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www.MBSWellness.org
Phone 404-478-9868
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PATIENT REGISTRATION FORM

Hello! Welcome to our office. Our staff at Mind Body Spirit Family Healthcare strives to make your appointment as convenient as possible. Please fill out this comprehensive questionnaire so we may better serve you by understanding your individual needs.

Patient Name:
First Name Middle Name Last Name

Social Security #: - - Date of Birth: - -

Address:
Street Address City, State and Zip

Contact Numbers:
Home Phone Work Phone Cellular Phone

Email Address:

Marital Status: (Circle one) ☐Single/☐Married/☐Divorced/☐Widowed Race

Employer Name: Employer Phone Number:

Employer Address:
Street Address City, State and Zip

Emergency Contact Information (Please provide the name of the nearest relative not living in the same household)

Contact Name: Relationship:

Address:
Street Address City, State and Zip

Contact Numbers:
Home Phone Work Phone Cellular Phone

How were you referred to Mind Body Spirit Family Healthcare: Circle response

☐Self ☐Previous/Other Patient* ☐PCP or Other Doctor* ☐Hospital*

☐Family Friend ☐Yellow Pages ☐Employee Insurance ☐Internet

Other

Person responsible for bill (Complete only if different from patient)

Guarantor Name: Social Security Number: - -

Relationship to Patient: (please check): ☐ self, ☐ spouse, or ☐ parent Date of Birth: / /

Address: Phone Number:

Primary Insurance Company

Insurance Carrier: Group #: ID#

Insured's Name:

Claims Address:
Street Address City, State and Zip

Benefits Number: Precertification Number:

Secondary Insurance Company

Insurance Carrier: Group #: ID#

Insured's Name:

Claims Address:
Street Address City, State and Zip

Benefits Number: Precertification Number:

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y ☐ N☐
IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Mind Body Spirit Family Healthcare. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: ____ Date: __________________

PATIENT HISTORY FORM

Date	Name	Birth Date	Age	Sex	Height	Weight	BloodType

Current Medical Team (Please list name and phone number of each practitioner)
Primary Physician Phone
Dentist Phone
Eye Doctor Phone
Ob/Gyn Phone
Preferred Pharmacy Phone
Other Phone

Health History
What brings you to MBS Wellness Inc?

What are your health goals?

A: Serious Childhood Illnesses (Please Describe)

B: Previous Medical Illnesses Including Surgery And Hospitalizations
Event Date
Event Date
Event Date
Event Date
Event Date

C: Women's Health History
Number of Pregnancies Number of Children Children's Ages
Pregnancies: # Live births: # Premature births: # Abortions/Miscarriages
Age at start of periods Age at end of periods/menopause
Menses (Check all that apply) ☐Regular ☐Irregular ☐Painful ☐PMS ☐Other (Describe Below

D: Allergies
Do you have an ALLERGY to a drug or other substance? ☐**NO** ☐**YES** (Describe Below)

E: Antibiotics
How often have you taken antibiotics? **Infant/Childhood** ☐More than five times ☐Less than five times
Teen ☐More than five times ☐Less than five times **Adulthood** ☐More than five times ☐Less than five times

F: Oral Steroids
How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?
Infant/Childhood **Teen** **Adulthood**

G: Current Medicine Used
Drug Name Strength Dosage
Drug Name Strength Dosage
Drug Name Strength Dosage
Drug Name Strength Dosage
Drug Name Strength Dosage

Do you use over the counter medicines, vitamins, herbs, and food supplements? ☐**NO** ☐**YES** (If yes, describe below)

Name	Strength	Dosage
Name	Strength	Dosage
Name	Strength	Dosage
Name	Strength	Dosage
Name	Strength	Dosage

I: Immunizations
☐Measles-Mumps-Rubella ☐Polio ☐Tetanus & Diptheria ☐Chicken Pox ☐Pneumovax ☐Tetanus Booster ☐DPT ☐Influenza ☐Hepatitis A-Series ☐#1 ☐#2 ☐Hepatitis B Series #1 ☐#2 ☐#3 ☐

J: Toxic Metals
Have you, to your knowledge, been exposed to toxic metals in your job or at home?
☐**NO** ☐**YES** (Check One) ☐Lead ☐Arsenic ☐Aluminum ☐Cadmium ☐Mercury

K: Dental
Do you have dental amalgams (silver fillings) or root canals? ☐**NO** ☐**YES**

N: Social History

Years of Education	**Highest Degree**
Occupation	**Employer**

Present marital status ☐Single ☐Partnered ☐Married ☐Divorced ☐Widowed
Spouse/Partner's Name
Number of children? Ages?
Total household, including your children?

O: Tobacco, Alcohol, Recreational Drug Use
Do you use tobacco in any way? ☐**NO** ☐**YES** If yes, frequency?
If yes, are you interested in quitting? ☐**NO** ☐**YES**
Have you smoked in the past? ☐**NO** ☐**YES** If yes, when did you stop?
Do you drink alcoholic beverages? ☐**NO** ☐**YES** If yes, frequency? (Drinks per week)
Do you use recreational drugs? ☐**NO** ☐**YES** If yes, type?
If yes, are you interested in quitting? ☐**NO** ☐**YES**

P: Sexual Activity
Are you sexually active? ☐**NO** ☐**YES** **Sexual Preference** ☐**Male** ☐**Female**
Birth control method? Practice safe sex? ☐**NO** ☐**YES**

Q: Energy Levels
Describe your energy level throughout a typical day rating on a scale of **1-10 1** = Extreme Fatigue / **10** = Feeling Great And Energized Early Morning Mid Morning to Noon Mid Afternoon Evening

R: Alternative Medical Treatment
Have you seen a practitioner of alternative medicine?
☐**NEVER** ☐**IN THE PAST 12 MONTHS** ☐**MORE THAN ONE YEAR AGO (**Please check any practices you have tried) ☐Acupuncture ☐Chelation Therapy ☐Homeopathy ☐Aroma Therapy ☐Environmental Medicine ☐Hypnosis ☐Nutritional Medicine ☐Ayurvedic Medicine ☐Fasting ☐Light Therapy ☐Biofeedback ☐Meditation ☐Traditional Chinese Medicine ☐Bodywork ☐Herbal Medicine ☐Naturopathy ☐Yoga

Family Medical History:

☐Allergies ☐Alcoholism/Addiction ☐Diabetes ☐High Blood Pressure ☐Seizures
☐Asthma ☐Anemia ☐Heart Disease ☐Mental Disorders ☐Stroke
☐Arteriosclerosis ☐Lupus ☐Other Autoimmune ☐Thyroid disorder ☐Cancer ☐Other:

Your Past Medical History (check any you currently have or have had in the past):
☐AIDS/HIV ☐Cancer ☐Heart Disease ☐Pacemaker ☐Stroke ☐Anemia ☐Headaches ☐GERD
☐Alcoholism/Addiction ☐Chicken Pox ☐Hepatitis ☐Pleurisy ☐Thyroid disorders ☐Arthritis
☐Allergies/Sinus problems ☐Diabetes ☐Herpes ☐Pneumonia ☐Tuberculosis ☐Digestive Problems
☐Appendicitis ☐Emphysema ☐High blood pressure ☐Polio ☐Acne/Eczema ☐Kidney Problems
☐Arteriosclerosis ☐Epilepsy ☐Measles ☐Rheumatic fever ☐Ulcers ☐Eating Disorder ☐Depression
☐Asthma ☐Goiter ☐Lupus ☐Other Autoimmune ☐Multiple Sclerosis ☐Scarlet fever ☐Sexually Transmitted Disease ☐Gout ☐Mumps ☐Seizures ☐Whooping cough ☐Anxiety/Panic Attack
☐Osteoporosis ☐Vitamin Deficiency ☐Other:

☐Surgery (please list)
☐Major Trauma (car, fall, etc; list)

S: Nutrition Evaluation

How many servings of fruit do you eat/drink each day?
(Serving = 1 small piece of fruit, 1 cup juice, 1 cup canned or chopped fruit, 1 cup dried fruit)

How many servings of vegetables do you consume each day?
(Serving = 1 cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, 1 cup dried vegetables, or 1 small piece)

How many servings of pasta/bread/carbohydrates do you consume each day?
(Serving = 1 cup pasta or 2 slices bread)

How many servings of sweets do you have in a day?
(Serving = desserts, hard candy, chocolate bars, etc)

Do you eat meat? ☐NO ☐YES If yes, what kind and how much?

How many servings of meat do you have in a day?
(Serving = red meat, poultry, pork)

Are you currently on a special diet? ☐**NO** ☐**YES** If so, please describe

Your Diet
Appetite: ☐Low ☐High ☐Normal

What do you drink on a typical day? ☐Coffee:(Number of cups per day)
☐Soft Drinks (Number of cups per day)
Thirst for water # glasses per day

Describe any associated food or drink cravings (sugar, coffee, cola's etc): ☐Rich/Greasy ☐Sugar
☐Salty foods ☐Bitter ☐Other

Average Daily Menu
Morning Snack Noon Snack Evening Snack

How would you describe your relationship with food?

Have you ever had a food that you craved or really "binged" on over a period of time?
☐**NO** ☐**YES** If yes, what food(s)?

Do you have an aversion to certain foods? ☐**NO** ☐**YES** If yes, what foods?

M: Emotional Well-Being, Lifestyle & Stressors
☐Stress ☐Occupational Hazards
☐Regular Exercise ☐No ☐Yes: Type and Frequency
☐Emotional Balance (perfect, great, good, fair, bad, horrible):
☐Spiritual Connection (describe):
☐Dysfunction ☐In the home ☐In the family ☐As a child
☐Abuse in the home ☐Abuse as a child (describe):
☐Recent Death in Family (who & when?):
☐Problems in Relationship or Recent Change in Marital Status (Describe):

Review of Systems

Symptoms	Past	Now	Comments	Symptoms	Past	Now	Comments
GENERAL IMMUNE				**EARS**			
Frequent Fatigue				Ear Infections			
Weight Gain/Loss>10#				Hearing Loss			
Hot/Heat Intolerant				Itching			
Poor appetite				Hard Ear Wax			
Cold/Cold Intolerant				Ringing/Tinnitus			
Perspire Easily				**NASAL**			
Lack of Perspiration				Bleeds			
Frequent Infections				Burning/Dryness/Crusts			
History of "Mono" or "EBV"				Sinusitis			
Swollen Glands				Sense of Smell Loss			
ENDOCRINE				**MOUTH/THROAT**			
Low body temperatures				Bleeding Gums			
Sweet smell of breath				Bone Loss(Periodontitis)			
Increased urination				Bruxism (Grinding)			
Bruise easily				Face/Jaw Pain/TMJ			
Increased thirst				Fillings: Silver/Mercury			
Abdominal obesity				Lip Cracks			
Mental slowing/confusion				Mouth Ulcers			
Cold Extremities				Swallowing Problems			
Thyroid Disorder				Taste Loss			
Prominence of forehead or eyes				Tongue coated			
Abnormal growth				Tongue Fissured			
Dizzy Upon Standing				Voice Hoarse			
Low Blood Pressure				**DIGESTIVE**			
SKIN/NAILS				Belching, Bloating, Gas			
Acne, Eczema, Dermatitis				Acid taste in mouth			
Brown Spots				Colitis/Irritable Bowel			
Hives/Rashes				Constipation			
Itching, Burning, Dry				Diarrhea			
Oily				Gastritis, Pain, Ulcer			
Pale				Heartburn, Reflux			
other				Hemorrhoids/Rectal Bleed			
HEAD & NECK				Liver/Gall Bladder Problem			
Hair: Brittle Dry				Vomiting blood			

Hair Loss of Color			
Hair Loss			
EYES			
Wear Glasses			
Blurred Vision			
Blood Shot			
Burning/Dry/Itching			
Cataracts			
Floaters (see spots)			
Glaucoma/Retina Problems			
Lids Crusty			
Light Sensitive			
Night Blindness			
CARDIOVASCULAR			
High Blood Pressure			
Chest Pain			
Dizzy Spells			
Fullness in chest or pressure			
Swelling of feet			
Shortness of breath in sleep			
Number of pillows to sleep			
Leg Pain With Walking			
Palpitations/Tachycardia			
Stroke			
Varicosities			
MUSCLES & JOINTS			
Back Pain/Disc Problems			
Gout			
Join Pins			
Muscle Aches/Pains			
Muscle Cramps/Spasms			
Muscle Weakness			
NEUROLOGICAL			
Clumsy			
Convulsions/Seizures			
Fainting Spells			
Neuralgia/Tingling			
Numbness			
Weakness of arms/legs			
Dizziness/Vertigo			
Raynaud's			
Spastic Motion/Tremors			
URINARY			
Bladder Infections-frequent			
Blood in Urine			
Frequent Urination			
Incontinence			
Kidney Stones			
Frequent urination at night			
Abnormal volume (small/large) of urine (describe):			
Abnormal color: (choose one)			
Strong smell to urine (describe):			
Dribbling of urine			

Nausea/Vomiting			
Bowel urgency			
Bowel Frequency: (choose)			
Everyday			
Every other day			
Every 3 days			
Once a week			
More than once daily			
Stool color/consistency: (describe):			
RESPIRATORY			
Snoring			
Obstructive sleep apnea			
Asthma			
Bronchitis			
Cancer-Lungs			
Chemically Induced Prob			
Chest Pain			
Colds + Flu (frequency)			
Cough-chronic			
Coughing blood			
Coughing Phlegm			
Emphysema			
Exercise Induce Problems			
MALE			
Discharge			
Impotence			
Pain-Testicular			
Hesitancy of stream			
Frequent urination at night			
Painful urination			
Incomplete urination			
Prostate Problems			
Weak Urine Stream			
STD's			
FEMALE			
Hot Flashes			
Mentstruationi # of Days			
Mood changes			
Cramps			
Heavy Flow			
With bright red blood			
Dark red blood			
With or without clots			
Irregular cycles			
Infertility			
Peri-Menopausal			
Menopausal: Natural			
Surgical			
Night Sweats			
Painful Intercourse			
Pap Smears-abnormal			
Pre-Menstrual Tension			
Pregnancies: Full Term			

Pain, Burning				Pre-Term			
BEHAVIOR/PSYCHOLOGY				Miscarriages			
Anxiety				Abortions			
Attention Deficit (ADD)				Ectopic			
Bizarre Behavior				STD's			
Depression				Vaginal: Dryness			
Developmental Delays				Discharge			
Fearful/Worrier				Describe Color?			
Hyperactivity/Manic				Odor? Describe			
Insomnia				Infection			
Learning Problems				Inflammation			
Memory Problems				**OTHER**			
Mood Swings				Best time of the day			
Obsessive/Compulsive				Worst time of the day			
Phobias				Beast season for you			
Schizophrenia				Worst season for you			
Suicidal				Sensitivity to the wind			
Insomnia				Surge of heat sensation			
Nightmares/Night Terrors				Night sweating			
Restless sleep				Sweating in head/neck only			
Vivid dreams				Sweating in legs only			
Talking in sleep				Sweating in palms only			
RHEUMATOLOGY				Strong odor when sweating			
Chronic Fatigue/Polymyalgia Rheumatica							

Mind Body Spirit Wellness

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NEW PATIENT AUTHORIZATIONS & ACKNOWLEDGMENTS

Treatment Authorization: I authorize medical treatment of myself or my minor child by Maiysha Clairborne MD, her medical assistants and other Mind Body Spirit Family Healthcare health professionals and staff.

Medical Records Release Authorization: I authorize Mind Body Spirit Family Healthcare to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company, managed care program, or Medicare carrier upon their specific request. I also authorize any physician or health care provider I have seen to release my medical records to Mind Body Spirit Family Healthcare. Such authorization extends to records regarding my minor child, if applicable.

Financial/Insurance Responsibility: I understand and agree to the following policies regarding financial and insurance responsibilities: Payment is due at the time of service (cash, check, and all major credit cards). To

avoid having to pay a cancellation fee, all patients are required to give a 24 hours notice when canceling an appointment, which must be done during normal business hours. I understand that if 24 hour notice is not given for cancellation there will be a cancellation fee of $25. Likewise, I understand that if I miss a scheduled appointment without any notice, I will also be charged a no-show fee of $25. I understand that after 3 such no-shows, that I am subject to being released from the practice with 30 day notice to find another provider. I will still be held responsible for any outstanding balances to that point. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I also agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treatment practitioner(s). I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Mind Body Spirit Family Healthcare to take action to secure payment of an outstanding balance owed.

I understand that Mind Body Spirit Family Healthcare will assist me as much as possible in understanding whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect.

Notice to Medicare Patients: Dr. Clairborne has opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at Mind Body Spirit Family Healthcare. I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that some services Dr. Clairborne and her staff provide may be considered by Medicare to be non-covered, excluded, or considered not medically necessary due to their nature as complementary medical practices. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for services.

Claim Management: My treating practitioner(s) will respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information.

Patient Acknowledgment: I certify that the information I have reported about my insurance coverage is correct. I certify that I am here to receive medical care and for no other purpose.

Notice as to Nature of Services: I understand that care I receive at Mind Body Spirit Family Healthcare may be non-traditional or unconventional. Such services are commonly referred to as complementary or alternative medical, holistic, or innovative services. Because many of these are efforts to resolve underlying difficulties in the body's capacity to function, they are also known as functional medicine. Although many of these services are evidence based, some of these services may not be recognized as standard medical practice, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition then that prescribed for me.

No Guarantees: I am aware that although Mind Body Spirit Family Healthcare practices to and beyond the standard of care of the physician community, that no practice of medicine is an exact science, and I acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive at Mind Body Spirit Family Healthcare.

New Patient Information: I acknowledge that I have received and read a sheet entitled "New Patient Information" and had any questions answered to my satisfaction.

Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

Patient Signature____

Patient Name____

Date____

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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 office.

This "Notice of Privacy Practices" describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required 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. Upon your request, we will provide you with any revised "Notice of Privacy Practices" by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this section. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

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 a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, 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 from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

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 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.

Other Uses and Disclosures of Protected Health Information Based upon 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. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. 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 physician 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.

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 use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. 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.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

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 such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes 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 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 include 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 governmental 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.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

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 enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (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.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information

to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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 physician and the practice use 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. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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, payment 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 state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested 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 physician. Your request must be submitted to the Privacy Officer in writing.

You have the right to request to receive 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 you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician 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 any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

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, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after October 15, 2002. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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.

Complaints

You may complain to us or to 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. You may contact our Privacy Officer, for further information about the complaint process.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to our Privacy Officer or by reviewing the current copy in our clinics waiting room binder.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

____
Signature

____
Date

____
Witness

Optional: Please restrict access to my personal health information (PHI) from:

____
Name Address

____
Phone Number

____
Name Address

____
Phone Number

Mind Body Spirit Wellness
Phone: 404-478-9868
Fax: 404-478-9869
www.mbswellness.org

Payment Policy

Thank you for choosing Mind Body Spirit Family Medicine as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We accept patients from most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan payment in full for each visit is required and a receipt will be provided to you to file a claim for reimbursement to you. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by other insurers. You must pay for these services in full at the time of visit.

3. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

4. Missed appointments. Our policy is to charge the full amount for missed appointments not canceled within a reasonable amount of time (one business day in advanced). These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

5. Packages. Packages are paid out as agreed upon in the initial terms between Mind Body Spirit and you, the patient. It is the responsibility of the patient to utilized the services associated with the package that is payed for. All packages expire in 180 days if not used. Packages WILL NOT be refunded. If a package is purchased our cancellation policy still applies for missed appointments, and a full visit will be charged (not the discounted package rate).

I have read and understand the payment policy and agree to abide by its guidelines:

__________________________ ____________________________ ____________

Signature Name Date

Mind Body Spirit Wellness

Phone: 404-478-9868
Fax: 404-478-9869
www.mbswellness.org

CONSENT FOR ELECTRONIC RECORDS

The undersigned patient acknowledges and agrees that Mind Body Spirit Family Healthcare may convert some or all of patient's medical record in possession of Mind Body Spirit Family Healthcare into electronic format and thereafter maintain such medical records only in electronic format.

The undersigned patient also acknowledges and agrees that this patient consent and all other patient consents together with patient's signatures on all such patient consents, that are obtained from patient by Mind Body Spirit Family Healthcare may be obtained and maintained by Mind Body Spirit Family Healthcare in electronic format.

For purposes of obtaining the patient's consent under O.C.G.A article 10-12-4, the undersigned patient hereby consents to patients being required by Mind Body Spirit Family Healthcare to receive, recognize, accept, be bound by, and/or otherwise use electronic records and signatures as described herein. The undersigned patient hereby agrees that such medical records and patient consents and signatures of patient in electronic format are valid and will have the same validity as the hard paper copy thereof. Likewise, facsimiles of any signed documents or consents shall have the same validity as the original.

The undersigned patient acknowledges that he or she has carefully reviewed this consent form and understands the contents hereof.

Patient Signature____

Patient Name____

Date of Execution____

Mind Body Spirit Wellness

Phone: 404-478-9868
Fax: 404-478-9869
www.mbswellness.org

Consent to Receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist and herbalist at Good _eedles. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of sterile, single-use needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's
physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to
me and that I am free to stop acupuncture treatment at any time. I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Moxibustion/Direct Moxibustion: Moxa is the furry underside of the leaf of the plant mugwort or artemesia vulgaris. It is used to add heat to the body or to move energy in the channels. Moxa is selected because it burns at a nice even pace and does not have intense heat to it. It is applied indirectly, on top of the needles, in the form of
stick-on moxa cones, or directly to the skin. I understand that there is a risk of burns and I am free to refuse this treatment. It may also be irritating to people with asthma or allergies and I will communicate to my practitioner if this product irritates me.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-_a Massage/Shonishin: I understand that I may also be given acupressure/tui-na massage/shonishin as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. This is the application of an electric current to the needles. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible
aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Gua Sha: I understand that I may be offered Gua Sha to help normalize the body's physiological functions or to

modify or prevent pain perception. I understand that certain adverse side effects could result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of
symptoms existing prior to acupuncture treatment. I understand that I may refuse this therapy.

Cupping: I understand that I may be offered cupping, which is the application of suction using glass cups for the purpose of relieving pain, increasing energy, breaking up stagnation, and treating disease conditions. This therapy leaves bruises which may be quite dark. I need to protect the area for the next 48 hours from excessive or
prolonged exposure to wind, sun, or direct spray from a shower. (A quick shower is fine.) This is because the pores are opened and may be quite sensitive. I understand that I will be asked each time this therapy is applied if I want it and that I may refuse it.

Ear Seeds: I understand that I may be offered ear seeds, which are seeds taped on an auricular acupuncture point in the ear. I understand that the ear has a minimal blood supply and that an inflammation of the outer ear is very serious. I agree if I receive ear seeds to remove them if they irritate or bother me. I agree to keep my ears clean
and to remove them after the time frame discussed with my practitioner. I understand that if the outer ear becomes infected due to my negligence in removing these seeds in a timely manner, that I need to seek western medical care and am fully responsible for the charges. I understand that I may refuse this therapy.
I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. (If I ask for and receive a more detailed explanation, both practitioner and patient will initial next to item.) I give my permission and consent to treatment.

Signature: ____

Date: ________________________