Personal Information:			
□ Mr. □ Miss □ Mrs. □ Ms. □ Dr.	First Name:	Mid:	Last Name:
Address:	City:	State:	Zip:
Gender: F M	Birth Date:	Age:	Last 4 of social:
Email:	Mobile Number:		Home Phone:
Occupation:	Employer:	May we contact you by: **Mobile:** □YES □NO **Home:** □YES □NO **Email:** □YES □NO **Mail :** □YES	
Current Weight:	Height:		

Emergency Contacts: *(You must list at least one person)*		
Name:	Relationship:	Number:

Pharmacy Information: *(In case we have to call in a prescription for you)*		
Pharmacy:	Phone #:	Zip Code:

How did you hear about us?
□Newspaper □Drive By □Living Social □Amazon □Groupon □Internet □Doctor Referral □TV □Billboard □ Radio □Door hanger □Grand opening balloon □Friend/Family □Previous location
Who may we thank for referring you?

Women Only:	
Date of Last Menstrual Period:	
Are you pregnant or chance you could be pregnant?	
What are you doing to prevent becoming pregnant?	
Are you menopausal or have you had a hysterectomy?	year

Weight history:	
How old were you when you start gaining weight?	years
Are you aware of any medical reasons for the weight gain?	
How much weight do you want to lose?	pounds
How long do you think it will take to get to your goal weight?	
How many meals/snacks do you eat per day?	
What is your main motivation to lose weight at this time?	□Want to Be Healthier □Event □Other_____
Are you feeling fatigued?	□ Yes □ No

What other programs have you tried?	Results:	Why it didn't work for you?

Have you taken prescription appetite suppressants in the past?
Which medication/what were the results?

There will be NO refunds once services have been performed.

Exercise: (frequency and type)			
	Never		Endurance (walking or jogging, yard work, playing sports, dancing, swimming)
	2-4 times a week		Strength (lifting weights or using a resistance band)
	5-7 times a week		Balance (standing on one foot, heel to toe walking, or tai chi)
	Once a week		Flexibility (yoga)

Major Health Events/Hospitalizations/Surgeries	
Reason/ Diagnosis	Year

Medication/Drug/Food Allergies	
Medication/Food	Reaction

Medical Conditions:					
past	present		past	present	
		Acid Reflux			Heart Disease
		Anemia (low blood count)			Heart Murmur
		Anxiety/Panic Attacks			Hepatitis Type____
		Arthritis			Fibromyalgia
		Asthma			Herpes
		Back Problems			High Blood Pressure
		Binge Eating			High Cholesterol
		Bipolar Disorder			HIV/AIDS
		Blood Disorder			Kidney Disease
		Cancer			Knee/ Leg Problems
		Chemical Dependency			Migraine Headaches
		Congenital Heart Lesion			Obesity
		COPD			Obsessive Compulsive Disorder
		Depression			Osteoporosis
		Diabetes			Polycystic Ovaries (PCOS)
		Eating Disorder (Anorexia/Bulimia)			Prostate Problem
		Epilepsy			Psychiatric Care
		Fatigue			Respiratory Disease
		Fibromyalgia			Sleep Apnea
		Glaucoma			Stroke
		Gout			Thyroid Problem

Please describe any other medical conditions not listed above:

There will be NO refunds once services have been performed.

Family Medical History (*please tell us about your blood relatives*)		
Family Member:	Does any family member listed have any of the following conditions? *(if so please check)*	Age at Death
Father	□ High Cholesterol □ Hypertension □ Heart Disease □ Diabetes □ Obesity	
Mother	□ High Cholesterol □ Hypertension □ Heart Disease □ Diabetes □ Obesity	
Brother(s):_____	□ High Cholesterol □ Hypertension □ Heart Disease □ Diabetes □ Obesity	
Sister(s): _____	□ High Cholesterol □ Hypertension □ Heart Disease □ Diabetes □ Obesity	
Other:	□ High Cholesterol □ Hypertension □ Heart Disease □ Diabetes □ Obesity	

Preventative Care:	
Are you under a doctor's care at the present time? If yes, for what conditions?	□Yes □ No
What is the doctor's name?	Phone number:
What was the date of your last physical/check-up?	

Tobacco Intake:	
Do you use tobacco?	□ cigarettes □ chew □ pipe □ cigars
Daily amount used/for how long?	
OR Year you quit	

Alcohol Intake:	
How many drinks per week?	□ 1-2 □ 3-5 □ 5-10 □ None
What type of alcohol do you usually drink?	

Drug Use:	
Do you use street/recreational drugs?	
What type/how often?	
OR Year you quit	

Caffeine Intake:	
Caffeine intake daily	□ 1-2 cups □ 3-5 cups □ 5-10 cups □ None
What type of caffeine do you drink?	□ coffee □ tea □ soda □ energy drinks

Current Medications/Vitamins/Supplements:		
Name	Dose	Frequency

There will be NO refunds once services have been performed.

Medication History:

For your safety and treatment, please circle ANY and ALL medications you are CURRENTLY taking or have been prescribed in the PAST YEAR (12 months).

	Adderall (dextroamphetamine)		Demerol (meperidine)		Lorcet/Lortab/Norco/ Vicodin (hydrocodone		Rybix/Ryzolt/Ultram/ Ultracet (tramadol)
	Adipex/Suprenza (phentermine)		Dexedrine/ProCentra (dextroamphetamine)		Lunesta (eszopiclone)		Soma (carisoprodol)
	Amrix/Fexmid/Flexeril (cyclobenzaprine)		Didrex (benzphetamine)		Marinol (dronabinol)		Stadol (Butorphanol)
	Ambien/Edular/ Intermezzo (zolpidem)		Dilaudid/Exalgo (hydromorphone)		Neurontin (gabapentin)		Talacen/Talwin (pentazocine)
	Ativan (lorazepam)		Dolophine/Methadose (methadone)		Norflex (orphenadrine)		Tenuate (diethylpropion)
	Avinza/Kadian/MS Contin/Oramorph/ Roxanol (morphine)		Duragesic (fentanyl)		Nucynta (tapentadol)		Toradol (ketorolac)
	Bontril (phendimetrazine)		Endocet/Oxycontin/ Percocet/Percodan/ Roxicet/Roxicodone/ Tylox (oxycodone)		Opana (oxymorphone)		Tranxene (clorazepate)
	Buprenex/Subutex/Suboxone (buprenorphine)		Esgic/Esgic Plus/ Fioricet/Fiorinal (Butalbital)		Restoril (temazepam)		Valium (diazepam)
	Codeine		Halcion (triazolam)		Revia/Vivitrol (Naltrexone)		Versed (midazolam)
	Concerta/Metadate/ Ritalin (methylphenidate)		Klonopin (Clonazepam)		Robaxin (methocarbamol)		Xanax (alprazolam)
	Darvocet/Darvon (propoxyphene)		Librium (chlordiazepoxide)		Rozerem (ramelteon)		

Signed Consents:

Laboratory Consent

The lab testing required by the programs included in the initial visit fee I paid OR may be billed to my insurance only if I have the blood drawn and testing performed at the laboratory named on the laboratory requisition given to me by the clinic. If I go to a different lab of my own choice or have the testing performed at a different facility other than that named on the requisition **I WILL BE RESPONSIBLE FOR ANY AND ALL CHARGES AND FEES ASSOCIATED WITH THOSE LABS.** I understand that payment by my insurance depends upon my individual insurance coverage at the time of service. **I WILL BE RESPONSIBLE FOR PAYMENT OF ANY AND ALL CHARGES NOT COVERED BY MY HEALTHCARE INSURER.** The risk involved in drawing blood from a vein may include, but are not limited to, momentary discomfort at the site of the blood draw, possible bruising, redness, and swelling around the site, bleeding at the site, feeling of lightheadedness when the blood is drawn, and rarely, an infection at the site of the blood draw.

Patient Printed Name _____ Patient Signature _____ Date _____

Photo Consent & Release

It is inspiring for others to see the success of other individuals just like them who have overcome their struggle with losing weight and keeping it off. We hope that you consider allowing us to use your "before" and "after" images demonstrating your success, as an inspiration to others. Please note that we will never use your image for defamatory, obscene or libelous purposes. I hereby authorize you to use "before" and "after" weight loss photos of me per the following:

_____ **External Use:** Including but not limited to printed flyers, brochures, postcards, posters, advertisements, postcards, direct mail, TV commercials, blogs, Facebook & other Social Marketing Pages and websites, etc. I acknowledge that my participation is voluntary and that I will receive no financial compensation. I further agree that my participation in any materials produced by Thinique Medical Weight Loss confers upon me no rights of ownership. I hereby release Thinique Medical Weight Loss, its owners, associates, licensees, franchisees, employees and contractors from liability for any claims by me or any third part in connection with my participation.

_____ **For Internal Use Only:** Photos may only be posted inside the clinics on the "before" and "after" success wall or in a picture in clinic locations. . I acknowledge that my participation is voluntary and that I will receive no financial compensation. I further agree that my participation in any materials produced by Thinique Medical Weight Loss confers upon me no rights of ownership. I hereby release Thinique Medical Weight Loss, its owners, associates, licensees, franchisees, employees and contractors from liability for any claims by me or any third part in connection with my participation.

_____ **No Use:** I do not give permission to have my photos used for any reason, but acknowledge that the clinic will take before and after photos for my private chart only.

Patient Printed Name _____ Patient Signature _____ Date _____

There will be NO refunds once services have been performed.

Non – Compete / Non – Circumvent Agreement

The literature, information, medication, & dietary protocols contained within Thinique Medical Weight Loss program is proprietary information belonging to Thinique Medical Weight Loss. This agreement exists between the undersigned parties. It is hereby agreed that any & all information, whether written, verbal, literature protocols or any other communications are considered proprietary & will not be used in any way without the consent of Thinique Medical Weight Loss. It is further agreed that proprietorship of said information extends to any & all usage in any & all weight loss centers, clinics, or by any other person or entity by the undersigned party or (his/her) associates in the United States. It is further agreed that neither they or their associates or designees will engage in any weight loss, or dietary business using any or all of the aforementioned proprietary information for any reason not contained in a written contract between said party & Thinique Medical Weight Loss.

Patient Printed Name _____ Patient Signature _____ Date _____

HIPAA

It is hereby agreed that any and all information, whether written, verbal, literature, protocols or any other communications are considered proprietary and will not be used in any form or shared with any other persons or entities without the expressed written consent of Thinique Medical Weight Loss. In addition, it is agreed that all patient information is to remain confidential under the guidelines of the Health Insurance Portability Act of 1996.

Patient Printed Name _____ Patient Signature _____ Date _____

Vitamin Consent

I _____, understand that the vitamins and supplements offered by Thinique Medical Weight Loss are not intended as supplements for medical treatment. They are considered to be wellness products. Some supplements are contraindicated for pregnant women and therefore one should not take these products if pregnant. The FDA has not recommended or approved any of these supplements as a treatment for a particular disease, although there is literature supporting the uses of the types of supplements offered. I realize that these products are sold at Thinique Medical Weight Loss as a convenience. There is no obligation that I purchase the supplements.

I have read all the above and understand all features of the above consent.

Patient Printed Name _____ Patient Signature _____ Date _____

B-12 Information and Consent

- B-12 injections are typically used as a treatment for a certain type of anemia (pernicious anemia). In this type of anemia, people lack intrinsic factor in the stomach which is necessary for the absorption of the vitamin.
- Vegetarians (especially vegans) are also given shots of B12 since their diet is low in animal products, the primary source of B12.
- People with chronic fatigue or anemia require monthly injections of vitamin B12 usually because the oral form is not dependable.
- Vitamin B12 shots are most effective when taken at regular intervals. A regular schedule to receive the injections can be customized to each individual.
- The body's ability to absorb vitamin B12 is reduced with increasing age. Older people often have a more potent vitamin B12 deficiency, even in cases where they do not suffer from pernicious anemia.

BENEFITS of B12

- May help increase energy, mental alertness and stamina
- May help boost immune system
- May help increase metabolism
- May help improve mood stabilization
- May helps reduces allergies, stress and depression and improve sleep
- May help lessen frequency and severity of migraines and headaches
- May help lower homocysteine levels in the blood, reducing probability of heart diseases and strokes

POSSIBE SIDE EFFECTS AND CONTRAINDICATIONS OF B12

- A vitamin B12 shot is safe and generally has no side effects.
- Some redness and swelling at the injection site may occur. This should start to get better within forty-eight (48) hours.

There will be NO refunds once services have been performed.

B-12 Information and Consent- Continued

- In rare cases, B12 can cause diarrhea, peripheral vascular thrombosis, itching, transitory exanthema, urticaria, feelings of swelling of the whole body.
- Sensitivity to cobalt and/or cobalamin is a contraindication.
- People with chronic liver and/or kidney dysfunction should not take frequent B12 injections.
- Interactions with drugs: Chloramphenicol can impede on the red blood cell producing properties of B12.
- Other drugs that decrease or reduce absorption of B12: antibiotics, cobalt irradiation, colchicine, colestipol, H2-blockers, metformin, nicotine, birth control pills, potassium chloride, proton pump inhibitors such as Prevacid, Losec, Aciphex, Pantaloc, and Zidovudine.
- B12 is contraindicated in Leber's disease, a hereditary optic nerve atrophic condition.

I have read the information regarding risks and benefits of B12 and/or Lipotropic injections and have had a chance to ask questions on the treatment. I have met with a member of the medical staff and understand that the ingredients in the B-12 and Lipotropic Injections could include any of the following: B1, B2, B3, B5, B6, B12 Cyanocobalamin or Methylcobalamin), Methionine, Inositol, Choline Chloride, Chromium Chloride, Procaine, Lidocaine, or Benzyl Alcohol. I am not allergic to any of the above ingredients and understand that I should not receive the vitamin injection if I am. I understand the possible complications of injection therapy are minor bruising and bleeding at injected sites, dizziness, headaches and possible fainting from the site of blood. I understand clearly that there may be a slight chance for sensitivities and reactions to injection solutions. I hereby release Thinique Medical Weight Loss and its staff, members and associates from all liabilities regarding my treatment associated with B12 and/or Lipotropic injections.

_____ _____ _____

Patient Printed Name Patient Signature Date

Consent To Participate

I have received and reviewed the literature associated with the program and have been given the opportunity to have all of my questions regarding the weight loss program answered. All of the medical/surgical information I have given to the doctors and staff at Thinique Medical Weight Loss is correct and complete to the best of my knowledge. I understand this program includes diet, exercise, behavioral and lifestyle changes, and prescription or non-prescription appetite suppressants, when appropriate. I understand that the abuse or overuse of appetite suppressants is potentially life threatening and illegal. Appetite suppressants are controlled substances that are regulated by State and Federal laws. I understand that it is illegal to obtain appetite suppressants from more than one physician or clinic and I agree I will not obtain any appetite suppressants from other prescribing physicians or have appetite suppressant prescriptions filled from multiple pharmacies. I understand that if I participate in the acquisition of appetite suppressants from multiple healthcare providers for any reason, I am participating in an illegal action and may be held liable for criminal activity. _____ Patient Initials

I understand that medications used in this program may cause or aggravate high blood pressure or alter insulin requirements in diabetics, and that both hypertension and diabetes may improve with weight loss. I understand that, although unusual, there may be adverse reactions to the medications, including rapid heart rate, restlessness, agitation, poor sleeping, dizziness, headaches, blurred vision, psychotic states, dryness of the mouth, constipation/diarrhea, nausea, stomach pains, frequent urination or discomfort urinating or changes in sex drive. I understand that weight loss alone carries some risk, including gall bladder disease. If I should have any other questions about the medications prescribed to me at this office, I will ask the attending provider or staff member for the answer. Subsequent to leaving the office, I will notify the staff immediately if I have further questions. I also know to stop taking the medications IMMEDIATELY and seek IMMEDIATE treatment if any of the following occurs: Decreased exercise tolerance, leg swelling, unexplained shortness of breath, chest pain, blurred vision, or loss of consciousness._____ Patient Initials

There will be NO refunds once services have been performed.

I understand that dietary management and physical exercise are necessary components of this program and must be utilized for optimum results. I have not been given any guarantees or promises regarding the expectations or results for me in this weight loss program. I freely and voluntarily consent to participate and agree to comply with the instructions given._____Patient Initials

Additionally, I will not hold Thinique Medical Weight Loss the company owners, physicians or other providers, franchisees, associates or employees liable for my health and or weight loss. I also confirm that I am under the care of my own primary care physician as well and agree that I will not change dosages or frequency of any medications prescribed and will notify the staff of Thinique Medical Weight Loss of any changes in medications immediately. I also understand that Thinique Medical Weight Loss reserves the right to change my medications at any time as deemed medically necessary, per the staff's discretion._____Patient Initials

WOMEN ONLY: I have been informed that I should NOT get pregnant while on this medication and I confirm that I am NOT pregnant or trying to get pregnant at this time and that if I do not disclose this information to the staff, that the medications I could be prescribed could be harmful or fatal to the fetus. I will not try to get pregnant while taking any prescribed medications prescribed by Thinique Medical Weight Loss and I agree to hold Thinique Medical Weight Loss harmless from any claims or lawsuits if I should get pregnant while taking medications prescribed by Thinique Medical Weight Loss._____Patient Initials

_____ _____ _____

Patient Signature Date WITNESS

Informed Consent and Controlled Substance Agreement

As a patient at Thinique Medical Weight Loss, you have the right to be informed about your condition and the recommended therapy so that you may make an informed decision whether or not to take medications, knowing the risks, benefits, and side effects involved. This disclosure is not intended to alarm or dissuade you from taking one of the prescription appetite suppressants available, but rather to help you make a better informed decision about what the best choice is for you in regard to medications that may be prescribed by the providers at Thinique.

Consent to Treatment and/or Drug Therapy:

I voluntarily request that the providers at Thinique Medical Weight Loss (physician, physician assistant, or nurse practitioner) may, as deemed necessary and advisable, to treat my condition which has been explained to me as: overweight/obesity. I hereby authorize and give my voluntary consent to use appetite suppressants (Phentermine or Phendimetrazine Tartrate) as prescribed as a tool to aid in my weight loss program.
It has been explained to me that these medications are central nervous system stimulants (sympathomimetics) similar to amphetamines, which can be harmful. I further understand that these medications can be addictive and may produce adverse effects. The alternative treatments (such as amino acid appetite suppressants, which are not stimulants), possible risks involved, and possibility of complications have been explained to me as listed below, including, but not limited to:

- Dependency, abuse, and/or withdrawal
- High blood pressure, chest pain, decreased ability to exercise
- Rapid heart rate
- Pulmonary hypertension, trouble breathing
- Insomnia, restlessness, depression, tiredness, and/or agitation
- Headache, dizziness, tremor
- Flushing, sweating, dry mouth
- Blurry vision, dry eyes
- GI symptoms (stomach pain, nausea, constipation, or diarrhea)
- Urinary frequency or painful urination
- (Women Only) Severe birth defects if I become pregnant while taking this type of medication
- (Women Only) Risks to my baby if I breast-feed while taking this medication
- I agree to read the package insert provided with my medication prior to my first dose.

Patient Initials_____NP/PA Initials_____

There will be NO refunds once services have been performed.

Informed Consent and Controlled Substance Agreement

I understand that I must undergo medical testing and examinations (including blood tests and an EKG) before and during my treatment at Thinique. I hereby give my consent to perform such testing. Refusal may lead to termination of treatment and discharge from the program and will not be entitled to any refund or reimbursement of program costs.

I understand that I may discontinue my participation in this weight loss program and discontinue use of these medications at any time.

Patient Initials_____NP/PA Initials_

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. I have been given an opportunity to discuss my condition, treatment, risks, and drug therapy and I believe that I have sufficient information to give this informed consent.

I am aware that certain medications can cause dangerous interactions with the medications I may be prescribed, and I have notified the Thinique provider of any and all prescription and over-the-counter medications I am currently taking. I also agree to notify the Thinique staff of any and all medications prescribed to me by any other provider while participating in the program.

If it is discovered that I am, or have been, receiving medications prescribed by another provider that have not been disclosed to Thinique staff, my participation in the program may be terminated, treatment discontinued, and I will be discharged from the program. I understand that I will not be entitled to any refund or reimbursement of program costs.

Patient Initials_____NP/PA Initials_ _____

This informed consent relates to my use of any controlled substances prescribed by Thinique providers. I understand that there are federal and state laws, regulations, and policies regarding the prescribing and use of controlled substances. There are very specific guidelines that govern the use of controlled substances in the treatment of obesity.

Therefore, controlled substances will only be prescribed so long as I am actively participating in the Thinique Medical Weight Loss program and adhere to the rules specified in this agreement.

Patient Initials_____NP/PA Initials_

The Thinique provider may, at any time, discontinue the prescription at his/her discretion. My progress will be monitored and reviewed and, if I no longer meet the requirements for treatment, I am not progressing with weight loss, if I experience adverse effects or reactions, or I am unable to adhere to the dietary guidelines or prescribed behavior modifications, the medication will be discontinued.

Patient Initials_____NP/PA Initials_____

I agree to use the medications prescribed only as directed. I agree to obtain my prescription only from a Thinique provider, to fill it at the same pharmacy when possible, and that my prescriptions will be refilled on a weekly basis only following a visit to the clinic. No faxed or phoned refill requests will be honored. I hereby give Thinique providers and appropriately authorized staff permission to communicate with any pharmacist regarding my use of controlled substances. I have signed a separate consent if I authorize Thinique providers to communicate with my personal physician.

Patient Initials_____NP/PA Initials_

Thinique providers may try alternative treatments and taper me off the prescribed medications as appropriate and every six months to satisfy the requirements of a mandatory drug holiday. I agree not to hold Thinique Medical Weight Loss providers or staff liable for any problems I may experience due to discontinuance of the controlled substance or problems caused by taking the medications in a manner other than as prescribed.

Patient Initials_____NP/PA Initials_

I fully understand the explanations regarding risks, benefits, and alternatives and I agree to the use of controlled prescription appetite suppressant medications as part of my treatment for overweight/obesity.

Signed_____ Date _____

Medical Provider_____Date _____

There will be NO refunds once services have been performed.

NOTICE OF PRIVACY PRACTICE
Effective Date: April 14, 2003

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

OUR OBLIGATIONS:

We are Required By Law To:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of out notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example: we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in our medical care and need the information to provide you with medical care.

Payment: We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health and Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have another relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services: We may use and disclose Health Information to contact your medical care or payment for your care, such as your family or a close friend. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS: ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissue to facilitate organ, eye or tissue donations, and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers Compensation: we may release Health Information for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks: We may disclose Health Information for public Health activities. These activities generally include disclosures to prevent or control disease, injury, or disability, report births and deaths; report child abuse or neglect, report reactions to medications or problems with products; notify people of recalls of products that they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of State, or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary: 1) for the institution to provide you with health care, 2) to protect your health and safety or health and safety of others, or 3) for the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to See Below.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing to See Below.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to See Below.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or payment for your care, like a family member or friend. For example, you could ask that we not share information about particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to See Below. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical manners in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request, in writing, to See Below. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the office manager. All complaints must be made in writing. You will not be penalized for filing a complaint. office Manager - Carri White info@thiniquekeller.com

Patient Printed Name	Patient Signature	Date

There will be NO refunds once services have been performed.