**The Farm: Wellness Club & MedSpa, LLC**

**Practice Policies & Consents**

**The Farm: Wellness Club & MedSpa, LLC Clinical Policies**

*PATIENT CONSENT FOR HORMONE THERAPY & WEIGHT LOSS TREATMENT*

**If you have any questions, please feel free to ask us. Please initial each point acknowledging you understand the following:**

\_\_\_\_\_\_\_ If you are consistently late or miss your appointment, you may be subject to a $25 fee.

\_\_\_\_\_\_\_\_Services must be paid for at the time of service.

\_\_\_\_\_\_\_\_Health insurance typically does not cover services provided at The Farm: Wellness Club & MedSpa, LLC. The practice will not be completing itemized invoices for superbills with insurance at this time – you will be notified should this policy change.

\_\_\_\_\_\_\_\_Testosterone and Phentermine are considered a controlled substance. I agree that I will take my medications as prescribed. I agree to follow my medical provider’s instructions. I also agree that I will not sell or share my prescriptions with other individuals.

\_\_\_\_\_\_\_\_I understand that treatments used at The Farm: Wellness Club & MedSpa, LLC might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment. At the core, we focus on providing service to those who are interested in keeping the youth and preserving the youth.

\_\_\_\_\_\_\_ I agree that if I am having any side effects or become sick, the best recommendation is to follow up with my primary care provider or go to an urgent care or emergency department, as appropriate.

\_\_\_\_\_\_\_\_I acknowledge that The Farm: Wellness Club & MedSpa, LLC and Robyn Farmer, APRN-CNP are not my primary care provider unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at The Farm: Wellness Club & MedSpa, LLC.

\_\_\_\_\_\_\_\_I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.

\_\_\_\_\_\_\_\_I understand that having an appointment with The Farm: Wellness Club & MedSpa, LLC does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical provider’s discretion to issue a prescription.

\_\_\_\_\_\_\_\_I understand that I must maintain my follow up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that Robyn Farmer, APRN-CNP manages my treatment, and it is at their discretion to provide such.

\_\_\_\_\_\_\_\_I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, side effects, and complications of treatment.

\_\_\_\_\_\_\_\_I am voluntarily requesting treatment with The Farm: Wellness Club & MedSpa, LLC and Robyn Farmer, APRN-CNP in regards to hormone and/or weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone and pertinent lab levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

\_\_\_\_\_\_\_\_I do not hold any medical practitioner of The Farm: Wellness Club & MedSpa, LLC responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold The Farm: Wellness Club & MedSpa, LLC and Robyn Farmer, APRN-CNP harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to The Farm: Wellness Club & MedSpa, LLC as this could change the treatment prescribed to me.

**I have read, understand and agree to all of the above statements.**

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Privacy Policy**

**OUR LEGAL RESPONSIBILITIES**We are required by law to give you this notice. It provides you with how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact The Farm: Wellness Club & MedSpa, LLC at thefarmwellspa@yahoo.com at any time to request a copy of this privacy policy.

**HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

**Treatment:** We may use and disclose your protected health information to provide your treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

**Payment:** Your protected health information may also be used to obtain payment from an insurance company or another third party. This may include providing an insurance company with your protected health information for pre-authorization, if completed, for a medication we prescribed.

**Health Care Operations:** We may use or disclose your protected health information in order to operate this medical practice.These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract in place that contains terms that will protect the privacy of your protected health information.

We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information @ thefarmwellspa@yahoo.com.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

**Appointment reminders:** We may contact you as a reminder that you have an appointment for your initial visit, follow-up visit, or lab work via text, phone or email.

**Others Involved in Your Health Care:** We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

**Research:** We will not use or disclose your health information for research purposes unless you give us authorization to do so.

**Organ Donation:** If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

**Public Health Risks:** We may disclose your protected health information, if necessary, to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

**Health Oversight Activities:** We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

**Required by Law:** We will disclose protected health information about you when required to do so by local, state, and/or federal law.

**Workman’s compensation**: We may disclose your protected health information to workman’s comp or similar programs.

**Lawsuits:** We may disclose your protected health information in response to a court action, administrative action or a subpoena.

**Law Enforcement**: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

**YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

**Access to medical records**: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

**Amendment:** If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason why it should be amended. If we deny your request, we will provide you with a written explanation. We may deny your request if we believe protected health information is accurate and complete.

**Accounting of Disclosures:** You have the right to receive a list of instances in which we disclose your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this “accounting of disclosures” to the individual listed at the bottom of this policy. After your request has been approved, we will provide you with the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

**Restriction Requests:** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this to be a written request submitted to the individual at the end of this policy.

**Confidential Communication:** You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

**Paper copy of this notice:** You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

**Name of Contact Person:**

Robyn Farmer, APRN-CNP

The Farm: Wellness Club & MedSpa, LLC

Please sign and date indicating you have read and understand your Patient Rights.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamin B-12 helps maintain optimal health and has been shown to be beneficial in helping to reduce fatigue, improve memory, and maintain a healthy body weight. It is what your body uses to help create energy, which is one of the reasons people feel more energized when they take B12.

All medications and supplements have potential side effects, including B12. Most people tolerate B12 without issue, side effects are rare. Potential common B12 side effects include but are not limited to: mild diarrhea, upset stomach, nausea, pain at the injection site, swelling, headache and joint pain.

You acknowledge:

1. That if I begin to have side effects, I will contact The Farm: Wellness Club & MedSpa, LLC/Robyn Farmer, APRN-CNP immediately and notify them of what is happening.

2. I understand that although rare, vitamin B12 injections can result in serious side effects. If these occur, you should follow up with a medical provider or go to the emergency department immediately. Uncommon and dangerous side effects may include the following: rapid heartbeat, chest pain, flushed face, muscle cramps, weakness, difficulty breathing and swallowing, dizziness, confusion, rapid weight gain, feeling of tightness in the chest, hives and rashes, shortness of breath when there is no physical exertion and unusual wheezing and coughing.

3. Before starting vitamin B12 injections I agree to make The Farm: Wellness Club & MedSpa, LLC/Robyn Farmer, APRN-CNP aware if I have any of these conditions: Leber’s Disease, liver disease, kidney disease, iron deficiency, folic acid deficiency, receiving any treatment or taking any medication that has an effect on bone marrow, or drug/supplement allergies.

4. I understand that there could be interactions with B12 and certain medications/supplements.

5. The use of B12 on a weekly to biweekly basis without a documented B12 deficiency is considered off label use and has not been FDA approved for increasing energy levels and weight loss.

5. Caution is advised while taking B12 if you have a sulfa allergy.

By signing below, I acknowledge that I have read the informed consent and agree to the treatment with its associated risks. I hereby give consent for B12 injections. I agree to inform my medical provider immediately if I have any side effects. I hereby release The Farm: Wellness Club & MedSpa, LLC/Robyn Farmer, APRN-CNP and the person injecting the B12 of any damages or liability if anything was to occur.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Farm: Wellness Club & MedSpa, LLC

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation for wellness services with The Farm: Wellness Club & MedSpa, LLC.
2. I understand that the video conferencing technology and/or phone consultations 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 that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.
4. 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 telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will 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.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with Robyn Farmer, APRN-CNP/The Farm: Wellness Club & MedSpa, LLC and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through The Farm: Wellness Club & MedSpa, LLC will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.
8. Telemedicine services offered through The Farm: Wellness Club & MedSpa, LLC is not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care, as appropriate.
9. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

By signing this form, I certify:

* That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
* That I have had the opportunity to ask questions and have had them answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

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**Indemnification Clause**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to indemnify, defend, protect, and hold harmless the medical providers employed by Robyn Farmer, APRN-CNP/The Farm: Wellness Club & MedSpa, LLC; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by Robyn Farmer, APRN-CNP/The Farm: Wellness Club & MedSpa, LLC; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by Robyn Farmer, APRN-CNP/The Farm: Wellness Club & MedSpa, LLC; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by Robyn Farmer, APRN-CNP/The Farm: Wellness Club & MedSpa, LLC. I am aware of the potential side effects associated with hormone replacement therapy and weight loss therapy provided by The Farm: Wellness Club & MedSpa, LLC, accept all the risks involved with injectable therapies, and will not seek indemnification or damages from the indemnified parties.

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_