All answers on this form are kept confidential according to HIPPA regulations.

New Patient History Today's Date:

Name Sex **Female** Sex at Birth **Female**

Date of Birth Email

Address

City State Zip

Age Height Weight

Home Phone Cell Phone Work Phone

Occupation Employer

Marital Status **Single** Number of Children (living) (deceased)

Who referred you to the Center for Chiropractic & Wellness?

Who is responsible for the bill?

Name of Spouse or Insured Employer

Spouse (Insured's) Birth Date:

Emergency Contact information

Name Phone Number Relationship to you

Primary Care Physician: Name: Phone

His/Her address

Other doctors seen for this condition

Diagnosis and type of treatment

What are your main reasons for seeking treatment today?

Have you lost any days of work? ☐Yes ☐No Dates:

What type of services do you desire?

- ☐1) Temporary relief of symptoms/pain control.
- ☐2) Eradication of the tendencies causing your condition.
- ☐3) Balanced optimum health care. Elimination of root/cause of problem, if possible.
- ☐4) Maintenance care.

How would you classify your condition?

- ☐1) Minor.
- ☐2) Involved.
- ☐3) Fairly severe and progressively getting worse.

Date of last: PAP Bone Density Scan Mammogram

Age of 1st period (menarche) Age of last period (menopause)

Have you had or do you have the following Sexually Transmitted Diseases:

☐Gonorrhea ☐Syphilis ☐HIV/AIDS ☐HPV ☐Chlamydia ☐Herpes Date

Please check the appropriate boxes if you currently have, or have had in the past, any of the following addictions. *If you are currently in a state of recovery, please also indicate the recovery period.*

☐Prescription Drugs Please indicate drug(s) and length of time of addiction:
☐Street Drugs Please indicate drug(s) and length of time of addition:
☐Alcohol Please indicate length of time of addiction:
☐Tobacco Please indicate length of time of addiction:

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last checkup

Please indicate the user and frequency of the following:

	Yes	No	How much and how often?
Coffee/black tea	☐	☐	
Non-medical drugs	☐	☐	
Tobacco	☐	☐	
Alcohol	☐	☐	
Water Intake	☐	☐	
Soda Pop	☐	☐	

List any accidents, surgeries, hospitalizations, or trauma (include date):

Lab Results (include copies):

List any allergies, food sensitivities, or food cravings that you have.

Is there anything in your personal or medical history that you have not listed (example: recent personal or occupational trauma)? If yes, please explain:

History of Chief Concern. 1) Provide an outline, chronologically, of your past experience in treating your primary concern. Note any diagnoses made, tests done to confirm the diagnosis, treatments, and your response to those treatments. 2) Include specific therapies done and your response to them; medications tried and your reactions, positive and negative.

This is an outline that we will review during your first visit. It need not be exhaustive or highly detailed. Some past responses to medications predict future responses to herbs, nutrients, and supplements. Please do not hesitate to request additional paper from the receptionist.

Doctor's Notes

Metabolic Assessment Form

Name: Age: Sex: **Female** Date:

PART I

Please list your 5 major health concerns in order of importance:
1.
2.
3.
4.
5.

PART II **Please select the appropriate number for all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	**0**
Lower abdominal pain relieved by passing stool or gas	**0**
Alternating constipation and diarrhea	**0**
Diarrhea	**0**
Constipation	**0**
Hard, dry, or small stool	**0**
Coated tongue or "fuzzy" debris on tongue	**0**
Pass large amount of foul-smalling gas	**0**
More than 3 bowel movements daily	**0**
Use laxatives frequently	**0**

Category II

Increasing frequency of food reactions	**0**
Unpredictable food reactions	**0**
Aches, pains, and swelling throughout the body	**0**
Unpredictable abdominal swelling	**0**
Frequent bloating and distention after eating	**0**
Abdominal intolerance to sugars and starches	**0**

Category III

Intolerance to smells	**0**
Intolerance to jewelry	**0**
Intolerance to shampoo, lotion, detergents, etc.	**0**
Multiple smell and chemical sensitivities	**0**
Constant skin outbreaks	**0**

Category IV

Excessive belching, burping, or bloating	**0**
Gas immediately following a meal	**0**
Offensive breath	**0**
Difficult bowel movement	**0**
Sense of fullness during and after meals	**0**
Difficulty digesting fruits and vegetables;	**0**
Undigested food found in stools	**0**

Category V

Stomach pain, burning or aching 1-4 hours after eating	**0**
Use antacids	**0**
Feel hungry an hour or two after eating	**0**
Heartburn when lying down or bending forward	**0**
Temporary relief by using antacids, food, milk, or	**0**
carbonated beverages	**0**
Digestive problems subside with rest and relaxation	**0**
Heartburn due to spicy foods, chocolate, citrus,	**0**
peppers, alcohol, and caffeine	**0**

Category VI

Roughage and fiber cause constipation	**0**
Indigestion and fullness last 2-4 hours after eating	**0**
Pain, tenderness, soreness on left side under rib cage	**0**
Excessive passage of gas	**0**

Category VI (continued)

Nausea and/or vomiting	**0**
Stool undigested, foul smelling, mucous like,	
greasy, or poorly formed	**0**
Frequent urination	**0**
Increased thirst and appetite	**0**

Category VII

Greasy or high-fat foods cause distress	**0**
Lower bowel gas and/or bloating several hours	
after eating	**0**
Bitter metallic taste in mouth, especially in the morning	**0**
Burpy, fishy taste after consuming fish oils	**0**
Difficulty losing weight	**0**
Unexplained itchy skin	**0**
Yellowish cast to eyes	**0**
Stool color alternates from clay colored to	
normal brown	**0**
Reddened skin, especially palms	**0**
Dry or flaky skin and/or hair	**0**
History of gallbladder attacks or stones	**0**
Have you had your gallbladder removed?	**0**

Category VIII

Acne or unhealthy skin	**0**
Excessive hair loss	**0**
Overall sense of bloating	**0**
Bodily swelling for no reason	**0**
Hormone imbalances	**0**
Weight gain	**0**
Poor bowel function	**0**
Excessively foul-smelling sweat	**0**

Category IX

Crave sweets during the day	**0**
Irritable if meals are missed	**0**
Depend on coffee to keep going/get started	**0**
Get light-headed if meals are missed	**0**
Eating relieves fatigue	**0**
Feel shaky, jittery, or have tremors	**0**
Agitated, easily upset, nervous	**0**
Poor memory/forgetful	**0**
Blurred vision	**0**

Category X

Fatigue after meals	**0**
Crave sweets during the day	**0**
Eating sweets does not relieve cravings for sugar	**0**
Must have sweets after meals	**0**
Waist girth is equal or larger than hip girth	**0**
Frequent urination	**0**
Increased thirst and appetite	**0**
Difficulty losing weight	**0**

Category XI

Cannot stay asleep	0
Crave salt	0
Slow starter in the morning	0
Afternoon fatigue	0
Dizziness when standing up quickly	0
Afternoon headaches	0
Headaches with exertion or stress	0
Weak nails	0

Category XII

Cannot fall asleep	0
Perspire easily	0
Under a high amount of stress	0
Weight gain when under stress	0
Wake up tired even after 6 or more hours of sleep	0
Excessive perspiration or perspiration with little or no activity	0

Category XIII

Edema and swelling in ankles and wrists	0
Muscle cramping	0
Poor muscle endurance	0
Frequent urination	0
Frequent thirst	0
Crave salt	0
Abnormal sweating from minimal activity	0
Alteration in bowel regularity	0
Inability to hold breath for long periods	0
Shallow, rapid breathing	0

Category XIV

Tired/sluggish	0
Feel cold – hands, feet, all over	0
Require excessive amounts of sleep to function properly	0
Increate in weight even with low-calorie diet	0
Gain weight easily	0
Difficult, infrequent bowel movements	0
Depression/lack of motivation	0
Morning headaches that wear off as the day progresses	0
Outer third of eyebrow thins	0
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0
Dryness of skin and/or scalp	0
Mental sluggishness	0

Category XV

Heart palpitations	0
Inward trembling	0
Increased pulse even at rest	0
Nervous and emotional	0
Insomnia	0
Night sweats	0
Difficulty gaining weight	0

Category XVI

Diminished sex drive	0
Menstrual disorders or lack of menstruation	0
Increased ability to eat sugars without symptoms	0

Category VXII

Increased sex drive	0
Tolerance to sugars reduced	0
“Splitting” type headaches	0

Category XVIII (*Males Only*)

Urination difficulty or dribbling	0
Frequent urination	0
Pain inside of legs or heels	0
Feeling of incomplete bowel emptying	0
Leg twitching at night	0

Category XIX (*Males Only*)

Decreased libido	0
Decreased number of spontaneous morning erections	0
Decreased fullness of erections	0
Difficulty maintaining morning erections	0
Spells of mental fatigue	0
Inability to concentrate	0
Episodes of depression	0
Muscle soreness	0
Decreased physical stamina	0
Unexplained weight gain	0
Increase in fat distribution around chest and hips	0
Sweating attacks	0
More emotional than in the past	0

Category XX (*Menstruating Females Only*)

Perimenopausal	0
Alternating menstrual cycle lengths	0
Extended menstrual cycle (greater than 32 days)	0
Shortened menstrual cycle (less than 24 days)	0
Pain and cramping during periods	0
Scanty blood flow	0
Heavy blood flow	0
Breast pain and swelling during menses	0
Pelvic pain during menses	0
Irritable and depressed during menses	0
Acne	0
Facial hair growth	0
Hair loss/thinning	0

Category XXI (*Menopausal Females Only*)

How many years have you been menopausal?	0
Since menopause, do you ever have uterine bleeding?	0
Hot flashes	0
Mental fogginess	0
Disinterest in sex	0
Mood swings	0
Depression	0
Painful intercourse	0
Shrinking breasts	0
Facial hair growth	0
Acne	0
Increased vaginal pain, dryness, or itching	0

PART III

How many alcoholic beverages do you consume per week?
How many caffeinated beverages do you consume per day?
How many times do you eat out per week?
How many times do you eat raw nuts or seeds per week?
List the three worst foods you eat during the average week:
List the three healthiest foods you eat during the average week:

Rate your stress level on a scale of 1-10 during the average week: 1
How many times do you eat fish per week?

PART IV

Please list any mediations you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Female Health History Questionnaire

Name: Age: Today's date:

Birth Date: Weight: Height: Occupation:

1. What is the reason for this visit?

2. List medications you are currently taking:

3. Any known drug allergies?

4. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.):

6. Date of last pelvic/gynecological exam: Last Pap Test: Last mammogram:

7. Last thermography? Unusual results?

8. List significant non-GYN health issues (diabetes, surgeries, etc.):

Lifestyle Indicators **< = less than** **> = greater than**

1. Do you use any of the following?
   - ☐ Alcohol **None** if stopped recently, when?
   - ☐ Coffee **None** if stopped recently, when?
   - ☐ Soda **None** if stopped recently, when?
   - ☐ Sweets/refined carbs **None** if stopped recently, when?

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? **No** Amount

3. How would you rate your stress level? (1=Low, 10=Extreme) **1**

4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1

5. How often do you exercise? **never**

INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.

Signs & Symptoms	Ongoing	Just w/ Period	Mild	Moderate	Severe	More Information
Mood swings	☐	☐	☐	☐	☐	
☐Anxiety ☐Nervousness ☐Irritable	☐	☐	☐	☐	☐	
☐ Overly reactive ☐Short fuse ☐Anger	☐	☐	☐	☐	☐	
☐Low mood ☐Depression	☐	☐	☐	☐	☐	
☐Low blood sugar ☐High blood sugar	☐	☐	☐	☐	☐	
☐Lowered self-esteem ☐self-image	☐	☐	☐	☐	☐	
Care for others before yourself	☐	☐	☐	☐	☐	
☐Sadness ☐Crying	☐	☐	☐	☐	☐	
Trouble concentrating	☐	☐	☐	☐	☐	
Memory difficulties	☐	☐	☐	☐	☐	
☐Fatigue ☐Anemia	☐	☐	☐	☐	☐	
☐Increased appetite ☐Constant hunger	☐	☐	☐	☐	☐	
☐Sweet cravings ☐Carbs ☐Chocolate	☐	☐	☐	☐	☐	
☐Caffeine ☐Stimulant cravings	☐	☐	☐	☐	☐	
Salt cravings	☐	☐	☐	☐	☐	
☐Headaches ☐Migraines	☐	☐	☐	☐	☐	
☐Muscle pain ☐Joint Aches ☐Backache	☐	☐	☐	☐	☐	
☐Weight gain ☐Trouble losing weight	☐	☐	☐	☐	☐	
Weight loss	☐	☐	☐	☐	☐	
Water retention	☐	☐	☐	☐	☐	
☐Bloating ☐Belching ☐Gas	☐	☐	☐	☐	☐	
☐Stomach burning ☐Nausea ☐Indigestion	☐	☐	☐	☐	☐	
Constipation	☐	☐	☐	☐	☐	
Light colored stool	☐	☐	☐	☐	☐	
☐Loose stool ☐Diarrhea ☐IBS	☐	☐	☐	☐	☐	
☐Acne ☐Rashes ☐Brown spots	☐	☐	☐	☐	☐	
☐Excessive facial hair ☐Body Hair	☐	☐	☐	☐	☐	
☐Body hair loss ☐Head hair loss	☐	☐	☐	☐	☐	
Infertility	☐	☐	☐	☐	☐	
☐Lowered libido ☐Heightened libido	☐	☐	☐	☐	☐	
☐Hot flashes ☐Night sweats	☐	☐	☐	☐	☐	
Palpitations	☐	☐	☐	☐	☐	
☐Breast tenderness ☐Breast cysts	☐	☐	☐	☐	☐	
Nipple discharge	☐	☐	☐	☐	☐	
☐Vaginal infections ☐Yeast infections	☐	☐	☐	☐	☐	
☐ Urinary Frequency ☐Incontinence ☐Infections	☐	☐	☐	☐	☐	
☐ Dry eyes ☐Dry skin ☐Overall dryness	☐	☐	☐	☐	☐	
☐Changes to labia ☐Clitoral tissue ☐atrophy ☐thinning ☐discoloration ☐itching ☐burning	☐	☐	☐	☐	☐	
Vaginal changes: ☐Dryness ☐tearing ☐decreasing size	☐	☐	☐	☐	☐	
Any other symptoms?						

Reproductive Health History *(please fill in or select the appropriate answer)*

1. Age at onset of menarche (first period): Approximate date of onset:

2. Are you currently using a method of birth control? **No**
   If yes, what method?

3. Are you, or have you used: ☐oral ☐injected ☐patch ☐ring hormone contraceptives?
   Or used Emergency Contraception (aka "the day after" pill)? **No**
   When and for how long?
4. Are you, or have you used an IUD? **No** If yes, when and for how long?
   What type of IUD did you use? ☐copper ☐hormone ☐other

5. Please describe problems that you may have experienced associated with the use of any and all birth control methods: *(such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)*

6. Have you used, or are currently using fertility or treatment? **No**
   If yes, please explain:

7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? **No** If yes, what hormone(s), dosage, and for how long? (Specify dates of use)

8. Have you been pregnant before? **No** Age(s) of children:
   Number of pregnancies: Details/Complications:
   Number of live births: Details/Complications:
   Miscarriages: Details/Complications:
   Premature births: Details/Complications:
   Cesarean births: Details/Complications:
   Stillbirths: Details/Complications:
   Abortions: Details/Complications:
   Ectopic pregnancies: Details/Complications:

9. If you have had a miscarriage, how many weeks pregnant were you?

10. Have you had an abnormal Pap test? **No** Details/Reason:
    Treatment and/or medication:

11. Have you had a vaginal infection? **No** If yes, what?
    Treatment and/or medication:

12. Any history of… Ovarian cysts? **No** Uterine fibroids? **No**
    Fibrocystic breasts? **No** Endometriosis? **No**
    Polycystic Ovarian Syndrome (PCOS)? **No** Lichen Sclerosis? **No**
    Vulvodynia? **No**

For Cycling-Age Women *(please fill in or select the appropriate answer)*

1. First day of last menstrual period (LMP): Have you had a tubal ligation? **No** When?
2. Has there been any recent change in your cycle or symptoms associated with your cycle? **No**
   If yes, please give details:
3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)
   < 20 20-30 30-40 40-50 >50
4. How many days does menstruation typically last?
5. Is your cycle regular? **No** Details:
6. Typical menstrual flow: **Light** Details:
7. How many ☐pads and/or ☐tampons are used on heavy days?
8. Do you pass clots? **No** How often?
9. Do you spot? **No** At what point in your cycle?
10. Do you experience cramping? **None**
    At what point in your cycle?
11. Do you experience abnormal vaginal discharge? **No** If yes, when?
12. Do you experience vaginal itching and/or odor? **No** If yes, when?
13. Do you experience breast tenderness? None
    At what point in your cycle? Change in breast size? **No**
14. Do you experience nipple discharge? **No** If yes, when? Color?

For Menopausal Women *(please fill in or select the appropriate answer)*

1. Your age at the onset of menopause: Year of onset:
2. Have you had a hysterectomy? **No** Complete? (ovaries AND uterus) **No** Partial (uterus only) **No**
3. Date of hysterectomy? Reason for hysterectomy:
4. List any other GYN related surgeries:
5. Describe your experience transitioning into menopause: (symptoms, strong emotions, thoughts, unusual stressors, etc.)

For Menopausal Women, continued *(please fill in or select the appropriate answer)*

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? **No**
   If yes, what were you prescribed?
   What dosage? For how long?

7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? **No**
   If yes, what were you prescribed?
   What dosage? For how long?

8. Have you utilized any alternative, complementary, or natural remedies in your management or menopause? **No**
   If yes, what?
   For how long?

9. Have you had, or do you have any vaginal spotting or bleeding since menopause? **No**
   If yes, when? Were you evaluated and/or treated by a GYN? **No**
   Treatment:

10. How would you have described your menstruation? **Easy**

11. What was your typical menstrual flow? **Light**

12. When you were cycling would you consider your cycle regular? **No**
    If no, explain:

Please describe any 'treatment' ever received for cycle issues:

Sleep Habits

1. How do you sleep? **Trouble staying asleep**
   How long has this been happening?

2. How many hours do you sleep a night on average?

3. Do night sweats wake you up? **No** How often?

4. Do you wake up tired? **No** How long has this been happening?

5. Is your room completely dark when you sleep at night? *(no night light, streetlamp, TV, etc.)* **No**

6. Do you get at least 30 minutes of outside daylight time, several days each week? **No**

Consent for Purposes of Treatment, Payment and Healthcare Operations

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

I consent to the use or disclosure of my protected health information by Center for Chiropractic & Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Center for Chiropractic & Wellness. I understand that Dr. Jennifer Greenfield, Dr. Kira Cervenka, and Sarah Steed, L. Ac. and Kathy Wilson, L.M.B.T. may refuse to diagnose or treat me if I do not consent to the disclosure of my protected health information for the purposes stated above. (My signature on this document is evidence of this consent).

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. Center for Chiropractic & Wellness is not required to agree to the restrictions that I may request. However, if Center for Chiropractic & Wellness agrees to a restriction that I request, the restriction is binding on Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, and Sarah Steed, L. Ac. and Kathy Wilson, L.M.B.T.

I understand I have a right to review Center for Chiropractic & Wellness' Notice of Privacy Practices prior to signing this document. Center for Chiropractic & Wellness' 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 Center for Chiropractic & Wellness. The Notice of Privacy Practices for Center for Chiropractic & Wellness is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Center for Chiropractic & Wellness duties with respect to my protected health information.

Center for Chiropractic & Wellness reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Center for Chiropractic & Wellness office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing at any time, except to the extent that Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, and Sarah Steed, L. Ac. and Kathy Wilson, L.M.B.T. have taken action in reliance on this consent.

Signature of Patient or Personal Representative Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Center for Chiropractic & Wellness

Patient Missed Appointment Policy

Definitions:

Policy-a method or course of action designed to influence and determine decisions/a guiding principle or procedure.

Appointment-a meeting with someone at a certain time or place

Missed-fail to keep, do, or be present at

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results.

If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all of your scheduled appointments. Arrange the activities in your life so that this can occur.
2. If you become ill, we still want you to come in, because your treatment will help you recover.
3. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment.
4. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change the appointment.
5. All canceled or missed appointments must be rescheduled and made up within 1 week.
6. Service charges for missing an appointment are as follows:

Dr. Jennifer Greenfield: Functional Medicine/NET
15 Minute Appt. $30.00
Sarah Steed, L.Ac.
Acupuncture Initial Consult $25
1 Hour Treatments $40
Dr. Jennifer Greenfield, Dr. Kira Cervenka
15 min. Chiropractic Appointment $40
30 min. Chiropractic Appointment $60
Kathy Wilson L.M.B.T
1 Hour Massage $40
Ion Cleanse:
Cleanse Treatment $25

**** Patients with packages will have one treatment deducted from their package for each 15-minute time slot.**

* Note: Confirmation calls are made the day before each patient's appointment. These calls are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a call does NOT validate a missed appointment.

I have read and understand the above policy.

Patient's Name: Signature:

Doctor's Signature:

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

(Concent to use PHI) Notice of Privacy Practices – Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Center for Chiropractic & Wellness or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature Date

Print Patient's Full Name Time

Witness Signature Date