

Ageless Skin & Laser Center
Holistic Nursing Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Even if some questions seem unrelated to your current condition, please answer this questionnaire as thoroughly as possible. Please print clearly, and mark any areas of confusion with a question mark. Thank you.

All information is strictly confidential.

Name _____ Date ____/____/____

Date of Birth ____/____/____ Place of Birth _____ Age _____

Address _____ Sex M / F / FTM / MTF / O

City _____ State _____ Zip _____

Home Phone Number (_____) _____ - _____ Cell Phone Number (_____) _____ - _____

Email Address _____ Relationship status _____

Would you like email reminders?

Would you like text message reminders?

Preferred method of communication? ☐ Email ☐ Mail ☐ Home Phone ☐ Mobile Phone

Emergency Contact Person _____

Emergency Contact Phone Number(s) (_____) _____ - _____ or (_____) _____ - _____

Primary Care Provider _____

Approx. Date of Last Visit _____ Physician's Office Phone Number (_____) _____ - _____

I would like you to send chart notes to my primary care provider _____ (sign here)

How did you hear about Ageless Skin & Laser? _____

Have you ever had integrated medicine treatment before? _____

What is the main reason for your appointment today? _____

How long have you been experiencing this problem? _____

What makes this condition worse? _____

What makes this condition better? _____

What other treatments have you tried for this condition? _____

What would you like to achieve from coming here?

1.

2.

3.

Please list any other health concerns in order of importance:

1.

2.

3.

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Medical History

Height: _____ ft. _____ in. **Weight:** _____ **Cholesterol:** _____

Blood Pressure: Most recent reading _____/_____ When was this taken? _____

Please answer the following questions:

Yes / No I have a pacemaker

Yes / No I am currently being treated with blood thinners or anti-clotting medications

Yes / No I am prone to excessive bleeding and/or poor wound healing

Yes / No I have a medical condition that may cause my liver, spleen, heart or lungs to be enlarged

Childhood Illness (please check all you have had):

☐Scarlet Fever

☐Mumps

☐German Measles

☐Rheumatic Fever

☐Measles

☐Chicken Pox

Immunizations (please check all you have had):

☐Polio

☐Measles/Mumps/Rubella

☐HPV (Cervical Cancer)

☐Tetanus

☐Diphtheria

☐Varicella (Chicken Pox)

☐Pertussis

☐Hepatitis B

☐Influenza (Flu)

Have you been diagnosed with any of these conditions? Check all that apply.

☐AIDS/HIV

☐Endocrine Disorder

☐Lyme's Disease

☐Alcoholism

☐Epilepsy

☐Multiple Sclerosis

☐Arterial disease

☐Fibromyalgia

☐Polio

☐Asthma

☐Gout

☐Rheumatic Fever

☐Birth trauma

☐Heart Disease

☐Scarlet Fever

☐Cancer

☐Hepatitis A / B / C

☐Seasonal Allergies

☐Diabetes

☐Herpes

☐Seizures

☐Drug Addiction

☐High blood pressure

☐Tuberculosis

☐Emphysema

☐Joint Replacement(s)

☐Thyroid Disorder

Have you suffered any major traumas, physical or emotional? ____ If yes, please describe:

Hospitalizations and Surgeries

Reason

Date

Reason

Date

Please list any known allergies (environmental, latex, food, medications, stings, etc.)

Allergen

Reaction

Allergen

Reaction

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List your current Medications, Vitamins & Supplements: (use the back of page if needed)

Medication/ Supplement	Dosage	For what purpose/condition?

Family Health History: Check all that apply to your Mother, Father, Siblings and Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Drug Abuse/ Alcoholism | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cholesterol, Elevated | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | |

Energy & Sleep

How is your energy? _____ Do you fatigue easily? _____

When is your energy highest? _____ Lowest? _____

How long do you normally sleep? _____ hours per night. Do you wake feeling rested? _____

Do you have difficulties with any of the following (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Falling asleep | <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Restless leg |
| <input type="checkbox"/> Staying asleep | <input type="checkbox"/> Snoring | <input type="checkbox"/> Mind racing at night |

Do you wake at a certain time of night? _____ If yes, when? _____

Emotions & Stress

- | | | | | |
|-------------------------------------|--|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Over-thinking | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritable | <input type="checkbox"/> Short temper |

How do you hold stress? _____

How do you relax? _____

What is your occupation? _____

How do you feel about your work? _____

What kind of exercise do you do? _____ How often? _____

Eating Habits: Please describe your current eating habits:

- | | | |
|--|---|--|
| <input type="checkbox"/> Low-carbohydrate diet | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Eat a lot of fried food |
| <input type="checkbox"/> Low-fat diet | <input type="checkbox"/> Eat a lot of dairy | <input type="checkbox"/> Eat a lot of red meat |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Eat a lot of carbohydrates | <input type="checkbox"/> Eat a lot of sweets |

Do you place any restrictions on your diet? _____ If yes, please explain _____

How do you perceive your current weight? Underweight/ Normal/ Slightly overweight/ Overweight

Tobacco/ Alcohol Use

- | | |
|---|---|
| <input type="checkbox"/> Smoke tobacco, # of packs per day: _____ | <input type="checkbox"/> Quit smoking _____ months/years ago |
| <input type="checkbox"/> Drink alcohol, # of drinks per week: _____ | <input type="checkbox"/> Quit drinking _____ months/years ago |

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Please write "C" next to symptoms you currently experience, and "P" next to symptoms you have experienced in the past year.

General

- ☐ Prefer cold drinks
- ☐ Prefer hot drinks
- ☐ Recent weight loss or gain
- ☐ Cold hands & feet
- ☐ Chills
- ☐ Fever or sensation of heat
- ☐ Frequent colds

Head & Neck

- ☐ Headaches/ Migraines
- ☐ Stiff neck
- ☐ Dizziness
- ☐ Fainting
- ☐ Swollen glands

Ears

- ☐ Ringing
- ☐ Hearing loss
- ☐ Frequent Ear Infections
- ☐ Earache

Eyes

- ☐ Glasses/ contacts
- ☐ Blurred vision
- ☐ Poor night vision
- ☐ Spots or floaters
- ☐ Eye inflammation
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataracts

Nose, Throat & Mouth

- ☐ Sinus infection
- ☐ Hay fever/ allergies
- ☐ Frequent sore throat
- ☐ Difficulty swallowing
- ☐ Mouth / tongue ulcers
- ☐ Nosebleed
- ☐ Dry nose/ mouth/ throat
- ☐ Nasal congestion
- ☐ Loss of voice
- ☐ Thirst
- ☐ Excessive phlegm
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems

Skin & Hair

- ☐ Hives / rashes
- ☐ Eczema/ psoriasis
- ☐ Night sweating
- ☐ Excess sweating
- ☐ Dry skin
- ☐ Skin texture changes
- ☐ Easy bruising
- ☐ Mole/ lump changes
- ☐ Itching
- ☐ Dry hair
- ☐ Hair loss
- ☐ Change in hair color
- ☐ Hair texture changes

Respiratory

- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Asthma / wheezing
- ☐ Chronic cough
- ☐ Wet cough
- ☐ Dry cough
- ☐ Coughing up phlegm
- ☐ Coughing up blood
- ☐ Pneumonia

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain / tightness
- ☐ Palpitations
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swollen ankles
- ☐ Phlebitis
- ☐ Anemia

Gastrointestinal

- ☐ Nausea
- ☐ Indigestion
- ☐ Stomach pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Vomiting
- ☐ Gas

- ☐ Hiccups
- ☐ Acid regurgitation
- ☐ Bloating
- ☐ Bad breath
- ☐ Bloody stool
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Gall Bladder disorder

Musculoskeletal

- ☐ Joint pain/disorder
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Difficulty walking
- ☐ Neck/shoulder pain
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Rib pain
- ☐ Reduced range of motion

Neurological

- ☐ Seizures
- ☐ Tremors
- ☐ Numbness or tingling
- ☐ Pain
- ☐ Paralysis
- ☐ Poor coordination

Urinary

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Incomplete urination
- ☐ Decreased urine flow
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Wake to urinate
- ☐ Kidney stones
- ☐ Lower abdominal pain

Male Reproductive

- ☐ Increased / decreased libido
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Pain of genitalia
- ☐ Genital itching
- ☐ Testicular pain / swelling
- ☐ Lumps in testicle(s)

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OB/GYN History

Date of last period: ___/___/___ Avg. duration of flow: _____ Avg. length of cycle: _____

Age at first menses: _____ Number of pregnancies: _____ Number of abortions: _____

Age at menopause: _____ Number of live births: _____ Number of miscarriages: _____

Do you use birth control? Y / N If yes, please describe: _____

Do you have any reason to suspect that you might be pregnant? Y / N

Are you currently trying to become pregnant? Y / N

Have you ever had any of the following?

☐ Abnormal pap smear

☐ Endometriosis

☐ Hysterectomy

☐ Abnormal mammogram

☐ Uterine fibroids

☐ Breast cancer

☐ IUD or Hormone IUD

☐ Mastectomy

☐ Cervical cancer

☐ Ectopic pregnancy

☐ Lumpectomy

☐ Uterine cancer

Please write "C" next to symptoms you currently experience, and "P" next to symptoms you have experienced in the past year.

___ Decreased libido

___ Breast lumps

___ Bleeding between cycles

___ Increased libido

___ Breast tenderness

___ Blood clots

___ PMS

___ Excess vaginal discharge

___ Heavy bleeding (weeks)

___ Pain before menstruation

___ Vaginal odor

___ Pain during intercourse

___ Pain during menstruation

___ Vaginal sores

___ Bleeding after menopause

___ Pain after menstruation

___ Vaginal dryness

___ Hot flashes

___ Bone density changes

___ Vaginal itching

___ Fibrocystic breasts

___ Vaginal pain

Do you experience any of the following pre-menstrual symptoms?

☐ Nausea

☐ Breast swelling

☐ Suicidal feelings

☐ Vomiting

☐ Breast tenderness

☐ Irritability

☐ Headaches

☐ Water retention

☐ Other emotions? _____

☐ Migraines

☐ Anxiety

☐ Dull pain, where? _____

☐ Food cravings

☐ Depression

☐ Sharp pain, where? _____

Medical Screening:

Most recent pap smear: ___/___/___

What was the result? Normal / Abnormal

Most recent mammogram: ___/___/___

What was the result? Normal / Abnormal

Hormone Replacement Therapy

Are you currently using Hormone Replacement Therapy? Y / N

Type/ Dose: _____ How long have you been on HRT? _____

Any side effects? _____

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Office Policies & Procedures

Before your first appointment

Contact your health care professionals to get copies of your recent medical records, including laboratory assessments. Of course, Seth McLaughlin or Dean McLaughlin may order additional lab work, if needed. Drop your records off at least one week before your appointment to give Seth time to review them. It's helpful to have a journal of your activities, foods, sleep record, nutritional supplements, medications, and how you felt for three days (two weekdays, 1 weekend day).

On the day of your appointment

You can expect to have some of the same evaluations you are used to and some new ones as well. We strive to start your appointment within 15 minutes of your appointment time. To keep us on time, we ask that you arrive before your appointment time. Please have all paperwork filled out by the time your appointment is set to start. Please bring a prioritized list of issues you'd like to address. Seth typically types out notes regarding your concerns and provides you a detailed copy of your encounter by mail or email a week after your appointment.

Insurance

We are happy to provide you with documentation you may need to file for insurance reimbursement of your visit. Your visit would typically fall into your out of network coverage. Although we are happy to help you with insurance requests, we do not participate in any insurance plans or file insurance at this time. For letters of medical necessity or complex forms, a form generation fee will be charged.

Fees

A new patient evaluation is typically 1 – 1 & ½ hours in length and costs \$200, regardless of length of the appointment. Subsequent appointments are billed in 15 minute increments at \$50/increment. Your first follow up appointment will typically be 45 minutes. Medications administered during your appointment represent additional cost. Fees may be paid by cash, check, Visa, MasterCard, American Express, Discover Card, or Care Credit. Returned checks will be charged the maximum fee allowed by law.

Lab Testing

We will happily order you labs through any of the local companies such as Solstas, Quest, Atherotec, Labcorp or Quest, who may attempt to bill your insurance provider. Advanced lab testing through specialty companies may not be covered. Although the most frequently used labs can be very helpful, their goal is to identify disease. Our goal is to help you reach optimum health. To do so, we may need to order more thorough labwork.

Primary Care Provider

Although we will work closely together, neither Seth McLaughlin nor M. Dean McLaughlin will become your primary care provider. You must have a primary care provider for annual screenings, after hours care, and in-hospital care, if ever needed. We will not assume responsibility for you getting screenings such as mammograms, pap smears, colonoscopies, or laboratory studies.

Telephone Consultations

Telephone consultations are billed at the same price as in-person consultations. Payment will be due at the time of your appointment or before your appointment.

Email Communication

We are available to all patients whenever possible by phone or email for clarification of treatment. According to the AMA, both phone and email communication are billable services. Due to the high volume of emails we receive, we ask that you keep email questions quick, clear, concise, and use yes/no questions. If you would like a lengthy email communication, understand that we can do so but we will bill for that time at the regular rate. We would rather see you in person for better communication. If we haven't seen you in over a year, we will be unable to answer medical questions by email. In the case of an emergency, do not email us, call 911. Please understand that email communication may not always be secure. In your new client paperwork, there will be a consent form for non-encrypted email communication.

Follow-up Appointments

We generally see patients every 3-6 months. If we order any prescription medication, you must be seen every six months, at minimum. To remain a patient, you must be seen at least annually.

Nutritional Supplements

Nutritional supplements may be recommended during your appointment. With over 15 years of experience working with supplements, Seth may specify a brand of supplements to use. You may purchase supplements from local health food stores & pharmacies, from online retailers, or from our web store below. If you choose to purchase them from the webstore, you must have an access code given during your appointment.

Cancellations

We request the kindness of 24 hours notice before an appointment is cancelled. If appointments are cancelled or you fail to show for your appointment, you may be asked to pre-pay for future appointments. After three short-notice cancellations or failures to show for appointments, you will be dismissed from the practice. If for any reason we ever have to change your appointment, we will endeavor to give you at least 24 hours notice as well.

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Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used And Disclosed By Ageless Skin & Laser Center And How You Can Get Access To It. Please Read This Notice Carefully.

1. Our Privacy Obligations: We are required by law to maintain the privacy of medical and health information about you (Protected Health Information or PHI) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure)

2. Permissible Uses and Disclosures Without Your Written Authorization:

PHI is held in strict confidence, only our physicians, receptionists, medical assistants, laboratory technicians and billers have access to PHI. In certain situations, described in section 111 below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our "health care operations" (e.g., internal administration, quality improvement and customer service) as detailed below:

Treatment. We use and disclose PHI to provide treatment and other services to you- for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

Payment: We may use and disclose PHI to obtain payment for services that we provide to you (ex. Disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (Your Payor or to verify that Your Payor will pay for health care.)

Health Care Operations. We may use and disclose PHI for our health care operations, which include internal administrations and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers, we may disclose PHI to our HIPAA officer to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such is needed for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for fraud and abuse detection or compliance.

B. Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to family members, other relatives, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures please notify the HIPAA Officer. If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling, disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of judicial or administrative proceedings in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the US military or the US Department of State under certain circumstances required by law.

M. Workers Compensation. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating in workers compensation or other similar programs.

N. As Required by Law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

III. Use and Disclosures Requiring Your Written Authorization.

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our authorization form ("Your Authorization") For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved.

B. Special Authorization. Confidential HIV- related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, HIV related illness or AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances, to public health or other government officials (as required by law) to persons specified in a special court order, to insurers as necessary for payment for your care or treatment, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with specified process set forth in Tennessee State Law) This opposed to Your Special Authorization: disclosures to a third party payor for any reason other than obtaining payment for health care services rendered to you.

C. Marketing Communications. We must also obtain your written authorization prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to face encounter, without obtaining your authorization. We are also permitted to give you a promotional gift of

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nominal value, if we so choose, without obtaining your marketing authorization. In addition, we may communicate with you about products or services relation to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

D. Parents or Legal Guardians of minors please note: portions of the medical record relating to sexual activity, sexual conduct tests for sexually transmitted diseases, contraception, family planning or abortion will not be accessible to you and will therefore not be a part of any records or results that are given to you unless we receive written specific authorization from the patient, although a minor.

IV. Your Individual Rights

A. For Further Information: Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our HIPAA Officer. You may also file written complaints with the Director, Office for Civil Rights of the US Department of Health and Human Services. Upon request, the HIPAA Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction, if you wish to request additional restrictions, please obtain a request form from our HIPAA Officer and submit the completed form to the HIPAA Officer. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative location.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form and submit the completed form to the HIPAA Officer. We will charge you \$0.75 cents for each page for any second requests of medical records, but there will be a \$10.00 charge for duplicate receipts/bills paid. You should take note that ,if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, parental care, care received by a married minor, and contraception and/or family planning services).

E. Right to Revoke Your Authorization. You may revoke your authorization, your special authorization, or your marketing authorization except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the HIPAA Officer identified below. (A form of written revocation is available upon request)

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form and submit the completed form to the HIPAA Officer. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive an Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you (\$1.50 per page) for the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

V. Effective Date and Duration of This Notice

A. This Notice is effective on the date signed

B. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the office. You may also obtain any revised notice by contacting the HIPAA Officer.

VI. HIPAA Officer You May Contact

Seth McLaughlin, MSN APN FNP-BC LMT CPhT

303 Med Tech Parkway STE 110

Johnson City, TN 37601

(423) 952-5300

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Email Policy

This Agreement on the Use of Electronic Mail for Patient Communications (“Agreement”) is entered into as of this ____ day of ____, ____ between Seth McLaughlin, MSN APN FNP-BC LMT CPhT and Ageless Skin & Laser Center (the “Practice”) and _____, an individual patient of the Practice (the “Patient”).

WHEREAS, the Practice and Patient believe that the use of e-mail will enhance communication between Patient, the Practice and Practice’s clinical providers (“Provider”) regard Patient’s care and treatment, and may also serve to expedite administrative matters related to health care services rendered to Patient;

WHEREAS, Patient has a confidential Practice-patient relationship with Practice physician and has been previously examined at the Practice; and

WHEREAS, the Practice and Patient wish to set forth in writing their understanding regarding the use of e-mail communications, in order to establish clear guidelines for the use of such communications.

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the ongoing medical services rendered to Patient by the Practice, and other valuable consideration, the receipt and sufficiency of which hereby acknowledged, the parties agree as follows:

1. Use of E-mail Communications. Patient agrees and understands that Patient may use e-mail to communicate with Providers regarding Patient’s care and treatment, and with the Practice regarding certain administrative matters arising from health care services rendered to patient.

The Practice and Providers shall make a reasonable attempt to return all e-mail messages received within two (2) business days. Notwithstanding the foregoing, the Patient does not receive a response by the close of business on the second business day following the Patient’s e-mail message; the Patient agrees to use other means of communication to contact the Practice or Provider. Similarly, the Patient agrees that the Practice and Providers may use reasonable professional judgment to determine whether any response by e-mail is appropriate or practical, and request that the Patient either speak with the Practice or Provider by telephone or make an appointment for an in-person visit.

2. Composing E-mail Messages. When composing e-mail messages to Providers, the Patient shall:

- (a) Write concisely;
- (b) Include the Patient’s full name in the subject line, and a brief description of the nature of the request (e.g., “prescription refill”, “medical advice”, “billing question”).
- (c) Keep copies of e-mail messages sent and received.
- (d) When requested by Provider, send a reply to Provider to acknowledge receipt and review of e-mail message from Provider.

3. Access to the Patient’s E-mail Communications. The Practice may use non-clinical personnel of the Practice to access e-mail messages sent to Provider or Practice which include inquires related to administrative matters.

4. No Liability. The Patient agrees that e-mail communications with the Practice and any Provider is offered as a convenience to the Patient, and the Patient shall not hold the Practice or Provider responsible for any expense, loss, or damage caused by, or resulting from:

- (a) a delay in Practice’s or Provider’s response to the Patient, or any damage to the Patient resulting from such delay, due to technical failures, including, but not limited to, technical failures attributable to the Practice’s internet service provider, power outages, failures of the Practice’s electronic messaging software, failure of the Practice’s computers or computer network. Or faulty telephone or cable data transmission;
- (b) any interception of the Patient’s, Provider’s, or Practice’s e-mail communications by a third party; or
- (c) the Patient’s failure to comply with the guidelines regarding use of e-mail communications set forth in Section 1, above.

5. Confidentiality. The Practice and Providers shall exercise reasonable efforts to ensure the confidentiality of the Patient e-mail communication, however, the Patient understands that e-mail communication to the Practice are not secure, and there is therefore some possibility that the confidentiality of such communications will be breached by a third party. Communication regarding highly confidential medical matters should therefore be reserved for other forms of communication (e.g., telephone, personal visit). If the Patient accesses the Practice through an employer e-mail system, the Patient should be aware that an employer has the right to review any e-mail communication transmitted through the employer’s mail system.

6. Archiving. The Practice may keep copies of e-mail messages that the Patient sends to Provider or the Practice, and may include such messages in the Patient’s medical record.

7. Termination. This Agreement may be terminated by the Practice if the Practice determines that the Patient has failed to comply with its provision. Upon termination of the Agreement, the Practice will no longer respond to the Patient’s e-mail communications in the regular course of providing services to the Patient. However, the Practice shall reserve the right to

Ageless Skin & Laser Center
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respond to any e-mail communications from the Patient, if the Practice determines that such a response is appropriate or practical.

8. Billing. If the time it takes to read and respond to your e-mail exceeds 5 minutes, you may be billed for this service at our regular hourly rate. (in 15 minute increments) The American Medical Association acknowledges e-mail communication between a provider and a patient as a billable service.

IN WITNESS WHEREOF, this Agreement has been executed by the practice and the Patient as of the day and the year first written above.

PRACTICE: Ageless Skin & Laser Center

Name and Title: Seth McLaughlin, MSN APN FNP-BC LMT CPhT

Print Patient's Name _____

RELATIONSHIP TO Patient _____

Signature _____

Acknowledgement / Receipt of Privacy Practices

Print Name _____ Relationship to Patient _____

Signature: _____ Date: _____

Consent to treat

The information that I have given to Ageless Skin & Laser is complete and true to the best of my knowledge. I authorize the providers and staff to administer such procedures as they deem necessary and that I find agreeable. I understand that Ageless Skin & Laser implies no guarantees of cure, that I have the right to choose my treatment plan, and that I may refuse any or all treatment suggestions at any time. I acknowledge that I have been given no guarantees or warranties, expressed or implied, regarding the outcome of procedures or care. I acknowledge that I have not been asked to discontinue care given to me by my primary care provider or specialists. I understand that our care including Holistic Nursing care employs techniques commonly used among integrative medicine practitioners but are not considered mainstream among conventional physicians. I have read the policies and procedures and agree to abide by them. In the event that any dispute shall arise, I agree that, if asked, I will submit information about that dispute in writing for clarity. I further agree to participate in mediation under the laws of the state of Tennessee. Both parties shall share equally in any associated costs of mediation. Mediation involves each party to a dispute sitting down with an impartial person, the mediator, to attempt to reach a voluntary settlement. I have read and understood the policies set forth above and do agree to them.

Print Name _____ Relationship to Patient _____

Signature: _____ Date: _____

Practitioner Signature _____

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Release of Information

Patient Name _____ DOB _____

I authorize Ageless Skin & Laser and/or the providers listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at any time of my choosing. I understand that Ageless Skin & Laser is not authorized by me to use or disclose my protected health information for any purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use or disclose the information, and the recipient(s) of that information. I further understand that other providers may charge me for copies of my records.

Description of information to be used or disclosed:

☐ The patient's full medical record for the past two years, including information that may contain psychiatric, alcohol, drug abuse, sexually transmitted infection testing, HIV testing, HIV results, or AIDS information

☐ Specific information as detailed below

☐ X-ray, CT, MRI _____

☐ Lab reports _____

☐ History & Physical _____

☐ Notes _____

To / From _____ Phone/Fax _____

To / From _____ Phone/Fax _____

To / From _____ Phone/Fax _____

This authorization Shall Shall Not (circle one) expire on _____ date of expiry, if desired. After this date, if one is entered, Ageless Skin & Laser can no longer disclose the patient's protected health information without first obtaining a new authorization form.

The patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization. I fully understand and accept the terms of this authorization.

Signature _____ Date _____

Ageless Skin & Laser Center
303 Med Tech Parkway STE 110
Johnson City, TN 37604
(423) 952-5300
FAX (423) 794-3057

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Medicare Private Contract (Opt-out Agreement)

This contract is necessary to obtain services by Seth McLaughlin MSN APN FNP-BC and associates of Appalachian Skin & Laser dba Ageless Skin & Laser Center due to the fact that he has “opted out” of Medicare.

This means that Seth McLaughlin, MSN APN FNP-BC and associates of Ageless Skin & Laser Center WILL NOT file Medicare/Medicaid, nor accept any Medicare/Medicaid payment. Seth McLaughlin has no stated Medicare specialty and has an National Provider Identification number of 1013073592.

The following conditions apply to all Medicare/ Medicaid beneficiaries and this contract must be read and signed by any and all Medicare/ Medicaid beneficiaries or their legal representative before any medical treatment can be rendered by Seth McLaughlin MSN APN FNP-BC and associates of Ageless Skin & Laser Center

I, _____, understand and agree to:

Give up all Medicare/Medicaid coverage of, and payment for services furnished by Seth McLaughlin MSN APN FNP-BC and associates of Ageless Skin & Laser Center.

Agree not to bill Medicare/Medicaid or ask Seth McLaughlin MSN ANP FNP-BC or his associates to bill Medicare/Medicaid for items of service furnished by Seth McLaughlin MSN APN FNP-BC and associates of Ageless Skin & Laser Center.

Agree that I am liable for all charges that I have agreed to of Seth McLaughlin MSN APN FNP-BC and associates of Ageless Skin & Laser Center, without any limits that would otherwise be imposed by Medicare/Medicaid.

Agree that Medigap will not pay toward the services and that other supplemental insurers may not pay either.

Agree that I have the right to receive items or services from other medical practitioners from whom Medicare/Medicaid coverage and payment would be available.

Agree to reimburse Seth McLaughlin MSN APN FNP-BC and associates of Ageless Skin & Laser Center for any costs and reasonable attorney’s fees that result from violation of this contract by patient [or his beneficiaries].

Patient acknowledges that a copy of this contract has been made available to him.

Signature_____

Date_____

Provider Signature_____

Seth McLaughlin, MSN APN FNP-BC
303 Med Tech Parkway STE 110
Johnson City, TN 37604
(423) 952-5300