# WHOLE HEALTH CATALYSTS

*Dr. Patty Powers, MD*

Dear Patient,

Welcome! And thank you for considering me as one of your health care providers. Jenny Hall, my assistant, and I, will do our best to assist you.

**New patient documents:** Enclosed is a questionnaire I am asking you to fill out and return to me (by mail, fax or in person). If you have any medical records or lab reports from the last 2 years or so, or that pertain to the reasons I will be meeting with you, I would appreciate the opportunity to review these before our appointment. **You can mail or fax them to us, upload them to the Practice Better platform I use for email and scheduling, or bring them by in person.**

**When we meet: Please bring your supplements with you.** 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 always 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.

**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 email Jenny and 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.

**Website**: www.drpattypowers.com

**Lab results:** For LabCorp tests, you can set up a patient account with LabCorp or Quest to view results. You will also be able to see your results thru the patient portal on Praxis, my electronic medical record (you can set up an account for that, too). I will either give you copies of your results when we meet, or email them to you through the Practice Better program.

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

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?_____

Goal/s: prescriptions for ivermectin hydroxychloroquine strategies for immune strength

Mask exemption "vaccine" exemption Other:_____

Preferred Pharmacy:

Current weight:

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

**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):

| 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

Please circle any problems you have had, or have now:

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

**Anything not already mentioned?**

**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 Delayed Avoid do you get an annual flu vaccine? Yes No

HPV vaccines: No Yes When_____

Shingles vaccines: No Yes When_____

Covid vaccine: Yes No If yes, when:_____

which brand/s?_____

Any problems from immunizations? Yes No Describe:

WHOLE HEALTH CATALYSTS
Dr. Patty Powers, MD

# 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 do not reschedule or cancel your appointment at least 24 hours in advance, then the $300 deposit will not be refunded, and will be considered a "no show" fee. 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_____

rev 2.15.23

WHOLE HEALTH CATALYSTS
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_____

rev 2.15.23

WHOLE HEALTH CATALYSTS
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_____

rev 2.15.23

WHOLE HEALTH CATALYSTS
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:_____

rev 2.15.23

WHOLE HEALTH CATALYSTS
Dr. Patty Powers, MD

# 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.

rev 2.15.23