INTEGRATIVE HEALTHCARE SOLUTIONS

NEW PATIENT INFORMATION PACKET

In this packet you'll find:

- New Patient Health History Forms
- Office Policies
- Consent forms

Thank you for considering including Integrative Healthcare Solutions in your wellness journey.

Our mission is to help you heal and resolve your chronic health struggles. We follow a systems-oriented approach, and take time with each patient; we will work together in an effort to get to the root of your health issue(s). We dedicate up to 1.5 hours for each patient's initial evaluation and up to 45 minutes for each patient's follow-up appointments. Additionally, we prepare for appointments by reviewing the patient's history and lab results. In light of these things, we require 72 hours' notice to cancel or reschedule your appointment.

All patients are required to have a signed credit card authorization form (included in this packet) on file before scheduling appointments. Patients who cancel with less than 72 hours' notice are responsible for paying for the time reserved for them in full and we will charge the credit card on file. We do make allowances in case of true emergencies.

A $200 deposit is required for the initial exam (only). The deposit will go towards the full cost ($395) of the new patient exam. If you provide less than 72 hours' notice of cancellation for your initial exam, you will forfeit your $200 deposit to cover the time set aside for, and the time the doctors spent preparing for your exam. Rescheduling your initial exam will require a new $200 deposit.

ON CALL DOCTOR CANCELLATION NOTICE (Dr. Lauren Caffery, DC ONLY): Please be advised that Dr. Lauren Caffery, DC has limited office hours (Monday mornings only) and is **on call** with the hospital during that time. While incredibly rare, your appointment is subject to being canceled at the last minute or cut short, if she gets called into the hospital. You will not be charged for an appointment that is canceled (in its entirety). For appointments that are cut short, they will be rescheduled and finished at a later date.

Continued on page 2

I fully understand and agree to the above cancellation policy and on call doctor cancellation notice, and am ready to begin my wellness journey.

_____
Print Name

_____ Date_____
Patient Signature

If the patient is a minor (under 18 years of age) or unable to give consent, consent must be granted by their authorized parent, custodian, or legal guardian.

I_____, the parent/legal guardian of _____, do understand the above informed consent in full.

_____ Date_____ Parent/Legal Guardian Signature

Thank you for carefully answering each question!

INTEGRATIVE HEALTHCARE SOLUTIONS

Patient: Black ink
Doctor: Red ink
CA: Green ink

PATIENT INFORMATION

Today's Date (Month/Day/Year): _____/_____/_____ Date of Birth (Month/Day/Year): _____/_____/_____ Age:_____

Legal Name: _____Gender: ☐M ☐ F

Preferred Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone: (_____) _____ Cell: (_____) _____ Email: _____

Name & Number of Emergency Contact:_____

Who referred you to our office? _____

Please list your 5 major health concerns in order of importance:

1._____
2._____
3._____
4._____
5._____

MEDICATIONS AND SUPPLEMENTS

Are you currently taking any medications (prescribed or over the counter), if so please list them .

Medication	**Duration on medication**	**Did it help?**
1.		
2.		
3.		
4.		
5.		
6.		

Supplement	**Duration on medication**	**Did it help?**
1.		
2.		
3.		
4.		
5.		
6.		

Doctor's Notes:_____

Do you have any known allergies, if so please list them? *(if more than 6, please tell us!)*

1. _____. 3. _____. 5. _____.

2. _____. 4. _____. 6. _____.

Please answer the following questions as completely as possible:

Please list all operations or surgeries you may have had with dates:_____

_____

Please list any hospitalizations you may have had with dates:_____

Please list any major illness you have had with dates:_____

Have you had any recent colds, flu, Lyme, or infections at the onset of your complaint? ☐No. ☐Yes:_____

Have you had any recent immunizations or immunizations around the onset of your complaint? ☐No. ☐Yes:_____

Please list any and ***all*** traumas or injuries you've ever had, with dates, from the simple to the serious:_____

_____

_____

Have you ever been diagnosed with a tumor, cancer, neoplasia, or dysplasia? ☐No. ☐Yes:_____

Have you ever been diagnosed with diabetes? ☐No. ☐Yes:_____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? ☐No. ☐Yes:_____

Have you ever had a stroke or heart attack? ☐No. ☐Yes:_____

Does anyone in your biological family have a history of <u>any</u> diseases or conditions? (ie: cancer, rheumatoid arthritis, depression, etc.)

Mother:_____

Father:_____

Brother(s):_____

Sister(s):_____

Maternal Grandfather:_____

Maternal Grandmother:_____

Paternal Grandfather:_____

Paternal Grandmother:_____

Please indicate your familial status? ☐Single. ☐Married. ☐Divorced. ☐Widowed.

How many children do you have? ☐None. ☐1. ☐2. ☐3. ☐4. ☐Other:_____.

What do you do for a living?_____. How many hours a week?_____

Do you have a second job?_____. How many hours a week?_____

Describe your work environment:_____

How long have you been at this job?_____What other jobs have you had in the past?_____

Describe your home life:_____

How many hours on average of sleep do you get a night? _____ Quality?_____

Do you have problems falling asleep? ☐No. ☐Yes, explain: _____

If you wake up in the night do you have problems getting back to sleep? ☐No. ☐Yes, explain: _____

Do you have trouble waking up in the morning? ☐No. ☐Yes, explain: _____

What is your highest level of education?_____. What are your hobbies?_____

Do you exercise? ☐No. ☐Yes, then what type and how often:_____

Do you use any tobacco products? ☐No. ☐Yes, then what kind, how often, & how long:_____

Doctor's Notes:_____

_____

_____

_____

Today's Date: _____

Patient: Black ink,
Doctor: Red ink
CA: Green ink

Have you used tobacco products in the past? ☐No. ☐Yes, then what, how long, & when did you quit?_____
Do you drink alcoholic beverages? ☐No. ☐Yes, then what kind and how many a week:_____
Have you had alcohol problems in the past? ☐No. ☐Yes, then how long ago & for how long:_____
Do you drink caffeinated beverages? ☐No. ☐Yes, then what kind and how many a day:_____
Do you drink sodas? ☐No. ☐Yes, then how many a day:_____
Do you use recreational drugs? ☐No. ☐Yes, then how long ago & for how long::_____
Have you used recreational drugs in the past? ☐No. ☐Yes, then what type, when, & for how long:_____
Are you vegetarian? ☐ Yes ☐ No Reason: (***circle one:*** Religious OR Moral/philosophical OR health reason)
Are you vegan? ☐ Yes ☐ No Reason: (***circle one:*** Religious OR Moral/philosophical OR health reason)
Would you consider consuming animal protein if it were indicated to improve your health? ☐ Yes ☐ No
What is your diet like? Describe what you eat. _____
Do you have any special dietary restrictions? ☐No. ☐Yes, then what type:_____
Are you sexually active? ☐No. ☐Yes. If yes have you ever been diagnosed with an STD or VD:_____
What are your expectations of care? What do you hope to gain by being treated here?_____
_____
What is your level of commitment on a scale from 0-10 to make diet and lifestyle changes and consistently take supplements (0 being no commitment and 10 being I am willing to do whatever it takes)?_____

Review of Systems & Medical History:

1. Are you currently experiencing any of the following symptoms, now or recently?

☐ Chest pain	☐ Jaw pain	☐ Left arm pain
☐ Shortness of breath	☐ Excessive sweating without exertion	☐ Pale skin or pallor
☐ Blackouts	☐ Swelling in your left arm	☐ Lightheadedness

2. Please check off any of the below symptoms that you are be experiencing, now or recently?

☐ Nausea	☐ Vomiting	☐ Difficulty with speaking
☐ Dizziness or vertigo	☐ Difficulty with swallowing	☐ Disequilibrium or feeling unsteady
☐ Double vision	☐ Feeling like your are going to fall	☐ Abnormal eye movements
☐ Numbness	☐ Abnormal sweating	☐ Severe headache

R/F

3. Have you noticed any of the following?_____.

☐ Change in appetite ☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Recent fever ☐ Recent fatigue

Please mark any of the below conditions that apply to you, past or present.

Condition	Past	Present
☐ Swollen or painful joints		
☐ Neck pain or stiffness		
☐ Upper back pain or stiffness		
☐ Mid back pain or stiffness		
☐ Low back pain or stiffness		
☐ Hip or pelvis pain		
☐ Auto accidents		

Condition	Past	Present
☐ Foot or ankle pain		
☐ Leg pain		
☐ Knee pain		
☐ Shoulder pain		
☐ Elbow pain		
☐ Arm pain		
☐ Hand or wrist pain		
☐ Jaw pain or click (TMJ)		
☐ Chronic headaches		
☐ Sprain or strain		
☐ Sports injuries		

Condition	Past	Present
☐ Trouble with prolonged sitting or standing		
☐ Trouble with walking		
☐ Trouble with bending, twisting, or lifting		
☐ Osteoporosis		
☐ Dislocated bones		
☐ Fractured bones		
☐ Bone infection (osteomyelitis)		
☐ Machine accident		

Condition	Past	Present
☐ Herniated disc		
☐ Lumbago or lumbalgia		
☐ Scoliosis or other spinal curvature		
☐ Difficulty walking		
☐ Osteoarthritis or DJD		
☐ Rheumatoid arthritis		
☐ Other arthritis		
☐ Gout		
☐ Ankylosing spondylitis		
☐ Accidental fall		

HxA-Pn

HxA-mva
HxA-Fa

Doctor's Notes:_____
_____
_____
_____

Doctor's Initials:_____

Today's Date: _____

Patient: Black ink,
Doctor: Red ink
CA: Green ink

Condition	Past	Present
☐ Migraines		
☐ Cluster headaches		
☐ Costen's syndrome		
☐ Balance problems		
☐ Mental or emotional disorder		
☐ Convulsions or epilepsy		
☐ Difficulty speaking		
☐ Difficulty swallowing		
☐ Losing time or blacking out		
☐ Changes in skin sensation		
☐ Muscle problems		
☐ Learning disability		
☐ Conduct disorder		
☐ Glaucoma		
☐ Dizziness		
☐ Motion sickness		
☐ Ear infections		
☐ Tinnitus		
☐ Sore throat		
☐ Pain in legs with movement or activity		
☐ Heart palpations (hearing racing heart)		
☐ Swelling in legs or feet		
☐ Congestive heart failure		
☐ Difficulty breathing		
☐ Chronic/frequent cough		
☐ COPD		
☐ Coughing up blood		
☐ Difficulty losing weight		
☐ Colon problems		
☐ Gall bladder trouble		
☐ Liver disease		
☐ Stomach/duodenal ulcer		
☐ Abdominal pain		
☐ Indigestion		
☐ Cirrhosis		
☐ Bloating		
☐ Craving sweets		
☐ Craving excessive salts		
☐ Pituitary disorder		
☐ Cold all the time		
☐ Dry skin		
☐ Change in hat size		
☐ Unexplained skin rash		
☐ Change in skin mole		
☐ Seborrhea		
☐ Acne		

Condition	Past	Present
☐ Trigeminal neuralgia or Tic Doloreaux		
☐ Hypertension headache		
☐ Seizures		
☐ Neurological disease		
☐ Trouble concentrating		
☐ Difficulty swallowing		
☐ Trouble understanding others		
☐ Stroke or CVA		
☐ Paralysis		
☐ Muscle weakness		
☐ Twitching muscles		
☐ Lost muscle tone		
☐ ADD or ADHD		
☐ Behavioral disorder		
☐ Macular degeneration		
☐ Vertigo		
☐ Unexplained giddiness		
☐ Ringing in ears		
☐ Sinus problems		
☐ Mouth sores		
☐ Heart attack (myocardial infarct)		
☐ Irregular heart beats		
☐ Experience passing out		
☐ Skipped heart beats		
☐ Congenital heart disease		
☐ Shortness of breath with activity		
☐ Short of breath at rest		
☐ Painful breathing		
☐ Hemorrhoids		
☐ Difficulty with control of bowel movements		
☐ Nausea &/or vomiting		
☐ Digestive problems		
☐ Constipation		
☐ Diarrhea		
☐ Polyps		
☐ Diverticulitis		
☐ Hormonal issues		
☐ Thyroid disorder		
☐ Adrenal disorder		
☐ Hot all the time		
☐ Trouble with sleep		
☐ Change in glove size		
☐ Itching		
☐ Change in nails		
☐ Eczema		
☐ Dermatitis		

Condition	Past	Present
☐ Tension headaches		
☐ Pain in your face		
☐ Temporal arteritis		
☐ Trouble sleeping		
☐ Difficulty with focus		
☐ Loss of memory		
☐ Fainting spells		
☐ Tire easily		
☐ Mini-stroke or TIA		
☐ Blurred vision		
☐ Double vision		
☐ Muscle cramping		
☐ Tremors (shaking)		
☐ Abnormal movements		
☐ Dyslexia		
☐ Asperger's syndrome		
☐ Cataracts		
☐ Unsteadiness		
☐ Difficult with balance		
☐ Earaches		
☐ Nose bleeds		
☐ Bleeding gums		
☐ Arrhythmia		
☐ Heart murmur		
☐ Atherosclerosis / arteriosclerosis		
☐ Dizzy or light-headed with exercise		
☐ Wheezing		
☐ Asthma		
☐ Coughing up mucus		
☐ Pneumothorax		
☐ Difficulty swallowing		
☐ Gall bladder stones		
☐ Intestinal issues		
☐ Heartburn		
☐ Gastric ulcers		
☐ Excessive belching		
☐ Digestive issues		
☐ Celiac Disease (Sprue)		
☐ Irritable bowel syndrm.		
☐ Night sweats		
☐ Decreased energy		
☐ Frequent urination		
☐ Hair loss		
☐ Increased sex drive		
☐ Under a lot of stress		
☐ Change in hair pattern		
☐ Bruise easy		
☐ Psoriasis		
☐ Skin cancer		

Condition	Past	Present
☐ Sinus headaches		
☐ Cervicogenic headaches		
☐ Other type of headache		
☐ Recent incoordination		
☐ Head seems heavy/tired		
☐ Head or arms feel tired		
☐ Loss of consciousness		
☐ Concussions		
☐ Head injury		
☐ Persistent headache		
☐ Spontaneous movement		
☐ Weak muscles of face		
☐ Numbness or tingling		
☐ Excessive sweating		
☐ Autism (PDD or ASD)		
☐ Bedwetting		
☐ Retinopathy		
☐ Pain with coughing or sneezing		
☐ Hearing loss		
☐ Difficulty swallowing		
☐ Hoarseness		
☐ High cholesterol		
☐ High blood pressure (hypertension)		
☐ Scarlet fever		
☐ Rheumatic fever		
☐ Other heart disease		
☐ Emphysema		
☐ Bronchitis		
☐ Snoring		
☐ Other lung problems		
☐ Hepatitis		
☐ More than 3 bowel movements a day		
☐ Less than 1 bowel movement a day		
☐ Excessive gas		
☐ Blood in stool		
☐ Ulcerative colitis		
☐ Crohn's disease		
☐ Diabetes		
☐ Hyperthyroidism		
☐ Hypothyroidism		
☐ Excessive thirst		
☐ Decreased sex drive		
☐ Change in skin color		
☐ Shingles		
☐ Herpes		
☐ Warts		
☐ Other skin disorder		

HxA-fn

HxA-GI

HxA-En

Doctor's Notes:_____

_____

_____

_____

Doctor's Initials:_____

Today's Date: _____

Patient: Black ink,
Doctor: Red ink
CA: Green ink

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
☐ Psychological issues			☐ Anxiety			☐ Panic attacks			☐ Work or social stress		
☐ Nervousness			☐ Feelings of hopelessness			☐ Mood changes			☐ Anger easy		
☐ Depression			☐ Phobias			☐ PTSD			☐ Feelings of suicide		
☐ Irritability			☐ HPV / genital warts			☐ OCD			☐ Eating disorders		
☐ Prostate problems			☐ PMS problems			☐ Syphilis			☐ Infrequent urination		
☐ Erectile dysfunction			☐ Menstrual problems			☐ Kidney problems or disease			☐ Blood in urine		
☐ Premature ejaculation			☐ Breast discharge			☐ Kidney stones			☐ Frequent urination		
☐ Problems with sexual libido or desire			☐ Vaginal discharge			☐ Difficulty urinating			☐ Painful urination		
☐ Discharge from urethra			☐ Breast lumps / soreness			☐ Feelings of urgency to urinate			☐ Awaken to urinate		
☐ Gonorrhea			☐ Menopause			☐ Leg pain with walking			☐ Bladder infections		
☐ Bleeding disorder			☐ Vascular disease			☐ Blood clots / phlebitis			☐ Other STD / VD		
☐ Anemia			☐ Varicose veins			☐ Frequent colds or flues			☐ Venous insufficiency		
☐ Allergies			☐ Autoimmune disease			☐ Alcoholism			☐ Bruise easily		
☐ The flu, how long ago _____			☐ A cold, how long ago _____			☐ Cancer			☐ HIV / AIDS		
									☐ Other:		

Hx-M/A

HxA-M
HxA-F

Females only:
Is there ***any*** possibility that you are currently pregnant? ☐No. ☐Yes.
What was the date of your last menstrual period?_____.

Primary Care Physician

Doctor's name: _____

Practice name: _____

Office number: _____ **Fax number:** _____

Thank you for taking the time to fill out this health history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at Integrative Healthcare Solutions. Any disclosure is outlined in our privacy policies.

_____ Patient's signature (or guardian's signature)

_____ Date

_____ Signature of translator or person assisting with this form (if any)

Printed name of said person _____ _____ Date

Doctor's Notes:_____

_____

_____

_____

Doctor's Initials:_____

Metabolic Assessment Form

Name: _____ **Date:** _____

Please circle the appropriate number on all questions below.
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII ***(Males Only)***

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX ***(Males Only)***

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX ***(Menstruating Females Only)***

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI ***(Menopausal Females Only)***

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

Brain Region Localization Form

INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

NAME: DATE:

Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12)		Level
1.	Difficulty with restraint and controlling impulses or desires	0 1 2 3 4
2.	Emotional instability (lability)	0 1 2 3 4
3.	Difficulty planning and organizing	0 1 2 3 4
4.	Difficulty making decisions	0 1 2 3 4
5.	Lack of motivation, enthusiasm, interest and drive (apathetic)	0 1 2 3 4
6.	Difficulty getting a sound or melody out of your thoughts (Perseveration)	0 1 2 3 4
7.	Constantly repeat events or thoughts with difficulty letting go	0 1 2 3 4
8.	Difficulty initiating and finishing tasks	0 1 2 3 4
9.	Episodes of depression	0 1 2 3 4
10.	Mental fatigue	0 1 2 3 4
11.	Decrease in attention span	0 1 2 3 4
12.	Difficulty staying focused and concentrating for extended periods of time	0 1 2 3 4
13.	Difficulty with creativity, imagination, and intuition [R]	0 1 2 3 4
14.	Difficulty in appreciating art and music [R]	0 1 2 3 4
15.	Difficulty with analytical thought [L]	0 1 2 3 4
16.	Difficulty with math, number skills and time consciousness [L]	0 1 2 3 4
17.	Difficulty taking ideas, actions, and words and putting them in a linear sequence [L]	0 1 2 3 4

Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6)		Level
18.	Initiating movements with your arm or leg has become more difficult	0 1 2 3 4
19.	Feeling of arm or leg heaviness, especially when tired	0 1 2 3 4
20.	Increased muscle tightness in your arm or leg	0 1 2 3 4
21.	Reduced muscle endurance in your arm or leg	0 1 2 3 4
22.	Noticeable difference in your muscle function or strength from one side to the other	0 1 2 3 4
23.	Noticeable difference in your muscle tightness from one side to the other	0 1 2 3 4
Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)		**Level**
24.	Difficulty producing words verbally, especially when fatigued	0 1 2 3 4
25.	Find the actual act of speaking difficult at times	0 1 2 3 4
26.	Notice word pronunciation and speaking fluency change at times	0 1 2 3 4
Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7)		**Level**
27.	Difficulty in perception of position of limbs	0 1 2 3 4
28.	Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	0 1 2 3 4
29.	Frequently bumping body or limbs into the wall or objects accidently	0 1 2 3 4
30.	Reoccurring injury in the same body part or side of the body	0 1 2 3 4
31.	Hypersensitivities to touch or pain perception	0 1 2 3 4

Brain Region Localization Form

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4 = I always have symptoms (100% of the time)

Parietal Inferior Lobule (Area 39 and 40)		Level
32.	Right/left confusion [L]	0 1 2 3 4
33.	Difficulty with math calculations [L]	0 1 2 3 4
34.	Difficulty finding words [L]	0 1 2 3 4
35.	Difficulty with writing [L]	0 1 2 3 4
36.	Difficulty recognizing symbols or shapes [R]	0 1 2 3 4
37.	Difficulty with simple drawings [R]	0 1 2 3 4
38.	Difficulty interpreting maps [R]	0 1 2 3 4
Temporal Lobe Auditory Cortex (Areas 41, 42)		**Level**
39.	Reduced function in overall hearing	0 1 2 3 4
40.	Difficulty interpreting speech with background or scatter noise	0 1 2 3 4
41.	Difficulty comprehending language without perfect pronunciation	0 1 2 3 4
42.	Need to look at someone's mouth when they are speaking to understand what they are saying	0 1 2 3 4
43.	Difficulty in localizing sound	0 1 2 3 4
44.	Dislike of left predictable rhythmic, repeated tempo and beat music [L]	0 1 2 3 4
45.	Dislike of non-predictable rhythmic with multiple instruments [R]	0 1 2 3 4
46.	Noticeable ear preference when using your phone	right, left, no preference
Temporal Lobe Auditory Association Cortex (Area 22)		**Level**
47.	Difficulty comprehending meaning of spoken words [L]	0 1 2 3 4
48.	Tend toward monotone speech without fluctuations or emotions [R]	0 1 2 3 4

Medial Temporal lobe and Hippocampus		Level
49.	Memory less efficient	0 1 2 3 4
50.	Memory loss that impacts daily activities	0 1 2 3 4
51.	Confusion about dates, the passage of time, or place	0 1 2 3 4
52.	Difficulty remembering events	0 1 2 3 4
53.	Misplacement of things and difficulty retracing steps	0 1 2 3 4
54.	Difficulty with memory of locations (addresses) [R]	0 1 2 3 4
55.	Difficulty with visual memory [R]	0 1 2 3 4
56.	Always forgetting where you put items such as keys, wallet, phone, etc. [R]	0 1 2 3 4
57.	Difficulty remembering faces [R]	0 1 2 3 4
58.	Difficulty remembering names with faces [L]	0 1 2 3 4
59.	Difficulty with remembering words [L]	0 1 2 3 4
60.	Difficulty remembering numbers [L]	0 1 2 3 4
61.	Difficulty remembering to stay or be on time (reduced left) [L]	0 1 2 3 4
Occipital Lobe (Area, 17, 18, and 19)		**Level**
62.	Difficulty in discriminating similar shades of color	0 1 2 3 4
63.	Dullness of colors in visual field	0 1 2 3 4
64.	Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects	0 1 2 3 4
66.	Floater or halos in visual field	0 1 2 3 4

Brain Region Localization Form

INSTRUCTIONS:

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KEY:

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3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

Cerebellum - Spinocerebellum		Level
67.	Difficulty with balance, or balance that is worse on one side	0 1 2 3 4
68.	A need to hold the handrail or watch each step carefully when going down stairs	0 1 2 3 4
69.	Feeling unsteady and prone to falling in the dark	0 1 2 3 4
70.	Proness to sway to one side when walking or standing	0 1 2 3 4
Cerebellum - Cerebrocerebellum		**Level**
71.	Recent clumsiness in hands	0 1 2 3 4
72.	Recent clumsiness in feet or frequent tripping	0 1 2 3 4
73.	A slight hand shake when reaching for something at the end of movement	0 1 2 3 4
Cerebellum - Vestibulocerebellum		**Level**
74.	Episodes of dizziness or disorientation	0 1 2 3 4
75.	Back muscles that tire quickly when standing or walking	0 1 2 3 4
76.	Chronic neck or back muscle tightness	0 1 2 3 4
77.	Nausea, car sickness, or sea sickness	0 1 2 3 4
78.	Feeling of disorientation or shifting of the environment	0 1 2 3 4
79.	Crowded places cause anxiety	0 1 2 3 4
Basal Ganglia Direct Pathway		**Level**
80.	Slowness in movements	0 1 2 3 4
81.	Stiffness in your muscles (not joints) that goes away when you move	0 1 2 3 4
82.	Cramping of hands when writing	0 1 2 3 4
83.	A stooped posture when walking	0 1 2 3 4
84.	Voice has become softer	0 1 2 3 4
85.	Facial expression changed leading people to frequently ask if you are upset or angry	0 1 2 3 4
Basal Ganglia Indirect Pathway		**Level**
86.	Uncontrollable muscle movements	0 1 2 3 4
87.	Intense need to clear your throat regularly or contract a group of muscles	0 1 2 3 4
88.	Obsessive compulsive tendencies	0 1 2 3 4
89.	Constant nervousness and restless mind	0 1 2 3 4
Autonomic Reduced Parasympathetic Activity		**Level**
90.	Dry mouth or eyes	0 1 2 3 4
91.	Difficulty swallowing supplements or large bites of food	0 1 2 3 4
92.	Slow bowel movements and tendency for constipation	0 1 2 3 4
93.	Chronic digestive complaints	0 1 2 3 4
94.	Bowel or bladder incontinence resulting in staining your underwear	0 1 2 3 4
Autonomic Increased Sympathetic Activity		**Level**
95.	Tendency for anxiety	0 1 2 3 4
96.	Easily startled	0 1 2 3 4
97.	Difficulty relaxing	0 1 2 3 4
98.	Sensitive to bright or flashing lights	0 1 2 3 4
99.	Episodes of racing heart	0 1 2 3 4
100.	Difficulty sleeping	0 1 2 3 4

Fees and Office Policies

Fee schedule:

New patient initial visit*	**$395**
Follow-up office visit or phone consultation (up to 45 mins)	**$165**
Re-evaluation office visit or phone consultation two years since the patient's last follow-up* (up to 45 mins)	**$240**

* The cost of labs and nutritional supplements are in addition to the visit(s).

***IF YOU HAVE AN EMERGENCY*:** We recommend you see your primary care doctor or go to the emergency department. We only treat patients with chronic conditions and do not treat acute conditions.

1) PAYMENT IS REQUIRED AT THE TIME SERVICES ARE PROVIDED: We accept cash, checks, and credit/debit cards. We accept Visa, Mastercard, Discover, and American Express.

2) ***CANCELLATION POLICY:*** All patients are required to have a signed credit card authorization form on file before scheduling appointments. We will do our best to honor your time by staying on schedule. Please help us by arriving on time for your appointments. If you arrive late, the time missed is deducted from your appointment. Due to the amount of time spent at patient visits, we require 72 hours' notice to cancel or reschedule your appointment. If you do not notify us at least 72 hours in advance, you are responsible for paying for the time reserved for you in full (we make allowances in case of true emergencies). We will use the credit card we have on file for this charge.

3) OFFICE HOURS AND LOCATION: We are located in Two Echelon Plaza. Our address is 221 Laurel Rd. Ste. 160 Voorhees, NJ 08043. We are available by appointment only.

4) HEALTH INSURANCE: We do not accept health insurance of any kind. We can provide a superbill of one's visit upon request. Lab services may or may not be eligible for insurance coverage, it is the responsibility of the patient to verify lab coverage before having labs drawn. We do offer non- insurance discount lab services for some testing but these can only be utilized before labs are drawn.

5) SCHEDULING & COMMUNICATION FOR ESTABLISHED PATIENTS: We are dedicated to providing all of our patients with personalized care. We enjoy practicing in a small office setting and running many aspects of our practice (with some help from one other). Bear in mind that our holistic model of functional healthcare is labor and time intensive. In order to stay current with the latest information we are constantly traveling, attending seminars, conferences, and webinars. With that being said, if you have a question, we will try our best to answer your question in a prompt fashion. E- mail is the best way to get your questions answered. You can contact Dr. Christopher Caffery, DC at drcaffery@gmail.com and Dr. Lauren Caffery, DC at drlaurencaffery@gmail.com. E- mails will usually be returned by the end of the next business day. This means if you email on Friday, your email will usually be returned by the end of the day Monday. If you do not have e-mail, you can fax questions to (682) 214-3197.

6) DISABILITY: We do not provide disability or impairment assessments and we do not fill out forms for disability ratings or claims. These types of evaluations would need to be sought from an alternate provider.

7) SUPPLEMENTS: You will be able to purchase the recommended supplements at the office, at our website www.drcafferysupplements.com, by phone, or fax. It is generally recommended that one purchase a supply of supplements to last until the next scheduled visit. If you need supplements before your next visit, you can do so through the aforementioned channels. Shipping charges apply to orders less than $100, shipping is free with orders above $100. The supplements and their shipping will have to be paid in full with a credit/debit card before they are shipped.

8) RETURN POLICY: There are no refunds for any office visits, phone visits, exams, or lab tests (once utilized). Supplements may be returned within 30 days of purchase if they are unopened. Special order supplement items may not be returned. There is a 15% restocking fee on all returned supplements.

9) I fully understand and agree to the above policies and fees. I request care from Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC.

_____Date_____
Patient Signature

If the Patient is a minor (under 18 years of age) or unable to give their own consent, permission for treatment must be granted by their authorized Parent, Custodian, or

Legal Guardian. I _____, the Parent/Legal Guardian of

_____, age _____, do hereby authorize and request Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC, to provide care for my child/legal trustee and I agree to be financially responsible for such care.

_____Date _____
Parent/ Legal Guardian Signature

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Informed Consent for Care

I understand that care from Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC (hereinafter collectively referred to as "the doctors") is not a substitute for conventional medical care with a medical doctor. I also understand that the doctors' involvement with my care is to provide dietary, nutritional supplement, exercise and lifestyle recommendations.

I understand that recommendations by the doctors are not treatment, prevention, or curative of any disease process. I also understand that none of the recommended nutritional supplements have been approved by the FDA.

I understand that there are possible adverse effects from any or all treatments and/or therapies rendered by the doctors. These possible adverse effects include, but are not limited to, aggravation of pre-existing symptoms, flu-like symptoms, allergic reactions, fatigue, and/or gastrointestinal disturbances. I also understand that some of the therapies that the doctors utilize are considered investigational and the long-term effects are not known.

I understand that the doctors cannot anticipate and explain all risks and complications. I also understand that the doctors do not claim any positive outcomes for cases, and there is risk of spending money, time, and energy without guarantee of results.

I have read, or have had read to me, the above consent. By signing below, I voluntarily consent to the treatment plan.

_____

Print Name

_____ Date_____

Patient Signature

If the patient is a minor (under 18 years of age) or unable to give consent, consent must be granted by their authorized parent, custodian, or legal guardian.

I_____, the parent/legal guardian of _____, do understand the above informed consent in full.

_____Date_____

Parent/Legal Guardian Signature

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ACKNOWLEDGEMENT OF NOTICE

I, _____acknowledge that the **Notice of Privacy Practices** (aka Notice) for Integrative Healthcare Solutions has been made available to me. I understand that I have the right to review the Notice prior to signing this document. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment and/or the performance of healthcare operations at Integrative Healthcare Solutions.

Integrative Healthcare Solutions reserves the right to change the privacy practices that are described in the Notice. I understand that I may obtain a revised Notice at www.drcafferyintegrativehealth.com, by calling and requesting a copy by mail, or by picking one up at one of the offices.

_____ _____

Signature of Patient or Personal Representative Date

CONFIDENTIALITY

In the event this office needs to contact you:

May we leave a message for you with someone at your home phone number? ☐ Yes ☐ No

May we leave a message for you on your home voicemail? ☐ Yes ☐ No

May we send you an email? ☐ Yes ☐ No

INFORMED CONSENT REGARDING E-MAIL

Integrative Healthcare Solutions provides patients the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail; however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist after the sender, or recipient has deleted his/her history.

b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Integrative Healthcare Solutions that all e-mail messages sent, or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Integrative Healthcare Solutions will use reasonable means to protect the security and confidentiality of e-mail, or internet communications.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following

INTEGRATIVE HEALTHCARE SOLUTIONS

conditions:
a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected health information, Integrative Healthcare Solutions physicians and upon written authorization other healthcare providers will have access to e-mail messages contained in protected health information.

INFORMED CONSENT REGARDING E-MAIL continued

b. Integrative Healthcare Solutions may forward e-mail messages within the practice as necessary for diagnosis and treatment. Integrative Healthcare Solutions will not; however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. Integrative Healthcare Solutions will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency. Just a reminder, if you have a medical emergency call 911, we do not treat acute conditions.

d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

f. Integrative Healthcare Solutions cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication, but Integrative Healthcare Solutions is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Integrative Healthcare Solutions of any type of information you do not want to be sent by e-mail.

h. It is the responsibility of the patient to protect their password, or other means of access to e-mail sent, or received from Integrative Healthcare Solutions, to protect confidentiality. Integrative Healthcare Solutions is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis, r treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Integrative Healthcare Solutions.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Print Patient Name:

_____

Patient Signature:

_____Date:_____

Informed Consent for Credit Card Authorization

By my signature, I understand that I must give Dr. Christopher Caffery, DC and/or Dr. Lauren Caffery, DC (hereinafter collectively referred to as "the doctors") at least 72 hours' notice of any cancellation or schedule change or I will be charged for the full new patient fee or office visit fee (whichever visit was scheduled) that will not count for the next scheduled appointment. I hereby authorize the doctors and Integrative Healthcare Solutions to charge my credit card if the aforementioned 72 hours' notice is not given. I understand that no appointment will be made or kept without a valid credit card on file.

In addition, I give Dr. Christopher Caffery, DC, Dr. Lauren Caffery, DC and Integrative Health Solutions authorization to pay for any outstanding office visit balances, cancellation fees, laboratory fees and products.

_____ _____

Patient's Name Printed Today's Date

_____ _____

Patient's or Guardian's Signature Date of Birth (Patient)

_____

Guardian's Name Printed if Patient is under 18 years.

Consent to Disclose Personal Health Information

This form is optional. This form only needs to be filled out when you, the patient, would like to share your medical information with someone else that is not a physician, e.g., spouse, parent, etc. After, "I" you will print your name, you will mark the appropriate box, and after "to" you will print the name and address of the person for which we can share your medical information. This form will then need to be signed and witnessed.

I, _____, authorize Dr. Christopher Caffery, DC, Dr. Lauren Caffery, DC
(Print your name)
and Integrative Healthcare Solutions to disclose

☐ my personal health information consisting of **all medical information**

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of **all medical information**

to _____
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:_____Address:_____

Home Tel.:_____Work Tel.:_____

Signature:_____Date:_____

Witness Name:_____Address:_____

Home Tel.:_____Work Tel.:_____

Signature:_____Date:_____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

INTEGRATIVE
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Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment and healthcare operations except for any restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical or mental health, to provision of healthcare services to you, and to the collection of payment for providing healthcare services to you.

Our Notice of Privacy Policies provides information about how we may use and disclose protected health information about you. As provided in our Notice, the terms of the Notice of Privacy Policies may change. If we change our Notice, you may obtain a revised copy by contacting our Privacy Officer, Lauren Caffery, D.C. at (856) 888-1860, who is also available to respond to any questions or receive any complaints you may have concerning your protected health information.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to any restrictions, but if we do, we are bound to our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restrictions.

If you do not sign this Consent Form, we have the right to refuse you as a patient. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. You may request to use our Authorization for Release of Information for purposes of requesting your revocation, or you may simply send us a letter in writing.

By signing this consent, you acknowledge that you have received a copy of the "Notice of Privacy Policies".

_____ _____

Patient's Name Printed Today's Date

_____

Patient's or Guardian's Signature

_____

Guardian's Name Printed if Patient is under 18 years.

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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 our Privacy Officer.
Our Privacy Officer is: Lauren Caffery, D.C.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out your treatment and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your Protected Health Information (PHI). Your PHI is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

This Notice of Privacy Practices serves as notice for Integrative Healthcare Solutions.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.drcafferyintegrativehealth.com, calling the office and requesting a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information (PHI)

A) Uses and Disclosures of PHI Based Upon Your Implied Consent
By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to support the operation of the practice.

Following are examples of the types of uses and disclosures of your protected health information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

> **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information to another physician or health care provider who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

A) Uses and Disclosures of PHI Based Upon Your Implied Consent (cont.)

Payment: Since we do not participate with any insurance carriers, your protected health information will not be used to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of students. We may also call you by name in the reception or treatment areas. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

B) Uses and Disclosures of Protected Health Information That May Be Made with Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

C) Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

D) Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may also use and 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, your location, or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

E) Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is 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. You will be notified, as required by law, of any uses or disclosures.

Public Health: We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: 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 includes government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcements purposes include (1) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of crime, (4) suspicion that death has occurred as a result of criminal activity, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy 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. A "designated record set" contains medical and billing records and any other records that your doctor and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interests to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your provider does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent to use and Disclosure of Protected Health Information" form. Complete the form, sign it, and ask the staff to provide you with a photocopy of your request initialed by them. This will serve as your receipt.

You have the right to request confidential communications from us by alternative means or at an alternative location.

We will accommodate reasonable requests. We may also condition this accommodation by asking for you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing using "Request for Confidential Communications of Protected Health Information" available from the Privacy Officer.

You have the right to have your doctor amend your protected health information.

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical records.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected

health information.
This right applies to disclosures for purposes other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after January 1, 2008. The right to receive this information is subject to certain exceptions, restrictions, and limits. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. Our Privacy Officer is Lauren Caffery, D.C. You may contact our Privacy Officer at (856) 888-1860 or via our website, which is www.drcafferyintegrativehealth.com for further information about the complaint process.

This notice was published and becomes effective on March 1, 2011.