Florida Integrative Medical Center

2415 University Parkway Suite 218, Sarasota FL 34243 Tel: 941-955-6220 Fax: 941-955-1410

Patient Information – Form must be updated annually

Welcome To Our Office

Date: ______________________________

Name: ______________________________ D.O.B.:________/________/__________

Mailing Address: ______________________________ Apt #: ______________________________

City, State: ______________________________ Zip: ________ Home Phone: ______________________

Email: ______________________________ Cell Phone: ______________________________

Sex: M / F Marital Status: ______________________

Employer's Name: ______________________________

Employer's Phone No.: ______________________________ Occupation: ______________________________

Spouse's Name: ______________________________ Spouse's Employer: ______________________________

Emergency Contact: ______________________________ Phone #: ______________________________

Do you have a living will?________________ Allergies? ______________________________

How did you hear about us? ______________________________

If a referral, please share who referred you to our office: ______________________________

Insurance Information:

Name of Insurance Company: ______________________________

City, State, & Zip: ______________________________ Phone No.: ______________________________

Name on Policy: ______________________________ Policy Number: ______________________________

Please sign that you have received a copy of the notice of Privacy Practices

______________________________ ______________________________

Signature Date

AUTHORIZATION:

"I authorize the release of any medical information needed to process necessary medical claims and authorize payment to the physician rendering service. I understand that I am financially responsible for all charges not covered or unpaid by insurance or other sources, unless otherwise arranges or agreed upon prior to time of treatment."

______________________________ ______________________________

Signature Date

Date: ______________ Allergy(ies): ____

PATIENT INTAKE & HEALTH HISTORY

- Please complete this patient intake and health history as thoroughly as possible.
- The form is used to learn about your unique healthcare needs.
- Print all information and mark anything you don't understand with a question mark.
- Fill out the Medications & Supplements page as complete as possible

When and where did you last receive medical or health care? ______________________________________

____

____

____

What was the reason? ____

____

____

____

What are your most important health problems? List in order of importance.

1. ____

____

2. ____

____

3. ____

____

4. ____

____

5. ____

____

____ ________________________

Signature Date of Birth

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REVIEW OF SYMPTOMS

For each of the following please circle Y, P, or N.
Y = Yes, a condition you have now. P = A condition you have had in the Past. N = Never had.

GENERAL INFORMATION			
WEIGHT			
Weight 1 year ago			
Maximum weight			
When			
Height			
Fatigue	Y	P	N
SKIN			
Rashes	Y	P	N
Eczema	Y	P	N
Hives	Y	P	N
Acne	Y	P	N
Boils	Y	P	N
Itching	Y	P	N
Color Change	Y	P	N
Lumps	Y	P	N
Night Sweats	Y	P	N
HEAD			
Headache	Y	P	N
Head injury	Y	P	N
EYES			
Impaired vision	Y	P	N
Glasses or contacts	Y	P	N
Eye pain	Y	P	N
Tearing or dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
EARS			
Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N
NOSE AND SINUSES			
Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Hay fever	Y	P	N
Sinus problems	Y	P	N
Drainage	Y	P	N

MOUTH AND THROAT			
Frequent sore throat	Y	P	N
Sore tongue	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N
NECK			
Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N
Pain or stiffness	Y	P	N
RESPIRATORY AND BREATHING			
Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Shortness of breath	Y	P	N
" " at night	Y	P	N
" " lying down	Y	P	N
Tuberculosis	Y	P	N
CARDIOVASCULAR (HEART)			
Heart disease	Y	P	N
Angina	Y	P	N
High blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Nose and Sinuses	Y	P	N
Palpitation, flutters	Y	P	N
BLOOD			
Anemia	Y	P	N
Easy bleeding or bruising	Y	P	N

GASTROINTESTINAL (DIGESTION)			
Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Vomiting	Y	P	N
Vomiting blood	Y	P	N
Belching or pass gas	Y	P	N
Jaundice (yellow skin)	Y	P	N
Liver disease	Y	P	N
Gall bladder disease	Y	P	N
Ulcer	Y	P	N
Hemorrhoids	Y	P	N
Bowel Movements:			
How often?			
Is this a change?			
URINARY			
Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N
MUSCULOSKELETAL			
Joint pain or stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasms/cramps	Y	P	N
Weakness	Y	P	N
PERIPHERAL VASCULAR			
Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N
Thrombophlebitis	Y	P	N
EMOTIONAL			
Depression	Y	P	N
Mood swings	Y	P	N
Anxiety/nervousness	Y	P	N
Tension	Y	P	N

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REVIEW OF SYMPTOMS - continued

For each of the following please circle Y, P, or N.
Y = Yes, a condition you have now. P = A condition you have had in the Past. N = Never had.

FEMALE REPRODUCTION			
Age menses began			
Average # of days			
Length of cycle			
Bled between periods	Y	P	N
Are cycles regular	Y	P	N
Pain during intercourse	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
Birth control	Y	P	N
What type?			
# of pregnancies			
# of live births			
# of miscarriages			
#of abortions			
Difficulty conceiving	Y	P	N
Menopausal symptoms	Y	P	N
Are you sexually active	Y	P	N
Sexual difficulties	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N

BREASTS			
Do you self exam	Y	P	N
Lumps	Y	P	N
Pain (or tenderness)	Y	P	N
Nipple discharge	Y	P	N
MALE REPRODUCTIVE			
Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Are you sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate disease	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N

NEUROLOGICAL (NERVOUS SYSTEM)			
Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness or tingling	Y	P	N
Loss of memory	Y	P	N
ENDOCRINE			
Hypothyroid	Y	P	N
Heat/cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N

NOTES: ______________________________

Question	Y	N
Do you eat three meals daily?	Y	N
Awaken rested?	Y	N
Sleep well?	Y	N
Average 6-8 hours sleep?	Y	N
Enjoy your work?	Y	N
Spend time outside? If so, how often?	Y	N
Watch television?	Y	N
How many hours a day?		
Read?	Y	N
How many hours a day?		
Been treated for drug dependence? If so, please explain what?	Y	N
Use recreational drugs? If so, how often?	Y	N

Question	Y	N
Use alcoholic beverages? If so how often.	Y	N
Been treated for alcoholism? If so, when?	Y	N
Use Tobacco? If so, how often? How many per day? How long?	Y	N
Do you exercise? If so, what type of exercise? How often? Minutes per day? Days per week?	Y	N
Do you have any interests or hobbies? If so, what are they?	Y	N

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ALLERGIES

Please list foods, drugs, or other allergens: ______________________________

____

FAMILY HISTORY

Check Those That Are Applicable	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if lliving)						
Health G=Good P=Poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hayfever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						

For The Following Sections, Please Circle: Y = Yes Or N = No

CHILDHOOD ILLNESSES HISTORY

Scarlet Fever	Y	N
Mumps	Y	N
Diptheria	Y	N
Measles	Y	N
Pheumatic Fever	Y	N
German Measles	Y	N
Other:		

IMMUNIZATION HISTORY

Polio	Y	N
Tetanus (not antitoxin)	Y	N
Diptheria	Y	N
Measles	Y	N
Pertussis	Y	N
Diptheria	Y	N
Other:		

HOSPITALIZATION AND SURGERY

Please list hospitalizations and surgeries you have had: ______________________________

____

____

X-RAYS AND SPECIAL STUDIES

X-rays, CAT scans, or MRI.'s you have had: ______________________________

____

____

Electrocardiogram (EKG) Yes No   Electroencephalogram (EEG) Yes No

______________________________ ______________________________

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MEDICATIONS & SUPPLEMENTS

Please List All Of The Following:

- Prescription Medications
- Over The Counter Medications
- Vitamins & Minerals
- Herbs
- All Other Supplements

Please provide ***Name of Prescription or Supplement, the Dose, How Often*** you take it, ***How Long*** you have been taking it, and ***Who Started*** you on it (a doctor or yourself).

MEDICATIONS & SUPPLEMENTS

Name of Prescription or Supplement	Dose	How often	How Long	Who Started
Example - Vitamin C	500mg	1 x day	1 year	(Dr. or Self)

* If more space is needed, please add more information on the back of this sheet.

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METABOLIC ASSESSMENT FORM

Name: ______________________ Age: ________ Sex: ________ Date: ______________

Please answer to the best of your ability each question.

Check the appropriate number "0 - 3" on all questions below. **"0" as the least/never to "3" as the most/always**

CATEGORY I	0	1	2	3
Feeling that bowels do not empty completely				
Lower abdonimal pain relief by passing stool or gas				
Alternating constipation and diarrhea				
Diarrhea				
Constipation				
Hard dry or small stool				
Coated tongue of "fuzzy" debris on tongue				
Pass large amount of foul smelling gas				
More than 3 bowel movements daily				
Do you use laxatives frequently				
CATEGORY II				
Excessive belching burping or bloating				
Gas imeediately following a meal				
Offensive breath				
Difficult bowel movements				
Sense of fullness during and after meals				
Difficulty digesting fruits and vegetables				
Undigested foods found in stools				
CATEGORY III				
Stomach pain, burning or aching 1-4 hrs after eating				
Do you frequently use antacids				
Feeling hungry an hour or two after eating				
Heartburn when lying down or bending forward				
Temporary relieve from antacids, food, milk or carbonated beverages				
Digestive problems subside with rest and relaxation				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine				
CATEGORY IV				
Roughage and fiber causes constipation				
Indigestion and fullness lasts 2- 4 hrs after eating				
Pain, tenderness, soreness on left side under rib cage bloated				
Excessive passage of gas				
Nausea and/or vomiting				
Stool undigested, foul smelling, mucous-like, greasy or poorly formed				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				

CATEGORY V	0	1	2	3
Greasy or high fat food cause distress				
Lower bowel gas and or bloating 1-4 hrs after eating				
Bitter metallic taste in mouth, especially in the AM				
Unexplained itchy skin				
Yellowish cast to eyes				
Stool color alternates for clay colored to brown				
Reddened skin, especially palms				
Dry or flaky skin and/or hair				
History of gallbladder attacks ro stones				
Have you had your gallbladder removed				
CATEGORY VI				
Crave sweets during the day				
Irritable if meals are missed				
Depend on coffee to keep yourself going or started				
Get lightheaded if meals are missed				
Eating relieves fatigue				
Feeling shaky, jittery, tremors				
Agitated, easily upset, nervous				
Poor memory, forgetful				
Blurred vision				
CATEGORY VII				
Fatigue after meals				
Carve sweets furing th day				
Eating sweets does not relieve cravings for sugar				
Must have sweets after meals				
Waist firth is equal or larger than hip girth				
Frequent urination				
Increased thirst & appetite				
Difficulty losing weight				
CATEGORY VIII				
Cannot stay asleep				
Crave salt				
Slow starter in the morning				
Afternoon fatigue				
Dizziness when standing up quickly				
Afternoon headaches				
Headaches with exertion or stress				
Weak nails				

Signature ______________________ Date of Birth ______________________

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PATIENT INFORMATION
ATHLETIX RX – A NEW HOLISTIC MEDICAL DIVISION
"Our Programs are Designed for Athletes in All Arenas"

NAME_________________________

DATE ______________ **ALLERGIES**___________________________________

PATIENT INTAKE AND INJURY HEALTH HISTORY

Please complete this patient ATHLETIX RX intake and injury health history as thoroughly as possible.

This form is used to learn about your unique ATHLETIX RX needs

1. **Athletix RX Patient Occupation** _________________________________.
2. **What is your Athletix Arena? (please describe your classification) for example, Sport=Baseball,**

   Sport ______________, **Dance** ___________________, **Fitness** ____________________, **Yoga** ___________________, **Everyday Activities** _______________________, **Other** _________________________ .
3. **What is your level of play in your Athletix Arena? Professional ____, College____, High School____, Recreational____, Everyday Activities ____.**
4. **Do you experience: pain ____, stiffness____, weakness____, (if yes: in your joints____, muscles____,) early in day____, during day____, end of day____, all the time_____.**
5. **Are you maximizing your Athletix performance potential to your peak? Yes ____, No ____, Not sure____.**
6. **What are your most important injury/performance problems? Please list in order of importance.**
   1. ____
   2. ____
   3. ____
   4. ____
   5. ____

Signature _______________________________ **Date of Birth** ___________________

METABOLIC ASSESSMENT FORM - CONTINUED

Check the appropriate number "0 - 3" on all questions below. **"0" as the least/never to "3" as the most/always**

CATEGORY IX	**0**	**1**	**2**	**3**
Cannot fall asleep				
Perspire easily				
Under high amounts of stress				
Weight gain when under stress				
Wake up tired even after 6 or more hrs of sleep				
Excessive perspiration or with little or no activity				
CATEGORY X				
Tired, sluggish				
Feel cold - hands, feet, all over				
Require excessive amounts of sleep to function				
Increase in weight gain even with low-calorie diet				
Gain weight easily				
Difficult, infrequent bowel movements				
Depression, lack of motivation				
Morning headaches that wear off as the day goes on				
Outer third of eyebrows thins				
Thinning of hair on scalp, face and genitals or excessive falling hair				
Dryness of skin and/or scalp				
Mental sluggishness				
CATEGORY XI				
Heart palpations				
Inward trembling				
Increased pulse even at rest				
Nervousness and emotional				
Insomnia				
Night sweats				
Difficulty gaining weight				
CATEGORY XII				
Diminsihed sex drive				
Mentrual disorders or lack of menstration				
Increased ability to eat sugars without symptoms				
CATEGORY XIII				
Increased sex drive				
Tolerance to sugars reduced				
"Splitting" type headaches				
CATEGORY XIV (MALES ONLY)				
Urination difficulty or dribbling				
Urination frequent				
Pain inside of legs or heels				
Feeling of incomplete bowel evacuation				
Leg nervousness at night				

CATEGORY XV (MALES ONLY)	**0**	**1**	**2**	**3**
Decrease in libido				
Decrease in spontaneous morning erections				
Decrease in fullness of erections				
Difficulty in maintaining morning erections				
Spells of mental fatigue				
Inability to concentrate				
Episodes of depression				
Muscle soreness				
Decrease in physical stamina				
Unexplained weight gain				
Increase in fat distribution around chest and hips				
Sweating attacks				
More emotional then in the past				
CATEGORY XVI (MENSTRUATING FEMALES ONLY)	**0**	**1**	**2**	**3**
Are you a menapausal	Y		N	
Alternating menstrual cycle lengths	Y		N	
Extended mentrual cycle, greater than 32 days	Y		N	
Shortened menses, less than every 24 days	Y		N	
Pain and cramping during periods				
Scanty blood flow				
Heavy blood flow				
Breast pain and swelling during menses				
Pelvic pain during menses				
Irritable and drepressed during menses				
Acne break out				
Facial hair growth				
Hair loss/thinning				
CATEGORY XVII (MENOPAUSAL FEMALES ONLY)	**0**	**1**	**2**	**3**
How many years have you been menopausal				
Do you ever have uterine bleeding since menopause	Y		N	
Hot flashes				
Mental fogginess				
Disinterest in sex				
Mood swings				
Depression				
Painful intercourse				
Shrinking breasts				
Facial hair growth				
Acne				
Increased vaginal pain, dryness or itching				
Other:				

Signature ____________________ Date of Birth ____________________

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NOTICE OF PRIVACY PRACTICES

Effective date: 08-01-06

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218, Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410.

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional: Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Optional: Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Optional: Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Optional: Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,

• Notifying a person regarding potential exposure to a communicable disease,
• Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
• Reporting reactions to drugs or problems with products or devices,
• Notifying individuals if a product or device they may be using has been recalled,
• Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
• Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

• Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
• Concerning a death we believe has resulted from criminal conduct,
• Regarding criminal conduct at our offices,
•In response to a warrant, summons, court order, subpoena or similar legal process,
•To identify/locate a suspect, material witness, fugitive or missing person,
•In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Optional: Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Optional: Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Optional: Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218 Sarasota, Fl 34243, Tel: 941-955-6220 Fax: 941-955-1410 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. 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 Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218, Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410.Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. In order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218 Sarasota, FL 34243, Tel:941-955-6220 Fax: 941-955-1410. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists 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.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway, Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 941-955-1410. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: We are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Dr John Monhollon, Florida Integrative Medical Center, 2415 University Parkway Suite 218 Sarasota, FL 34243, Tel: 941-955-6220 Fax: 7941-955-1410. Large Print Copies of this Notice are available on request.

I have received and understand the Notice of Privacy Practices

Signature of patient or person acting on patient's behalf ____________ Date ____________

Signature ____________ Date of Birth ____________