

NATUROPATHY HEALTH HISTORY FORM

Client Confidential Information *(please print)*

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Phone Number (cell) _____ (home) _____ (work) _____

Please leave any phone messages on my: Cell Phone Home Phone Work Phone

Email: _____ Date of Birth: _____ Age: _____ Male Female

Occupation: _____ Hours per week: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

History of Condition:

When and where did you last receive medical or health care? _____

What was the reason? _____

When was your last blood test? _____ Result? _____

What are your most important health issues? (List in order of importance)

1. _____

2. _____

3. _____

4. _____

How long has your main concern been bothering you? _____

When was the first time you noticed this concern? _____

What do you suspect is causing your problem or contributing to it? _____

What treatment approaches have you tried? _____

Does anything you do at work make your condition worse? Yes No What? _____

Have you seen a Naturopathic Doctor before? Yes No If yes, who? _____

If yes, what was the therapy and the results? _____

Are you currently working with a Doctor of conventional medicine? (M.D. or D.O.): Yes No

List Diagnoses: _____

| Medical Practitioner | Name | Address and Phone Number |
|----------------------|------|--------------------------|
| Primary Care | | |
| Specialist | | |
| Other | | |
| Other | | |

Family History: Please list ages, health problems and if deceased, the cause of death

| | | | | | | |
|-------------------------|--------|--------|----------|---------|-------|--------------|
| | Mother | Father | Brothers | Sisters | Child | Grandparents |
| Age if living | _____ | _____ | _____ | _____ | _____ | _____ |
| Health (G=good, P=poor) | _____ | _____ | _____ | _____ | _____ | _____ |

| | Mother | Father | Brothers | Sisters | Child | Mom's | Father's |
|----------------------------|---------------------------------|---------------------------------|-----------------------------------|----------------------------------|--------------------------------|---|---|
| Cancer | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Diabetes | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Heart Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| High Blood Pressure | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Stroke | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Epilepsy | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Mental Illness | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Respiratory, | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Hayfever, | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Hives | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Anemia | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Kidney Disease | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Glaucoma | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Tuberculosis | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Brothers | <input type="checkbox"/> Sisters | <input type="checkbox"/> Child | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> F |
| Age at death/cause | Mother | Age: _____ | Cause: _____ | | | | |
| | Father | Age: _____ | Cause: _____ | | | | |
| | Brothers | Age: _____ | Cause: _____ | | | | |

Sisters Age: _____ Cause: _____
Child Age: _____ Cause: _____
Grandparents Age: _____ Cause: _____

Do you have any blood relatives, who have had:

- Allergies Skin disease Depression Heart Attack Ulcers
 Genetic problems Thyroid problems Seizures Sickle cells Arthritis

What is your nationality? (Please list all backgrounds & give approximate %) _____

The general state of your health is? Excellent Good Average Fair Poor

Please Check box if you have had any of the following Childhood illnesses:

- Scarlet Fever Diphtheria Rheumatic Fever Polio Measles Mononucleosis
 Mumps Smallpox German measles Chickenpox Whooping cough

Please Check box if you have had any of the following Immunizations:

- Polio Diphtheria Pertussis Measles/Mumps/Rubella Tetanus Shot (not anti-toxin) Hepatitis B

Other, please specify: _____

Hospitalizations and Surgery: Yes No

If yes, when and why? _____

Please check special studies you have had: CAT scan MRI X rays other

Please list any abnormal lab results (include when and if you re-tested with a normal result): _____

Current Medications:

Please list prescription medications, over the counter medications, vitamins or other supplements you are taking (give full name, dosage and how long you have been taking it, write on back if you need more space)

Prescription: _____

Over the Counter: _____

Vitamins/Supplements:

Which of the following do you currently use?

Tobacco: Yes No, if YES, Packs per day _____ **Alcohol:** Yes No, if YES, _____ per week

Chewing Tobacco: Yes No, if YES, Tins per day _____

Coffee: Yes No, if YES, Cups per day _____ **Soda:** Yes No, if YES, _____ per day

Sweetener(Artificial): Yes No, if YES, _____X per day

Describe any exercise you currently do: _____

Do you eat three meals a day? Yes No

Do you sleep well? Yes No Number of hours per night? _____

Wake rested? Yes No

Do you enjoy your work? Yes No

Review of Systems:

General: Weight _____ Weight 1 year ago _____ Maximum weight _____ Height _____

Ideal weight: _____

Describe your energy level: Poor OK Good Great

Is this a change in the last 6 months? Yes No

Please check the box: **Y (yes)** a condition you have now, **P (past)** a condition you have had before, and **N (never)** a condition you have never had:

Blood:

Anemia: Yes Past Never
Recent Blood Pressure: _____

Cardiovascular:

Heart Disease: Yes Past Never
Angina: Yes Past Never
High Blood Pressure: Yes Past Never
Murmurs: Yes Past Never
Chest Pain: Yes Past Never
Swelling in ankles: Yes Past Never
Palpitations: Yes Past Never
Irregular Heart Beat: Yes Past Never

Ears:

Impaired Hearing: Yes Past Never
Ringing: Yes Past Never
Earaches: Yes Past Never
Dizziness: Yes Past Never

Emotional:

Depression: Yes Past Never
Mood Swings: Yes Past Never
Anxiety or nervousness: Yes Past Never
Tension: Yes Past Never

Endocrine:

Hypothyroid: Yes Past Never
Heat or cold intolerance: Yes Past Never
Excessive Thirst: Yes Past Never
Excessive hunger: Yes Past Never

Eyes:

Impaired Vision: Yes Past Never
Glasses/contacts: Yes Past Never
Eye pain: Yes Past Never
Tearing/dryness: Yes Past Never
Double vision: Yes Past Never

Eyes:

Glaucoma: Yes Past Never
Cataracts: Yes Past Never

Head:

Headache: Yes Past Never
Head Injury: Yes Past Never
Migraines: Yes Past Never

Gastrointestinal:

Ulcer: Yes Past Never
Heartburn: Yes Past Never

Change in Thirst/Appetite: Yes Past Never
Nausea/Vomiting: Yes Past Never
Vomit blood: Yes Past Never
Hemorrhoids: Yes Past Never
Belching/gas: Yes Past Never
Excessive flatulence: Yes Past Never
Blood in Stool: Yes Past Never
Gall bladder Disease: Yes Past Never
Liver disease: Yes Past Never
Reflux : Yes Past Never

Mouth/Throat:

Frequent sore throat: Yes Past Never
Tongue lesions: Yes Past Never
Gum problems: Yes Past Never
Hoarseness: Yes Past Never
Dental cavities: Yes Past Never
Cold Sores: Yes Past Never

Musculoskeletal:

Joint pain or stiffness: Yes Past Never
Arthritis: Yes Past Never
Broken bones: Yes Past Never
Muscle Spasms/cramps: Yes Past Never
Weakness: Yes Past Never

Neck:

Lumps: Yes Past Never
Swollen Glands: Yes Past Never
Goiter: Yes Past Never
Pain or Stiffness: Yes Past Never
Trouble Swallowing: Yes Past Never

Neurologic:

Fainting: Yes Past Never
Seizures: Yes Past Never
Paralysis: Yes Past Never
Muscle weakness: Yes Past Never
Numbness or tingling: Yes Past Never
Loss of memory: Yes Past Never
Mental Confusion: Yes Past Never

Nose/Sinuses:

Frequent colds: Yes Past Never
Nose Bleeds: Yes Past Never
Stuffiness: Yes Past Never
Hay fever: Yes Past Never
Sinus problems: Yes Past Never

Nasal polyps: Yes Past Never

Erectile Dysfunction: Yes Past Never

Peripheral vascular:

Deep Leg Pain: Yes Past Never

Cold hands/feet: Yes Past Never

Varicose veins: Yes Past Never

Respiratory:

Cough: Yes Past Never

Sputum: Yes Past Never

Spit up blood: Yes Past Never

Wheezing: Yes Past Never

Asthma: Yes Past Never

Bronchitis: Yes Past Never

Pneumonia: Yes Past Never

Pleurisy: Yes Past Never

Emphysema: Yes Past Never

Difficulty breathing: Yes Past Never

Pain on breathing: Yes Past Never

Tuberculosis: Yes Past Never

Shortness of breath: Yes Past Never

 At night? Yes Past Never

 Lying down? Yes Past Never

Sleep apnea: Yes Past Never

Urinary:

Pain on urination: Yes Past Never

Increased frequency: Yes Past Never

Frequency at night: Yes Past Never

Inability to hold urine: Yes Past Never

Frequent infections: Yes Past Never

Kidney Stones: Yes Past Never

Skin:

Rashes: Yes Past Never

Eczema: Yes Past Never

Acne: Yes Past Never

Itching: Yes Past Never

Color Change: Yes Past Never

Lumps: Yes Past Never

Dryness/Brittle nails: Yes Past Never

Male Reproductive:

Hernias: Yes Past Never

Testicular Masses: Yes Past Never

Testicular Pain: Yes Past Never

Sexually Active: Yes Past Never

Prostate Disease: Yes Past Never

Venereal Disease: Yes Past Never

Discharge or sores: Yes Past Never

Female Reproductive:

Age Menses Began: _____

Last Menstrual Period: _____

If periods have stopped at what age? _____

Average # of days long: _____

Total Days in Cycle: _____

Bleeding between: Yes Past Never

Are cycles regular: Yes Past Never

Pain during intercourse: Yes Past Never

Painful menses: Yes Past Never

Excessive flow: Yes Past Never

Birth Control: Yes Past Never

of pregnancies: _____

of live births: _____

of miscarriages: _____

of abortions: _____

Difficulty conceiving: Yes Past Never

Menopausal Symptoms: Yes Past Never

Night Sweats: Yes Past Never

Sexually Active: Yes Past Never

Venereal Disease: Yes Past Never

Breasts:

Do you do self exam: Yes Past Never

Lumps: Yes Past Never

Pain or Tenderness: Yes Past Never

Nipple Discharge: Yes Past Never

Breastfeeding: Yes Past Never

Any known allergies:

Bowel movement, how often: _____ Formed? _____ Mucous? _____

Has there been a change in your bowel movement recently? _____

Personal Habits

What do you enjoy most in your life? _____

What are your main interests or hobbies? _____

What do you worry most about in life? _____

Do you have a religious or spiritual practice: Yes No If yes, what? _____

Do you take vacations? Yes No

Do you take some extra time for yourself (Ex. receive massages, or other activities that include pampering yourself) Yes No

Are you currently in a happy satisfying relationship with someone? Yes No Very Mostly Somewhat

Occupational/household

How long have you lived at your present address? _____

Where have you lived previously? (Please describe location, if old or new place, i.e., new construction, damp or moldy)

Do you have specialized air filtration at home? Yes No Do the windows open? Yes No

Do you work in an office building? Yes No Do the window open? Yes No

Do you have specialized air filtration at your work place? Yes No

Do you work in the presence of toxic fumes or chemicals? Yes No

Do any of your hobbies involve toxic materials? Yes No

Are you exposed to second hand smoke currently? Yes No

What do you use for drinking water? bottled filtered tap water

What percentage of the food you eat is organic? _____

Health Choices:

Which of the following would you like included in your health plan if appropriate?

- | | | | |
|--|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Vitamins | <input type="checkbox"/> Minerals | <input type="checkbox"/> Dietary Supplementation | <input type="checkbox"/> Hydrotherapy |
| <input type="checkbox"/> Dietary Recommendations | <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Botanicals | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> | <input type="checkbox"/> Other_____ | |

What do you think is the most important part of your healing process?_____

Other comments_____

I have read the above information and certify it to be true and hereby authorize Dr. Jacqueline S. Rho, ND to recommend whatever is necessary for the care and management of my concern(s).

Signature of client or legal guardian: _____ Date: _____

NATUROPATHY INFORMED CONSENT

I hereby request and consent to the performance of naturopathic treatments and other naturopathic procedures on me (or on the patient named below, for whom I am legally responsible) by the doctor of naturopathy named below and/or other licensed doctors of naturopathy who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of naturopathy named below, including those working at the office listed below or any other office whether signatories to this form or not.

I understand that the doctor of naturopathy will perform a health history, conduct a physical examination, and when indicated request additional laboratory testing such as saliva, blood, urine, or stool samples. I understand that methods of treatment may include, but are not limited to, botanical medicine, homeopathy, nutritional supplementation including herbs, vitamins, and minerals, vitamin-mineral injections, hot and cold therapies, physical medicine, the recommendation of dietary changes, and patient education and counseling. I understand that the herbs, vitamins, and minerals recommended to me may be prepared in the form of pills, capsules, teas, tinctures, or creams and need to be consumed according to the instructions provided orally and in writing. I will immediately notify the doctor of naturopathy of any unanticipated effects associated with the consumption of the herbs, vitamins, and supplements.

I have been informed that naturopathy is a generally safe method of treatment, but that it may have some side effects including aggravation of pre-existing symptoms, the appearance of new symptoms, pain, bruising or injury from vitamin-mineral injections, or allergic reactions to herbs, vitamins, or supplements. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of naturopathy, however, rare allergic reactions, including headaches, itching, hives, difficulty breathing, and very rarely, even shock or death. I understand that the interactions between herbs, and between herbs and drugs are not yet defined, and that while unlikely I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for the control of high blood pressure or blood sugar. I understand that some methods of treatment may be inappropriate during pregnancy or while breastfeeding. I will notify the doctor of naturopathy who is caring for me if I am or become pregnant or if I am currently breastfeeding.

I understand that Dr. Rho is not a medical doctor and that naturopathy is not currently a conventional medical specialty but a separate and distinct health care tradition. I understand that Dr. Rho graduated from an accredited four year graduate program as a naturopathic doctor. Naturopathic physicians are licensed in 14 states, and in the District of Columbia, but the State of Massachusetts does not currently offer licensing for naturopathic doctors. I understand that Dr. Rho's assessments and recommendations are intended to assist me in using natural means to support my health and are not intended to serve as medical diagnosis or treatment. If I believe that I have a condition which requires medical care, I will consult my primary care physician or an appropriate specialist. I understand that Dr. Rho may, during her assessment, see evidence of a condition which should be diagnosed and treated by a medical physician or require laboratory or other testing to support good health care decision making, and in that event necessary referrals will be made. Furthermore, I will not avoid any diagnostic work-ups or discontinue medical treatment based upon my consultation with Dr. Rho.

I do not expect the doctor of naturopathy to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the doctor of naturopathy to exercise judgment during the course of treatment which the doctor of naturopathy thinks at the time, based upon the facts then known is in my best interests. I understand that results are not guaranteed. I understand the doctor of naturopathy may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathy and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of client or legal guardian _____ Date _____

Office Signature _____ Date _____

Client Agreement and Policies

Welcome to OMBE Boston and the office of Dr. Jacqueline S. Rho, ND. To familiarize you with the financial and billing policies of our office, I would like to explain how your medical bills will be handled.

Declaration: You are the primary person responsible for your bill. Charges for the treatment are due at the time of service, unless other payment arrangements are made.

Payment Methods: OMBE accepts cash, checks, MasterCard and Visa as methods of payment for services. A credit card is required to reserve your appointment. A receipt will be furnished for you upon request. If you wish to submit claims to your insurance company, a detailed description of your visit will be made available to you upon written request.

Returned Checks: If your check is returned by the bank due to insufficient funds, there will be an additional \$25.00 charge added to your account which you are responsible to pay.

Cancellation Policy: Thank you in advance for observing OMBE's 24-hour cancellation policy. If you need to reschedule or cancel your appointment, please call OMBE (617.447.2222) 24-HRS in advance of your scheduled session. If you are unable to provide 24-HRS notice for the scheduled appointment, you will be responsible for the full charge of the session.

I have had the opportunity to read and discuss all of the above information, and I fully understand all of its meaning and its terms. I am aware of and accept these policies noted above.

Client Signature: _____ Date: _____

Office Signature: _____ Date: _____

OMBE Privacy Policies Notice

This notice describes how your medical information may be used and disclosed, how you can access this information, and how your privacy is being protected at OMBE. OMBE, all health care providers at OMBE, and all associates providing service at OMBE are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. The privacy of your medical records is important to us and we are committed to protecting your medical records. We create a record of the services you receive at OMBE in a paper chart and on a computer. We need this record to provide you with quality care and to comply with certain legal requirements. In order to maintain the service level that you expect from a health care office, we may need to share limited personal medical and financial information. Your medical records are the property of this health care office, but the information in the medical record belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.

How OMBE May Use or Disclose Your Health Information

Treatment: We use medical information about you to provide your health care. We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or health care operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with OMBE. We may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may share this information with a physician who will need to treat you, or a laboratory that performs a test.

Payment: We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. For example, we may disclose your health information to your insurance provider or a third party for the purpose of payment, to receive prior approval, or to determine whether your plan will cover the treatment.

Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Health Care Operations: We may use and disclose medical information about you to operate this health care practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence, and qualifications of our staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud detection and compliance programs. We may also share your medical information with our "business associates", such as our appointment scheduling and billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. Additionally, the health care practice has an open waiting room where patients may be seen by other patients. The secure area around the front desk also has a computer and fax machine that may be visible to the public. This area is limited to OMBE staff and health care providers only and the computer has an automatic screen saver that is activated after two minutes without activity.

Appointment Reminders: We may contact you for appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine, or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Notification and Communication with Family: We may disclose your health information to notify a family member or another person responsible for your care about your location and general condition in the event you are sick or injured. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. We may disclose this information in an emergency situation.

Marketing: We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

Required by Law: When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may, and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your

health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Health & Safety: We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; and reporting domestic violence. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Special Government Functions: If you are a member of the armed forces, we may release protected health information about you if it relates to military and veteran activities. We may also release your protected health information for national security purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Deceased Persons: We may disclose your health information to coroners, medical examiners, funeral directors, or organizations involved in procuring, banking, or transplanting tissues.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit in our use or disclosure. We reserve the right to accept or reject your request, and will notify you of our decision.

Right to Request Confidential Communications: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable communication requests submitted in writing.

Right to Inspect and Copy: You have the right to inspect and copy your health information. To access your health information, submit a written request detailing the information you want access, inspect, or copy. We will charge a reasonable fee, as allowed by federal law. We may deny your request under limited circumstances. You have the right to appeal our decision if we deny access your child's records in the case that access could cause harm to your child.

Right to Amend or Supplement: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about OMBE's denial and how you can disagree with the denial within thirty (30) days of receipt of your written request. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures: You have a right to receive an accounting of disclosures of your health information made by this office, except that this office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the Treatment, Payment, Health Care Operations, Notification and Communication with Family paragraphs. Additionally, this office does not have to account for disclosures otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this office has received notice from that agency or official that providing this accounting would be likely to impede their activities.

More About OMBE's Privacy Policy

We reserve the right to amend this Privacy Policies Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain. You have the right to request a current copy of this Notice which is maintained on our website and at the front desk. If you would like a more detailed explanation of these rights, to exercise one or more of these rights, or submit any complaints in regards to this Notice, please contact our Privacy Officer, Jessica Molleur. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 202

OMBE Privacy Policies Acknowledgement

I have received, read, and understood OMBE's Privacy Policies Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

Signature of Client or Authorized Representative

Date