DR. PATTY POWERS MD

Whole Health Catalysts, P.C.

Dear Patient,

Welcome! And thank you for considering me as one of your health care providers. We at Whole Health Catalysts strive to address the whole person: the physical, the emotional, and the spiritual parts of you.

We've been taught that we just need to find the magic pill, or the one answer that will solve our health dilemmas. I have come to find that simply isn't the case. Instead, I find that health struggles are caused by a combination of the following:

1. Nutritional deficiencies
2. Toxicities (glyphosate, heavy metals, Electromagnetic Radiation, endocrine-disrupting chemicals, solvents, mold)
3. Infections (Lyme and coinfections, parasites, bacteria, oral infections like infected root canals, cavitations and gingivitis)
4. Structural malalignments, sticky fascia and connective tissue
5. The emotional and spiritual contributors (unresolved trauma, unforgiveness, stuck emotions, and more).

By addressing and correcting these areas, you will aid your body and remove the barriers that have been in the way. Unlike just taking a pill, these changes require effort on your part – in the form of diet and lifestyle changes.

You are ultimately in charge of your own health. You will be deciding which labs we order and which treatment plans and modalities you will pursue. I endeavor to guide you through these decisions, answer your questions, teach you how to take care of yourself, and bring new ideas to the table. I typically bring up many unfamiliar ideas and concepts during each appointment - you are welcome to bring someone with you to help remember what we talk about. You may record our sessions if you prefer. I always have a lot of handouts to reinforce what we discuss, and I always encourage note-taking.

I serve as a consultant. I do not offer primary care and I encourage you to maintain your relationship with your primary care practitioner. You are always welcome to copies of your office notes (which are handwritten as I move away from the electronic medical record system), and I make sure you have copies of all your test results. I recommend you consider building a health care team - this might include a chiropractor, an herbalist or naturopath, a massage therapist, an acupuncturist, a homeopath, or others in different specialties. I also recommend you start building a reference library on health care basics, to help you deal with basic medical issues. One of my favorites is Prescription for Natural Cures (Third Edition) by Balch and Stengler, because it includes herbal remedies, homeopathics, and more.

Supplements: I sell a limited number of supplements in the office. If you want something and you are not here for an appointment, you can email or call. We will get the items ready and put them in a bag in the pickup basket in the waiting

room with your name on it. We will tell you in advance the final price, and you can drop off a check or cash (exact change, please), or we can bill you electronically and you can pay online with a 3% processing fee.

New patient documents: Enclosed is a questionnaire I am asking you to fill out and return to me using one of the following methods:

Postal mail: 800A Blue Ridge Ave., Bedford, VA 24523

Fax: (434) 208-2682

Email: drpatriciapowers@gmail.com

You may also drop it off at the office. There is a drop box mounted to the wall outside our entrance.

If you have any medical records or lab reports from the last year or so, or that pertain to the reasons I will be meeting with you, I would appreciate the opportunity to review these several days before our appointment.

Office hours: We are in the office Monday and Thursday, with appointments generally between 9 am and 4 pm.

When we meet: Please bring your supplements with you to your first appointment. I will review your history, do a physical exam, and make recommendations for lab tests that will be appropriate for your specific health issues. Lifestyle and diet changes are key components to your health, and we will arrange for you to have some one-on-one help and guidance with making these changes.

After you have completed your lab tests, I will schedule an appointment with you to review your results and explain what they mean. I will create an individualized therapeutic program for you, which includes medication if needed, diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

Subsequent consults are scheduled to monitor your progress, but intervals vary.

Video and phone visits are available, and you can choose those options in the Practice Better patient portal. I prefer in-person visits, but if you live a distance away, I can see you in person at least once a year and meet virtually in-between. I only offer video and phone visits for Virginia residents; I don't have a license to practice in any other state. If you do reside outside of Virginia, then you must come in person to all of our appointments.

Payment will be due at the end of the appointment, by cash, check, HSA, or credit card. If paying by card, there will be a 3% fee added.

Contact us: I will invite you to join our secure Patient Portal on Practice Better. This portal will allow you to schedule appointments online and message Jenny or me. You may also call, should you have any questions during the course of your treatment.

Emails: I use the Practice better portal for password-protected, HIPAA compliant emails. Please allow 1- 2 days for responses. You are welcome to ask questions via email, but if your questions are complex, I'll ask you to schedule an appointment to discuss issues in detail.

I use **my Face Book page** https://www.facebook.com/pages/Patty-Powers-MD/457560211067399 and my website email newsletters to announce educational events, workshops and group programs. I encourage you to like my page and stay informed, and sign up for my newsletters on **my website** www.drpattypowers.com

Lab results: For LabCorp or Quest tests, you can set up a patient account with LabCorp or Quest to view results. I will email results to you through the Practice Better program so you will have access to them.

I look forward to assisting you in achieving your current health and wellness goals, and to guiding you in maintaining wellness throughout your life.

To health in all areas of your life,

Patty Powers, MD

800A Blue Ridge Ave.
Bedford, VA 24523
434-382-1825; Fax 434-208-2682
drpatriciapowers@gmail.com
jenny@drpattypowers.com

Patricia Powers, MD
Whole Health Catalysts, P.C.
800A Blue Ridge Ave.
Bedford, VA 24523
434-382-1825 fax 434-208-2682

Patient's Name: _____ Today's Date:_____

Date of Birth:_____ Patient's Age_____

Address:_____

City: _____State_____Zip_____

Home Phone_____Work Phone_____Cell_____

Email:_____

I do / do not (please circle your choice) permit Dr. Powers to add me to her newsletter email list. Initials_____

Sex: M F

How did you find out about me?_____

If you are now being treated by another physician or physical or mental health practitioner, please describe each problem and write the name of the physician, health practitioner or medical facility treating you.

Best way to contact you: home phone work phone cell phone

Circle which phone(s) I may leave messages on: home phone work phone cell phone What

are your top 3 medical issues / problems?

What are you hoping I can help you achieve?

To tell the story of your health issues, I want you put together a timeline of your life and health. Get out a sheet of paper and map out in chronologic order everything that you can think of that might impact your health, starting from childhood through now. Include when symptoms started, a brief summary of what tests showed, what happened next, what treatments you tried, how they worked (or not). Many factors can contribute to health issues, including surgeries & anesthesia, hospitalizations, vaccinations, infections, toxin exposures, root canals, emotional and physical trauma, and head injuries. I'm including a link to Dr Izabella Wentz' timeline as an example.
https://thyroidpharmacist.com/wp-content/uploads/2015/11/sample_timeline.pdf

Where you live can also be important, such as living on a farm (pesticides) or having a flooded home or office or school (mold), or home renovation projects (lead, asbestos, mold, VOC's).

Please use more than one sheet of paper if you need to!
Doing this once will serve you well in the future, as you can keep a copy and add to it as needed. It will save you a lot of time when meeting new doctors.

Allergies: Please list all allergies (medications, foods, pollen, animals, etc.) and the reaction(s) to each:

Medications & Supplements

Please list your current medications and supplements, including hormones & over the counter products (attach list if necessary): (and please bring them to your appointments)

Name	Dose	Frequency	Start date (month/year)	Reason for use

Have any of these medications or supplements ever caused unusual side effects? No Yes (describe)

Are you very sensitive to medications or supplements? No Yes

Your early years

Did your mother have any trouble with her pregnancy with you? Yes No Describe:
Were you born at [ ]full term? [ ] premature? If premature, how many weeks gestation? C/section Vaginal delivery Forceps
Were there any problems with delivery? Yes No Describe: Were there any problems in the first week after delivery? Yes No Describe: Did your mother breast-feed you? Yes No
Did you have any health problems in the first year? Yes No Describe:
Did you have any health problems in your preschool years? Yes No Describe:
Did you have any health problems in your school years? Yes No Describe:

Please circle any problems you have had as an adult, or have now :

ADHD	Fibrocystic breasts	IBS	Parasites
Anemia	Food sensitivities	Infertility	Periodontal disease
Anxiety	Gall bladder disease	Jaundice	PCO
Panic attacks	GERD/reflux	Kidney disease	Prostatitis
Arthritis	Headaches	Liver disease	Recurrent infections
Asthma	Heart attack	Lung disease	Seizures
Bipolar	Heart disease	Lyme/tick disease	Thyroid problems
Blood disorder (what?)	Hepatitis	Meningitis	Urinary infections
Cancer (what type?)	High cholesterol	Menstrual irregularities	Uterine fibroids
COVID	HIV/AIDS	Mold illness	Vaginitis
Depression	Hives	Muscle disease	Other:
Diabetes	Hypertension	OCD	
Eczema	Hypoglycemia	Osteopenia	
Endometriosis	Inflammatory bowel disease	Osteoporosis	

Anything not already mentioned?

Dental history: root canal/s No Yes how many?_____ When?_____

Amalgam (silver) fillings No Yes How many?_____

Have you had amalgam fillings removed? No Yes when?_____

Any teeth removed? No Yes Dry socket? No Yes Dental implants? No Yes if so, what kind?_____

Genetics: Have you had any genetic testing? Yes No If so, what did it show?

Injuries: Please list any significant injuries, and the year. Please include broken bones, concussions, car accidents, etc.

Have you had any significant **emotional trauma** in your life?

Have you used any of the following in the past or present, either for regular use or prolonged use?

NSAIDs (Aleve, Advil, Motrin, aspirin)? No Yes, now Yes, in past (If so, for what?)

Tylenol? No Yes, now Yes, in past (if so, for what?)

Acid Blocking Drugs (Tagamet, Zantac, Prilosec, Nexium, etc) No Yes, now Yes, in past

How many times have you been on antibiotics in your life?_____ In the last 2 years?_____

For what?

Steroids (prednisone, nasal allergy inhalers)? No Yes, now Yes, in past (if so, why?)

Hormone replacement therapy? No Yes, now Yes, in past which hormone/s?_____

For Women

Birth Control Methods: current method:
Have you ever used birth control pills? Yes No
Have you ever used an IUD? Yes No If so, what type?
Describe any problems with pills or IUD:

Pregnancies

Have you ever been pregnant? Yes No	How many times have you been pregnant?
Describe any complications with pregnancies/deliveries:	
Did you breastfeed? Yes No	If so, how long?
Number of miscarriages:	
Any medical complications? Yes No	
Number of stillbirths:	Reason(s):
Number of premature births:	Reason(s):
Number of Cesarean sections:	Reason(s):
Number of abortions:	Reason(s):

Hospitalizations/surgeries: List all times (and reasons) you have been hospitalized, operated on, or severely injured.

Date	Hospital admissions, procedures (what & why) for all illnesses, injuries	Doctor & Medical Facility

Immunizations: Up to date Avoid do you get an annual **flu vaccine**? Yes No

COVID vaccines: No Yes **Pfizer Moderna J&J when:**_____

Shingles vaccines: No Yes When_____

HPV vaccines: No Yes When_____

Any problems from immunizations? No Yes Describe:

Lifestyle

Status: Pediatric Single Married Widowed Divorced # children_____

Occupation:_____ Employer_____Yrs Employed_____
Full time Part time

Who is living in household? _____
Do you smoke? Yes No amount/day_____ Did you smoke in the past? Yes No
How many years?_____ When did you quit?_____
Vape? Yes No
Any smokers in the home? Yes No
Pets? Yes _____ No
Have you ever used marijuana? Past user current user no
Do you use chewing tobacco? Yes No
Do you drink alcohol? Yes No How many drinks/week?_____
Do you use recreational drugs? Yes No What kind?_____
How many years?_____

Have you ever been treated for substance abuse? No Yes When?_____

Hobbies:_____

Exercise: How many hours/week on average?_____How many days/week?_____

What types of exercise?_____

How many hours of screen time per day (add up time on computer, TV, video games, phones and other electronic devices)_____

How physically fit do you think you are right now? Unfit Below average Average Above average Very fit

Does exercise: energize you? wear you out? Neither

Sleep: Sleep problems: No Yes (describe)_____

How many hours on an average night?_____ Sleep is: Refreshing? Unrefreshing?

When is your energy best?_____ Worst?_____

How often do you drink caffeinated beverages?_____Do you need the caffeine for energy? Yes No

Stress: How would you rate your current stress level? Low Moderate High
Main sources of stress_____

How do you deal with your stress?_____

EATING PATTERNS

Do you follow any particular eating plan? Vegetarian Vegan Paleo Raw Atkins Mediterranean

Other:_____

Are you gluten free? Yes No Dairy free? Yes No Soy free? Yes No

Organic? Yes No Usually Sometimes

How many days per week do you eat breakfast?_____ at home fast food

What are some typical breakfast meals and beverages? (please be as specific as possible)

Is there a midmorning snack? Yes No If so, what foods/drinks?

For lunch: home-made fast food sit-down restaurant other

What are some typical lunch meals and beverages?

What do you typically eat and drink for afternoon snacks?

What are some typical dinner meals and beverages?

Evening snacks/beverages:

How many meals per week do you eat at fast food restaurants?_____

What kinds of fats & oils do you cook with?

What kinds of fats &n oils do you use at the table?

What kind of salt do you use?

How much of the following beverages do you drink in an average DAY?

Milk_____whole 1% 2% skim flavored Juice/juice drinks_____

Soda_____regular diet Sports drinks_____

Sugar free/flavored waters etc_____ Plain water_____

Sweet tea_____Unsweet tea_____ Coffee_____

Other:_____

Water source at home: City/County Well

How Purified/ Filtered? Fridge filter Brita or similar Distilled Bottled Alkaline

Berkey Reverse Osmosis None

How many servings of fruit in an average day?_____

How many servings of vegetables in an average day?_____

Cravings for any particular or unusual foods or drinks? No Yes If so, what?

Travel history:

Country visited	Year	Any health problems during/afterwards?

Is there any evidence of mold in your home, school, place of work? No Yes Don't know In past

Does your home smell musty? No Yes Any water damage or flooding in your home or work or school? No Yes

What kinds of jobs have you held in the past? (considering chemical or toxicant exposures)

Any implants? (breast, joint, cardiac stents?) No Yes_____

Do you use pesticides (bug killers) in or around the home? No Yes Termite service? No Yes

Do you use Glyphosate (RoundUp) around the yard/garden? No Yes Professional yard care? No Yes

Please mark your current and/or recurrent symptoms

General
□ Fatigue
□ Fever
□ Loss of appetite
□ Increased appetite
□ Unusual weight gain
□ Unusual weight loss
□ Can't gain weight
□ Can't lose weight
□ Frequent dieting
□ Frequent infections
□ Salt cravings
□ Sugar cravings (candy, cookies)
□ Carbohydrate cravings (bread,pasta)

Skin
□ acne
□ Athlete's foot
□ Bumps on back of arms
□ Coarse or brittle hair
□ Dandruff
□ Dark circles under eyes
□ Dry skin
□ Eczema
□ Hair loss
□ Hives
□ Rash
□ Strong body odor
□ Warts

Nails
□ Brittle or fragile nails
□ Ridges
□ Thickened
□ White spots/lines
□ Nail fungus

Eyes/Ears/Mouth
□ Change in vision (other than glasses) □ Double vision
□ Eye redness/conjunctivitis
□ Wears glasses or contacts
□ Hearing loss or problem
□ Frequent ear infections
□ Ringing in ears
□ Vertigo/spinning sensation
□ Frequent nosebleeds
□ Frequent colds
□ Nasal congestion
□ Post-nasal drip
□ Seasonal allergies
□ Sinus infections
□ Bad breath
□ Bleeding gums
□ Periodontal disease
□ Lots of strep throat
□ Hoarseness
□ Frequent canker sores
□ Difficulty swallowing
□ Dry mouth
□ Decreased sense of smell
□ Braces or retainer
□ Lots of cavities
□ Dental problems

Neck
□ Neck mass or lump
□ Swollen glands
□ Goiter/enlarged thyroid
□ Dark color around neck

Respiratory
□ Asthma or wheezing
□ Chronic cough
□ Difficulty breathing with Exercise
□ Snoring
□ Sleep apnea
□ CPAP
□ Frequent pneumonia/bronchitis

Heart/Vessels
□ High blood pressure
□ Low blood pressure
□ Fainting
□ Dizziness on standing up
□ Chest pain
□ Palpitations
□ Heart murmur
□ Varicose veins
□ Heart arrhythmia
□ Swelling of feet or legs
□ Raynaud's

Digestive
□ Abdominal pain
□ Black, tarry stool
□ Bloating
□ Bloody stool
□ Burping
□ Constipation
□ Cramps
□ Diarrhea
□ Alternating diarrhea & constipation
□ Excessive gas
□ Fissures
□ Full after small amounts of food
□ Heartburn/reflux
□ Hemorrhoids
□ Indigestion
□ Intolerance: Lactose
□ Intolerance: All dairy products
□ Intolerance: Wheat
□ Intolerance: Gluten (wheat/barley/rye)
□ Intolerance: corn
□ Intolerance: eggs
□ Intolerance: fatty foods
□ Intolerance: yeast □ Intolerance/other:
□ Irritable bowel syndrome
□ Liver disease/jaundice
□ Abnormal liver tests
□ Nausea
□ Vomiting
Stool frequency_____per day

Endocrine
□ Feel hot a lot
□ feel cold a lot
□ Excessive sweating
□ Decreased sweating
□ Excessive thirst
□ Excessive urination
□ Hypoglycemia
□ Shaky or irritable when hungry
□ Cold hands or feet

Urinary
□ Blood in urine
□ Frequent urination
□ Dysuria/burning urination
□ Kidney stones
□ Leaking/incontinence
□ Urinating at night
□ Urgency (have to go NOW)
□ Recurrent urinary infections

Musculoskeletal
□ Arthritis
□ Back pain
□ Joint pain
□ Joint swelling
□ Muscle cramps
□ Muscle weakness
□ Muscle pain
□ Broken bones
□ Scoliosis
□ TMJ
□ Double or loose-jointed

Nerves/Mood
□ Anxiety
□ Brain fog
□ Clumsiness
□ Depression
Difficulty with
□ concentrating
□ balance
□ thinking
□ judgment
□ speech
□ memory
□ word-finding
□ Fainting
□ Fearfulness/phobias
□ Hallucinations
□ Headaches
□ Migraines
□ Hyperactive
□ Numbness
□ Tingling
□ Ice pick pains
□ Seizures
□ Tremor

Hematology
□ Anemia
□ Easy bruising
□ Prolonged bleeding
□ Excessive bleeding

Lymph Nodes
□ Enlarged nodes
□ Tender nodes

For Women

Menstrual history: How old were you when you had your first period?
If you are still menstruating:
Date of last menstrual period
How many days from start of one period to the next?
How many days does your period last?
Is the flow Heavy? Medium? Light? How many pads or tampons used on heavy days?
For menopausal women: Last menstrual cycle:
Date of last mammogram and findings:
Date of last pelvic exam/Pap smear and findings:

Please circle any that apply to you currently or on an ongoing basis. If you have PMS or PMDD, describe in space to right:

Breast lumps/masses	PMDD
Breast pain/tenderness	Extra face/body hair
Nipple discharge	Cramps before periods
Fibrocystic breasts	Cramps during periods
Irregular periods	Hot flashes
Heavy periods	Night sweats
Scanty periods	Memory problesm
Vaginitis	Decreased sex drive
Vaginal discharge	Vaginal dryness
PMS	Painful intercourse

For Men

Do you have a history of undescended testicles? Yes No

Please circle any of the following symptoms you are having:

Low sex drive	Decreased muscle mass	Prostatic hypertrophy
Erectile dysfunction	Prostatitis	Weak urine stream
Man boobs/gynecomastia	Hot flashes	Nipple discharge

Fee Schedule

Hourly fee: $450.00/hour

Dr. Powers will track how much time (minutes) she spends with each patient and bill accordingly.

Payment is due at time of service by credit, cash, HAS or check payable to Patricia Powers. If you pay by credit/HAS, a 3% fee will be added to your bill.

Note: this price does not include laboratory testing fees. If you have extensive records to review, Dr. Powers may also charge for the time involved in their review, which will be added on to your appointment time.

Rescheduling, Returns

If you need to reschedule an appointment, please do so a minimum of 24 hours in advance.

If you miss a new patient appointment you will be still be charged for the appointment. If you miss a follow-up appointment, there is a $100 charge, which will be billed to your credit card.

If you wish to return a lab kit, there will be a 15% restocking fee.

Documentation

At the end of each visit, you will be given a "superbill" that lists ICD 10 codes for diagnoses, along with CPT codes for labs ordered. This document will also serve as your receipt for payment. If you choose to submit this superbill to your insurance provider(s) for your reimbursement, you will be able to access your medical records through the secure Patient Portal for any other documentation you may need. We will be happy to print copies of your records, the charge is $0.50 per page for the first 50 pages, and $0.25 per page for additional copies beyond the first 50 pages.

I have read and agree to the above policy.

Signature_____ Date_____

Name (print)_____

Witness_____ Date_____

DR. PATTY POWERS MD

Third Party Insurance Policies

I understand Dr. Patricia Powers and Whole Health Catalysts, P.C.'s policies regarding third party insurers as follows:

1. Dr. Powers does NOT participate with any insurance companies.
2. Dr. Powers will NOT send medical records to insurance companies.
3. Dr. Powers does NOT negotiate with insurance companies for authorizations or prior authorizations for any services, lab work, x-rays, devices, or any other test that I order.
4. Dr. Powers does NOT participate in Medicare Parts A or B, or in Medicaid.
5. Dr. Powers will not file with, honor, or accept any insurance company's payments.

Dr. Powers encourages me to check with my insurance companies to verify coverage **before** having any lab work or diagnostic testing.

Some questions to ask your insurance provider include:

1. If lab work is ordered by an out-of-network physician but is performed at an in-network lab, will these tests be covered the same as if an in-network physician were ordering them?
2. What are the names and locations of some in-network labs?
3. What are my out-of-network benefits?
4. Have I met my out-of-network deductible?

I understand and fully comprehend the above and agree to abide by these policies.

Name (print)_____ Date_____

Signature_____ Date_____

Witness_____ Date_____

DR. PATTY POWERS MD

Informed Consent

The purpose of my evaluation and treatment of each patient is to provide a functional assessment and treatment plan based on the individual's physiological and metabolic needs. My assessments take time and careful analysis. I formulate a treatment plan tailored to each patient's own individual need. My purpose in treatment is to identify and treat those hormonal, metabolic, and physiologic pathways leading to illness and to chronic disease. It is my goal to decrease toxicity by giving less priority to drug and surgical treatment and more priority to nutritional and lifestyle changes.

I will always attempt to give each patient the clear option of selecting from other approaches to one's medical problems and treatment goals. There are options and alternatives to every treatment that I recommend. Each patient is free to question any and all suggestions that I give. I recommend that each patient seek a second opinion from any other physician for any medical problem that is even the least bit controversial. I encourage each patient to question my reasons, qualifications, and expectations. Do not remain unclear about any treatment that you as a patient choose, as any treatment you undertake will be at your discretion. Please be clear that I never attempt to order any patient to do anything. I will make recommendations and attempt to aid each individual to understand these recommendations fully before embarking on a course of treatment.

Risks, therefore, include foregoing other treatment like certain surgeries versus an alternative upon which you and I may agree. Vitamin, supplement, nutraceutical, herbal, and hormonal therapy, including the administration of these substances by intramuscular and intravenous routes, may not be widely accepted by traditional medical authorities. Some medical experts, in fact, claim that by choosing an alternative like the above described therapy, you endanger your life and health because of delay in receiving what they consider proper therapy. Vitamin, supplement, nutraceutical, herbal and natural hormonal therapy are clear examples of alternative treatment. It should be noted that there is wide disagreement among medical experts about most details of orthodox therapies as well as alternative therapies.

I will make a special note of cancers and diseases considered incurable. I make no claim of cure or improvement of any diseases, including cancer. Any patient who comes to me with such a condition will receive the nutritional support and lifestyle changes in addition to their other therapies. The patient MUST maintain a relationship with his/her oncologist or any specialist by whom he/she may be treated.

I do not do primary care. All patients must maintain their relationship with their primary physician. My primary focus is as a consultant, not primary care.

Dangers of treatment: Any time a needle for injection or diagnosis is inserted into the body, there is danger of infection, allergy, toxicity, bleeding, or structural damage to some tissue like nerve or artery or vein. This damage may result in permanent injury, disfigurement or death. This is true of every treatment administered in this office, including intravenous or intramuscular therapies.

By signing below, I have read this informed consent notification. I understand it and agree to its conditions. I have been given the opportunity and time to ask all of my questions. They have been answered to my satisfaction.

Patient Acknowledgement

Signature_____ Date_____

Witness_____ Date_____

DR. PATTY POWERS MD

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____ ,
understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

> A basis for planning my care and treatment; A means of communication among the many health professionals who contribute to my care; A source of information for applying my diagnosis and surgical information to my bill; A means by which a third-party payer can verify that services billed were actually provided, and; A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

I authorize Dr. Patricia Powers, Whole Health Catalysts, PC, to release medical information including
_____laboratory results or tests,
_____office notes
_____ special requests _____

To: _____ _____
_____ _____
_____ _____
Relationship: Relationship:

I fully understand and accept/decline the terms of this consent.

Name: _____ Signature:_____
DOB:_____ Date:_____

If patient is a minor, printed name of person signing above_____
Relationship to patient:_____

Notice of Privacy Practices

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.

If you have any questions about this Notice please contact Dr. Powers at 434-382-1825.

Effective Date: Sept 1, 2015

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.

- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include accounting companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact Dr. Powers at 434-382-1825.

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 1, 2015.