

# Vitality Integrative Medicine

## Health & Nutrition History

Please complete this questionnaire in preparation for your consultation. Your careful consideration of these questions will provide for more effective use of your scheduled consultation time and will help identify priorities.

**General Information**

Date:

First Name:		Last Name:		Preferred Name	
Date of Birth	Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Genetic Background	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic		<input type="checkbox"/> Asian	
	<input type="checkbox"/> Native American	<input type="checkbox"/> Caucasian		<input type="checkbox"/> Other ( <i>please note</i> )	
	<input type="checkbox"/> Mediterranean	<input type="checkbox"/> Northern European			
Address:		Apt#:	City:		Zip:
Cell Phone				Work Phone	
Home Phone				Fax	
Email					
Best Way to Reach?					
Which method(s) of contact may we use to leave confidential messages?					
Job Title/Employer					
Nature of Business					
Primary Physician				Phone:	
Address					
Referred by					
Emergency contact relationship:					
Emergency contact phone number:					

**Main Health Concerns**

What do you hope to achieve in your visit?

Please list your three main health concerns.

<b>1</b>	
<b>2</b>	
<b>3</b>	

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Notes:

**Allergy Information**

Please list food, drug, supplement or environmental allergies and symptoms that you experience from each.

FOOD allergies		<i>Symptoms:</i>
DRUG allergies		<i>Symptoms:</i>
SUPPLEMENT allergies		<i>Symptoms:</i>
OTHER: allergies		<i>Symptoms:</i>

**Medical History**

*Please check those health conditions that your doctor has diagnosed (provide the date of onset)*

**GASTROINTESTINAL**

**INFLAMMATORY/AUTOIMMUNE**

- Inflammatory Bowel Disease
- Crohn's Disease
- Ulcerative Colitis
- Gastric or Peptic Ulcer Disease
- GERD (reflux/heartburn)
- Celiac Disease
- Hepatitis C or Liver Disease
- Other Digestive:

- Rheumatoid Arthritis
- Lupus SLE
- Poor Immune Function (*frequent infections*)
- Severe Infectious Disease
- Herpes-Genital
- Multiple Chemical Sensitivities
- Gout
- Other:

<input type="checkbox"/> Irritable Bowel Syndrome <p style="text-align: center;"><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Heart Disease (heart attack) <input type="checkbox"/> Stroke <input type="checkbox"/> Elevated Cholesterol <input type="checkbox"/> Irregular heart rate – Pacemaker <input type="checkbox"/> High Blood Pressure    Hyperthyroidism (overactive thyroid) <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) <input type="checkbox"/> Other Heart & Vascular:	<input type="checkbox"/> Chronic Fatigue Syndrome <p style="text-align: center;"><b>METABOLIC/ENDOCRINE</b></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2 <input type="checkbox"/> Metabolic Syndrome (insulin resistance) <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypothyroidism (low thyroid) <input type="checkbox"/> Mitral Valve Prolapse/heart murmur <input type="checkbox"/> <input type="checkbox"/> Other:
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<b>RESPIRATORY</b>	<b>MUSCULOSKELETAL/PAIN</b>
<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea  <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis    Other:	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Other:  <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Migraines

**Medications** (Please list all prescribed medications you are taking, dose and note reason.)

Name:	Dose:	Reason:

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin?     Y     N

Have you had prolonged or regular use of Tylenol?     Y     N

Have you had prolonged or regular use of acid-blocking drugs (Tagamet, Zantac, etc.)?     Y     N

Frequent antibiotics >3 times per year?     Y     N      Long term antibiotics?     Y     N

**Surgeries/Hospitalizations**

Please list any surgeries or hospitalizations (include dates).

*N Medical Symptoms Questionnaire (MSQ)*

**Please check symptoms you CURRENTLY/RECENTLY experience**

ABO Blood Type (if known)	(circle one) <b>O</b> <b>A</b> <b>B</b> <b>AB</b>	Have you ever had a blood transfusion? <b>Y</b> <b>N</b>
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**HEAD**

- Headaches
- Faintness
- Dizziness
- Insomnia

**EYES**

- Watery or itchy eyes
- Swollen, reddened/sticky eyelids
- Bags, dark circles  Blurred or tunnel vision (*does not include near or far-sightedness*)

**EARS**

- Earaches, ear infections
- Drainage from ear
- Ringing /hearing loss

**NOSE**

- Stuffy Nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucous

**MOUTH/THROAT**

- Chronic coughing
- Gagging/throat clearing
- Sore throat, hoarseness
- Swollen/discolored tongue, gums, lips
- Canker sores

**HEART**

- Irregular /skipped beats
- Rapid/pounding beats
- Chest pain

**SKIN**

- Acne
- Hives, rashes, dry skin
- Hair loss
- Flushing, hot flashes
- Excessive sweating

**LUNGS**

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

**DIGESTIVE TRACT**

- Nausea, vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching, passing gas
- Heartburn
- Intestinal/stomach pain

**URINE**

- Painful urination
- Urination at night
- Blood in urine
- Frequent urination
- copious  scanty urine
- Retention of urine or difficulty urinating  Urgent urination
- Incontinence
- Prolapse of bladder or uterus

**JOINTS/MUSCLE**

- Pain or aches in joints
- Arthritis
- Stiffness/limited movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

**WEIGHT**

- Binge eating/drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

**ENERGY/ACTIVITY**

- Fatigue/sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

**IMMUNE SYSTEM**

- Fever/chills
- Frequent colds/flu
- Lymph node swelling (i.e. "swollen glands")
- Frequent illness
- Bone pain

**SEXUAL HISTORY**

- Sexually active Y / N
- Syphilis  Gonorrhea  Chlamydia
- Genital sores/discharge/itch
- HPV
- Herpes (oral/genital)
- Testicular pain/swelling
- Erection issues
- pain w/intercourse

**FEMALE REPRODUCTIVE HISTORY**

- Date of Last menstrual period:
- Spotting
- Irregularity
- PMS (symptoms: \_\_\_\_\_)
- menstrual pain
- menopause
- heavy periods
- scanty periods  early periods
- late periods pale/bright red/dark red blood  blood clots
- # of: pregnancies  births  abortions  living children
- Leukorrhea (vaginal discharge)

**MIND**

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

**EMOTIONS**

- Mood swings
- Anxiety, fear, nervousness
- Anger, irritability, aggressiveness
- Depression

**Family History**

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, liver disease, kidney disease, diabetes, autoimmune disease, mental illness or addiction.*

Mother's Health Conditions:

Father's Health Conditions:

Other Family member:

Health Condition:

Other Family member:

Health Condition:

**Dental History**

Do you have any silver/mercury amalgam fillings?  Y  N If Y, how many?

Do you have any  Tooth extractions  Root canals  Implants  Bridges  Crowns

Do you have any  Tooth pain  Bleeding gums  Gingivitis  Chewing problems

Do you visit a dentist regularly (twice per year)?  Y  N

**Nutrition History**

Do you currently follow a special diet or nutritional program?  Y  N

Please describe:

Please list all **nutritional supplement/herbs** you currently take daily. Please include brand names and dosages (amount per time and times per day). Use a separate page if necessary.


Do you drink alcohol?  Y  N If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages?  Y  N If yes, # daily?

Do you have (or had) any eating disorders?  Y  N If yes, please describe.

**Exercise & Lifestyle**

Please note any physical activities that you engage in regularly along with the intensity, frequency and duration.

ACTIVITY	TYPE/INTENSITY (low-moderate-high)	# DAYS/WEEK	DURATION (minutes)
Cardio/Aerobic	/		
Strength Training	/		
Yoga/Stretching	/		
Sports or Leisure	/		

Note any problems that limit your physical activity:

Do you smoke? <input type="checkbox"/> Y <input type="checkbox"/> N	Packs per day?	How many years?	Other exposure? <input type="checkbox"/> Y <input type="checkbox"/> N
Is there excess stress in your life? <input type="checkbox"/> Y <input type="checkbox"/> N		Do you easily handle stress? <input type="checkbox"/> Y <input type="checkbox"/> N	

Daily Stressors: Rate on a scale of 1 (low) to 10 (high)

Work  Family  Social  Finances  Health  Other: \_\_\_\_\_

Average number of hours you sleep per night <b>during the week?</b> _____ <b>Weekends?</b> _____	Trouble falling asleep? <input type="checkbox"/> Y <input type="checkbox"/> N
	Trouble staying asleep? <input type="checkbox"/> Y <input type="checkbox"/> N

If you wake up during the night, note how many times and the cause: (if known):

Do you feel rested upon waking? <input type="checkbox"/> Y <input type="checkbox"/> N	Other: _____
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**Environmental Information**

Do you have known adverse reactions or environmental sensitivities? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please describe symptoms.
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Are you exposed regularly to any of the following? (check all that apply)

Please note any regular exposure to harmful chemical/substances.

<input type="checkbox"/> Cigarette smoke	<input type="checkbox"/> Perfumes
<input type="checkbox"/> Auto exhaust/fumes	<input type="checkbox"/> Paint fumes
<input type="checkbox"/> Dry-cleaned clothes	<input type="checkbox"/> Mold
<input type="checkbox"/> Nail polish/hair dyes	<input type="checkbox"/> Pesticides
<input type="checkbox"/> Heavy metals	<input type="checkbox"/> Fertilizers
<input type="checkbox"/> Chemicals	<input type="checkbox"/> Pet dander
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Do you use any recreational drugs? If so, please note.

**Readiness Assessment**

Rate on a scale of 5 (very willing) to 1 (not willing) In order to improve your health, how willing are you to:

Significantly modify your diet	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1
Take several nutritional supplements each day	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1
Keep a record of everything you eat each day	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1
Practice a relaxation technique	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1
Engage in regular exercise/physical activity	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1
Have periodic lab tests to assess your progress	<input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1

**Thank you for completing this questionnaire. Please send back to Vitality Integrative Medicine prior to your appointment.**

**Vitality Integrative Medicine**  
**CONSENT FOR TREATMENT**

I hereby authorize Vitality Integrative Medicine and its doctors, clinicians and assistants to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**General Diagnostic Procedures** including but not limited to venipuncture and phlebotomy, pap smears, speculum exams, imaging studies, and blood and urine laboratory analysis, general physical exams, neurological and musculoskeletal assessments)

*Health education and health counseling, therapeutic exercise, breathing and relaxation exercises*

**Minor office procedures** including dressing a wound, ear cleansing

**Herbs/Natural Medicines** includes the prescribing of various therapeutic substance including plant, mineral and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

**Dietary Advice and Therapeutic Nutrition** includes the use of foods, diet plans or nutritional supplements for treatment.

**Therapeutic Administration of Medicines-** includes oral, nasal, auricular, ocular, rectal, vaginal, intramuscular, intradermal, joint, transdermal, subcutaneous or intravenous administration of medicines.

**Soft Tissue and Osseous Manipulation** includes the use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, stretching, resistance, and joint play examination.

**Electromagnetic therapy, Thermal therapy and Hydrotherapy Therapies** includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, and microcurrent stimulation, other forms of electromagnetic energy, hot and cold hydrotherapies, sauna therapy, colon hydrotherapy

**Devices** including durable medical equipment, barrier contraception, and therapeutic devices

**Chinese medicine procedures** including tongue and pulse assessment, treatment with therapeutic insertion of acupuncture needles, cupping, direct and indirect moxa, use of Chinese herbal/animal/mineral medicines

**Potential Risks:** Pain, discomfort, blistering, discolorations and minor bruising, bleeding, infection, burns (from thermal therapies and moxibustion), broken needle, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed medicines; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**Notice to Pregnant Women:** All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Vitality Integrative Medicine or its doctors. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

\_\_\_\_\_  
Guardian/Personal Representative's Name (PRINT)

\_\_\_\_\_  
Patient's Name (PRINT)

\_\_\_\_\_  
Guardian/Personal Representative's Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relationship/Representative's Authority

\_\_\_\_\_  
Date

**Vitality Integrative Medicine  
Patient Payment Policy**

Vitality Integrative Medicine is not contracted with any insurance company. The patient agrees to be responsible for paying the costs associated with any visits or labwork, whether the lab fees are billed by the clinic or by the lab itself. At the patient's request, a superbill may be provided, which the patient can submit to their insurance company for potential reimbursement. No reimbursement is guaranteed, as this is dependent upon the terms of the patient's individual health insurance plan. All fees are to be paid at the time of the visit.

Reviewing labwork and creating a treatment plan (including the prescribing of medications) based on that labwork constitutes a medical consultation/evaluation, and the doctor therefore bills for his/her time in doing so. Please understand that, if you are receiving IV treatment, although the doctor may listen to your medical details while in the IV room with you, the IV treatments are a separate service from medical consultations/evaluations, and they are therefore billed separately.

Vitality Integrative Medicine has instituted a 24 hour cancellation policy, in order to reduce the losses incurred from last-minute cancellations. When the office isn't notified in advance of a change in scheduling, this prevents the doctor from seeing another patient at that time. As the time of the doctor is valuable, and the room and doctor are reserved for one patient at a time, and quite a bit of time is reserved for each patient, the clinic therefore requires patients to notify Vitality Integrative Medicine 24 hours of business days, or more, in advance of any appointment if they are not going to be able to come to their scheduled appointment time. **If the appointment falls on a Monday, 24 hours in advance of business days falls on Friday since the weekend days are not considered business days.** No-shows and last-minute cancellations will be subject to the 24 hour cancellation policy.

In order to secure your appointment time, please supply your credit card information, which will be securely maintained on file, and utilized only in the event of a no-show or cancellation within 24 hours of business days of the appointment time (last minute cancellations), or non-payment of services, in order to pay for the services that have been booked. These no-shows or last minute cancellations will be charged for the full price of the type of visit and/or service that was booked. For IV treatment, as IV formulas must be prepared before the visit, in the case that the IV treatment had already been agreed upon with the patient, the charge will be for the scheduled IV. If no specific IV has been scheduled, the charge will be for the IV drip of least cost, which is \$169 as of June 16th, 2024. Initial consultation is \$350, up to 90 minutes. Extended Initial Consultation is \$500.00 up to 120 minutes. Standard follow-up consults are maximum 45 minutes, \$198. Extended follow-up consults of a maximum of 70 minutes are \$275, or for a maximum of 90 minutes, \$325, with no fractional pricing in between noted prices. Costs for visits of durations beyond those noted here are available. Prices may be updated as needed at future dates after the signing of this form.

Cardholder's name as written on the card: \_\_\_\_\_

Type of card (AMEX, Mastercard, Discover, Visa, Debit etc. are all accepted): \_\_\_\_\_

Card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_

3 digit security code (4 digits for AMEX): \_\_\_\_\_ ; Zip code on the account: \_\_\_\_\_

I, \_\_\_\_\_, consent to the payment policy, and to having my card on file charged as per the policy described above, in the event that Vitality Integrative Medicine is not notified of a change in appointment status of the patient within 24 hours of business days from the scheduled appointment time, or to pay for unpaid services/products received.

Cardholder's signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Guardian/Personal Representative's Name (PRINT)

\_\_\_\_\_  
Patient's Name, if different from that of cardholder (PRINT)

\_\_\_\_\_  
Guardian/Personal Representative's Signature

\_\_\_\_\_  
Patient's Signature, if different from that of cardholder

\_\_\_\_\_  
Relationship/Representative's Authority

\_\_\_\_\_  
Date



**s NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: • Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

Relationship to Patient: \_\_\_\_\_

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

Date: \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:                      Initials:                      Reason:

## NOTICE OF PRIVACY PRACTICES

Updated 5/31/2024

### **THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice tells you about the ways Vitality Integrative Medicine may collect, store, use and disclose your protected health information and your rights concerning your protected health information. “Protected Health Information” is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

**Uses and Disclosures of Your Protected Health Information** We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **Treatment.** We may use and disclose your protected health information to assist your other health care providers in your diagnosis and treatment.
- **Health Care Operations.** We may use and disclose your protected health information in order to perform various operational activities.
- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for you.

#### **Other Permitted or Required Disclosures**

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose your protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners or Funeral Directors.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

#### **Other Uses or Disclosures With an Authorization**

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

## Your Rights Regarding your Protected Health Information

You may have certain rights regarding protected health information that Vitality Integrative Medicine maintains about you.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right to Amend Your Protected Health Information.** If you feel that your protected health information maintained by Vitality Integrative Medicine is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask us to amend information that was not created by Vitality Integrative Medicine, or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

## Health Information Security

Vitality Integrative Medicine requires its employees to follow its security policies and procedures that limit access to health information about patients to those employees who need it to perform their job responsibilities. In addition, Vitality Integrative Medicine maintains physical, administrative and technical security measures to safeguard your protected health information.

## Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

## Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. We support your right to protect the privacy of your protected health information. *We will not retaliate against you or penalize you for filing a complaint.*

## Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Dr. Jeremy Fischer, ND (424-278-4325)

Vitality Integrative Medicine 4849 Van Nuys Blvd #104, Sherman Oaks, CA 91403