigue	☐ STDs

Please note any other information you feel is relevant to your health history that has not been mentioned elsewhere:

OFFICE USE ONLY: HISTORY REVIEW/UPDATE ***Please have patient review history, mark NC if no changes, initial and date. Patient to complete a new history if any changes have occurred since the last history review was completed.***

Skin Consent for Injectable Treatment

Please initial the paragraphs that apply to you and sign and date at the bottom of the form.

_____ I hereby authorize the provider for *Center for Wellness* to inject any of the following products for the purposes of improving my appearance and/or function. There are generally no major risks if I elect not to have treatment and no guarantee has been given to me regarding the outcome of these procedure(s). The products, along with their indications, expected effects, duration of effect. risks and possible side effects have been fully explained to me, as well as alternative methods of treatment. I understand that these products can and may be used in both an "on-label" and "off-label" manner during my treatment session(s). The products and risks explained to me today include those checked below.

☐ **Botox/Xeomin**

_____ I understand that these are the trade names for botulinum toxin and are injectable medications meant to reduce facial wrinkles. I understand that they will produce (and are meant to produce) muscle weakness and superficial paralysis. I understand that the medication may take 1-2 days to start working and the maximum effects may not be reached until 21 days after injection. I understand that repeat treatments may be required every 3-4 months to achieve lasting effects.

_____ The following risks have been explained to me by the provider performing the treatment:

- Failure to achieve the result I wanted
- Results may not last as long as I expected
- Pain was greater than I expected
- Results were not as immediate as I expected
- Asymmetry – one side doesn't match the other
- Infection
- Allergic reaction to the medication
- Unforeseen complications not encountered in the medical literature and common patient experience
- Damage to deeper structures
- Side effects, which may include: Swelling at treatment site, headache, localized numbness, bruising, rash, temporary loss of function of nearby muscle, such as drooping lid, asymmetrical brows

_____ I do not have any of the following contraindications:

- Neuromuscular disorders (i.e. Myasthenia Gravis or Lambert-Eaton syndrome)
- Dysphasia (swallowing difficulties)
- Chronic respiratory hypersensitivity to any ingredients to be injected
- Pregnancy or breast feeding (These products have not been tested on pregnant/nursing women.)

_____ I am not taking aminoglycoside antibiotics, anticoagulants, aspirin, or muscle relaxants.

_____ I have not recently had anesthesia or topical anesthetics.

☐ **Kybella**

____ I understand that this product is an injectable meant to reduce fat in the upper neck. I understand that I may need multiple injections and multiple sessions.

_____The following risks have been explained to me by the practitioner performing the treatment:

- Failure to achieve the result I wanted
- Results did not last as long as I expected
- Pain was greater than I expected
- Results were not as immediate as I expected
- Asymmetry -one side doesn't match the other
- Infection
- Allergic reaction to the medication
- Damage to deeper structures such as nerves, blood vessels, and muscles. This may include injury to the marginal mandibular nerve, which helps control facial expressions, causing an off-balance smile.
- Unforeseen complications not encountered in the medical literature and common patient experience
- Side effects, which may include: Bruising and swelling, numbness, redness, areas of hardness lasting up to 4 weeks.

☐ Dermal fillers including: **Voluma, Juvederm Ultra Plus XC, Juvederm Ultra XC, Volbella**

_____These products are designed to fill facial lines for facial contouring and lip augmentation. I understand that more than one treatment session may be required to obtain maximum effects.

_____The following risks have been explained to me by the practitioner performing the treatment:

- Failure to achieve the result I wanted
- Results did not last as long as I expected
- Pain was greater than I expected
- Results were not as immediate as I expected
- Asymmetry -one side doesn't match the other
- Unforeseen complications not encountered in the medical literature and common patient experience
- Migration of the filler from the injection site
- Side effects, which may include redness, tenderness at the injection site, swelling, bleeding. bruising. firmness, lumps, bumps, pain, itching, infection, discoloration, and hypersensitivity
- Accidental injection into a blood vessel
- Post-treatment allergic reaction or hypersensitivity to the procedure.

☐ **Sclerotherapy**

_____ I understand that this procedure involves injection of a medication ("sclerosant") via needle into unwanted veins. The goal is to irritate and scar the veins from the inside such that these abnormal veins close and no longer fill with blood. Several treatments may be required to obtain maximum improvement.

_____ The following risks have been explained to me by the practitioner performing the treatment:

- Failure to achieve the result I wanted
- Results did not last as long as I expected
- Pain was greater than I expected
- Results were not as immediate as I expected
- Side effects, which may include redness, tenderness at the injection site, swelling, bleeding. bruising. firmness, lumps, bumps, pain, ulceration, itching, infection, discoloration, and hypersensitivity
- Unforeseen complications not encountered in the medical literature and common patient experience
- Accidental injection into an artery can occur very rarely. Consequences range from discomfort, scarring of the skin, injury to muscle or nerves or other tissue, or loss of limb.
- Deep vein thrombosis (blood clots) and pulmonary embolism (clots in the lungs) are rare.

_____ I am not taking minocycline or other tetracycline antibiotics.

_____I understand that individuals who are using substances that can prolong bleeding. such as ibuprofen, Aleve, Aspirin, or who have consumed alcohol in the past 72 hours may experience increased bruising or bleeding at injection site. I have informed the medical providers if I am on any of the above medicines or consumed alcohol in the past 72 hours. If I have proceeded with the procedures despite taking one of these medications or consuming alcohol in the past 72 hours, I assume any risk of prolonged bleeding.

_____ I understand that payment is due at the time of treatment. If an enhancement or touch-up of the treated area is necessary, this is typically performed several weeks after the last injection session and will require an additional charge if additional product is used.

_____My questions have been answered to my satisfaction and I elect to undergo these procedures.

_____I understand that failure to follow pre/post procedure instructions may alter the expected outcome of my procedure(s).

______________________________ ______________
Signature Date

______________________________ ______________
Witness Date

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Telemedicine Consent Form

Patient Name: ____ DOB: ____________________

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider and/or their designee has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me and am choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine provider is to advise my local practitioner and that the telemedicine provider's responsibility will conclude upon the termination of the video conference connection.
7. I have had a direct conversation with my provider and/or their designee, during which I have had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
8. I understand that this telemedicine consent form will remain in effect until I request for it to be rescinded. Such request may be required to be in writing.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

______________________________	______________	______________
Patient/Parent/Guardian signature	Date	Time
______________________________	______________	______________
Witness signature	Date	Time

Center for Wellness
WEIGHT LOSS | SKIN CARE | INTEGRATIVE MEDICINE

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General Consent to Treat and Acknowledgement of Office Policies

- It is my choice to receive services from Center for Wellness. I have completed this form to the best of my knowledge.
- I have stated all medical conditions that I am aware of and have listed all medications that I am taking. I am aware that this office monitors the Tennessee Controlled Substance Monitoring Database, and the discovery of any controlled medications prescribed to me that have not been disclosed to staff will be construed as an act of deception violating the trust inherent in a provider/patient relationship which may result in this office declining to participate in my care.
- I will update the staff at Center for Wellness of any changes to my contact information or health status.
- I consent for the CFW providers and staff to perform reasonable and necessary medical examination, testing and treatment for the condition(s) which have brought me to seek care at this office, both at this initial visit and any future visit(s). I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
- I acknowledge that I may leave treatment at any time and that it is my responsibility to notify the provider(s) that I am discontinuing treatment. If I leave treatment, I will find another provider who is able to assume care for me.
- I understand that if a prescription is felt to be appropriate, it will be dispensed at this office, if available, unless I request otherwise.
- I have been given the opportunity to review the HIPAA/Notice of Privacy Practices and understand that a copy is available to me at any time at my request.
- I understand that Center for Wellness does not participate with any insurance provider(s) and that payment in full is expected at the time of service.
- I understand that all sales are final. No refunds or exchanges are given on any products or services.
- If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case, I will call ASAP to notify staff and reschedule my appointment. I understand I may be charged a fee for failing to keep or cancel an appointment under these guidelines and this fee may be required to be paid prior to any future services being rendered. I understand a non-refundable deposit may be required for some skin care services.
- I grant permission to the designated person(s) named below to: make or confirm appointments; have access to test findings; have access to telephone communications and answering machine messages, as well as other common means of communication; pick up medications and/or supplements; be made aware of my diagnosis, prognosis, treatment plans; and have access to my financial health information. Unless otherwise noted below, this authorization grants CFW permission to leave messages on my answering machine/voicemail using my protected health information regarding information deemed appropriate/necessary by my health care provider(s). I understand that this authorization is voluntary. I understand that once this information is released, it may no longer be protected by federal privacy regulations.

By assigning a designated party, Center for Wellness will be allowed to give information to the following individuals:

Name: ____________________		Relationship to patient: ____________
Phone Number: (________)____________		Cell Number: (________)____________
☐ Full Access	☐ Rx/Product Pick Up Only	☐ Other: ____________
Name: ____________________		Relationship to patient: ____________
Phone Number: (________)____________		Cell Number: (________)____________
☐ Full Access	☐ Rx/Product Pick Up Only	☐ Other: ____________

☐ **PLEASE DO NOT LEAVE MESSAGES ON ANSWERING MACHINE**

______________________________ ______________________

Patient Signature Date

Consent to Photograph

I, *(print name)*____,

a current patient/client of Center for Wellness ("CFW"), hereby authorize CFW, by and through its employees, agents or contractors, to photograph me and/or any portion of my body, in order to provide supporting documentation of my medical condition and care provided.

The term "photograph," as used in this agreement, shall mean motion picture or still photography in any format such as slides, negatives, and/or prints, as well as videotape, video disc, and any other means of recording and reproducing images.

Such photographs and/or videos shall be used only for medical records, teaching, publication, marketing, or scientific research by my provider and Center for Wellness, provided that in any such publication the use of my name and identity is kept confidential and protected. Such photographs may be edited at the discretion of my provider to protect my confidentiality or emphasize a treatment area.

I understand that my physician, other providers of my health care, insurance company or third party payor may be furnished with a copy of said photograph, if needed to document the care provided by CFW.

I understand that I have the right to revoke this Consent provided that I do so *in* ***writing,*** except to the extent that CFW has already used or disclosed the information in reliance on this Consent. This Consent will remain in effect until modified or revoked by the patient/client.

☐ By checking this box, I decline to authorize CFW the use of my photograph(s) for teaching, publications, research, or marketing purposes in print, electronic, or other media formats.

Patient Name *(print)* ____

Patient Signature ____ Date_____________

NOTICE OF PRIVACY PRACTICES

This notice is effective as of January 1, 2015, and describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. THIS OFFICE DOES NOT ACCEPT OR PROCESS INSURANCE AT THIS TIME.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web sit

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Medical Director: Crystal Dyer, MD

Office Manager: Misty Hodge