CelebrityCare MEDICAL CLINIC
Promoting Lifestyle Medicine

37131 IH-10, Suite 101 Boerne, Texas 78006
(830) 249-8400 Office (830) 255-4660 Fax

Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

Patient Questionnaire

Patient Name _____ DOB _____ Age _____
mm/dd/yyyy

Medical History – Please check if you or any blood relative has/had any of the following:

	You	Relative		You	Relative
Diabetes	☐	☐	Anemia	☐	☐
High/Low Blood Pressure	☐	☐	Alcoholism	☐	☐
Hepatitis/Liver Problems	☐	☐	Mental Illness	☐	☐
Heart Disease	☐	☐	Depression	☐	☐
Pulmonary Disease	☐	☐	HIV +	☐	☐
Kidney/Bladder Problems	☐	☐	AIDS	☐	☐
Arthritis	☐	☐	Blood Transfusions	☐	☐
Osteoporosis	☐	☐	Hearing Disorder	☐	☐
Heart Attack	☐	☐	Eye Disease	☐	☐
Stroke	☐	☐	Epilepsy/Convulsions	☐	☐
High Cholesterol	☐	☐	Recent Weight Loss/Gain	☐	☐
Stomach Ulcer	☐	☐	Migraine Headaches	☐	☐
Bowel Problems	☐	☐	Sinus/Throat Infections	☐	☐
Neurological	☐	☐	Angina/Chest Pains	☐	☐
Cancer (Type)	☐	☐	Any Other Disease (If yes, give details)	☐	☐

Any Unusual Family Illnesses ☐
(If yes, give details)

Are your immunizations current? Y N **Height** _____ **Weight** _____ **B/P** _____

Are you currently taking Medications?
(This includes prescription, non-prescription, vitamins and herbal preparations)

Medication	Dose	Times/Day	Medication	Dose	Times/Day

DRUG ALLERGIES

Drug	Reaction

Do You Now or Have You Ever Used:

Cigarettes? Y N _____ pk/day

Alcohol? Y N _____ glasses/week

Drugs of Abuse? Y N _____

Women: Is there any chance you may be pregnant? Y N

Surgery: Have You Ever Had Surgery? Y N (If yes, please give details)

Have you ever been advised to have any Surgical Procedure, which has not been done? Y N (if yes, explain)

Signature _____ **Date** _____
mm/dd/yyyy

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When entering phone numbers, social security number etc. below please enter numbers only. Do not enter dashes or other symbols.

PATIENT REGISTRATION FORM

Today's Date: _____ ☐ **New Patient** ☐ **Updated Information**

Patient Legal Name: _____ **Age:** _____ **Date of Birth:** _____
Last First Middle mm/dd/yyyy

Address: _____ TX
Street or PO Box City State Zip Code

Hm. Phone # _____ **Mbl #** _____ **Other #** _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other **Sex:** ☐ Male ☐ Female

Social Security # _____ **Driver's License #** _____ **State** _____

Employer/School: _____ **Occupation:** _____ **Work #** _____

Spouse/Parent's Name: _____ **Hm#** _____ **Wk#** _____

RESPONSIBLE PARTY: (If other than patient): Relationship to Patient: _____

Name Address City State Zip code

Home # Work # Occupation

LOCAL PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ **Relationship:** _____ **Phone #:** _____

Address: _____
Street or PO Box City State Zip Code

MEDICAL ARE: I authorize CCMC Providers or designee to provide myself or my dependent with reasonable and proper medical care according to today's standards.

Signature of Patient or Guarantor: _____ **Date:** _____

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PATIENT INTAKE: MEDICAL FORM
(To be completed by patient)

Date: _____

Name: _____ DOB: _____ SS# _____

Address: _____ TX

Phone: (H) _____ (C) _____ Email: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact/Relationship/Phone#: _____

Primary Care Physician/Phone #: _____

Date of Last Physical: _____ Date of Last Menstrual Cycle: _____

Childhood History (where did you grow up, # brothers & sisters): _____

_____

Educational History: _____

Employment History: _____

Relationship/Marriage: _____

Children: _____

Current Living Arrangement: _____

Criminal Justice History: _____

Reproductive History (LMP, # of pregnancies): _____

CURRENT/PAST MEDICAL CONDITIONS

(Asthma, Hypertension, Liver/Thyroid/GI Disease, STDs, Cardiovascular, Seizure Disorder, Diabetes, Head Trauma, other)

CURRENT or PAST MEDICAL CONDITION	APPROXIMATE DATE OF ONSET OR DIAGNOSIS

PAST SURGERIES

(Gall Bladder removal, Appendectomy, Hysterectomy, Heart Surgery, Angioplasty, other)

PAST SURGERIES	APPROXIMATE DATE OF SURGERY

ALLERGIES

Medical/Environmental Allergies and Reaction: (Example rash, swelling, trouble breathing)

ALLERGIC TO	REACTION

MEDICATIONS

Please list any other medications you take that are not listed in the substance abuse patient questionnaire page (include any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia, ADD, ADHD or any other psychiatric illnesses).

MEDICATION NAME	DOSAGE/ FREQUENCY	PRESCRIBING PHYSICIAN	REASON TAKING MEDICATION

LIST PRIOR INPATIENT TREATMENT PROGRAMS INCLUDING OUTPATIENT TREATMENT PROGRAMS (IOP)

NAME OF PROGRAM	DATES	LENGTH

Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

What is your longest period of (clean and sober) sobriety? _____

What helped you remain sober? _____

Do you have a family history of addiction? Yes No
If yes, who:_____

Do you have any current legal problems? Yes No
If yes, please describe:_____

Are you currently in a Pain Management Program? Yes No
If yes: Name of Program/Phone #:_____

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? Yes No
If yes: Name/Phone #_____

Have you ever experienced, witnessed, or been confronted with traumatic events (abuse)? Yes No

Have you ever thought about, planned or attempted suicide? Yes No
If yes please explain (include dates): _____

Are you currently suicidal? Yes No
If yes please explain: _____

CURRENT SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

PAST SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

TOBACCO HISTORY

	HOW MUCH DAILY	HOW MANY YEARS	PAST/PRESENT
CIGARETTES			
SMOKELESS			
VAPE			

Have you ever experienced any of the following when you attempted to stop drinking or using? Please check all that apply.

☐	Seizures	☐	Loss of Consciousness
☐	Tremors	☐	Hot/Cold Sweats
☐	Nausea and Vomiting	☐	Blackouts
☐	Hallucinations (DT's)	☐	Falls

The consequences of drug use change over time. Initially, there is a "honeymoon" period in which few, if any, of the costs have time to emerge. But, as drug use continues the consequences begin to accumulate. In what way has your perception of benefits become overwhelmed by consequences?

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NAME: _____ DOB: _____ Date: _____

Beck Depression Inventory

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

1	**0** I do not feel sad. **1** I feel sad. **2** I am sad all the time and I can't snap out of it. **3** I am so sad or unhappy that I can't stand it.	8	**0** I don't feel I am any worse than anybody else. **1** I am critical of myself for my weaknesses or mistakes. **2** I blame myself all the time for my faults. **3** I blame myself for everything bad that happens.
2	**0** I am not particularly discouraged about the future. **1** I feel discouraged about the future. **2** I feel I have nothing to look forward to. **3** I feel that the future is hopeless and that things cannot improve.	9	**0** I don't have any thoughts of killing myself. **1** I have thoughts of killing myself, but I would not carry them out. **2** I would like to kill myself. **3** I would kill myself if I had the chance.
3	**0** I do not feel like a failure. **1** I feel I have failed more than the average person. **2** As I look back on my life, all I can see is a lot of failure. **3** I feel I am a complete failure as a person.	10	**0** I don't cry any more than usual. **1** I cry more now than I used to. **2** I cry all the time now. **3** I used to be able to cry, but now I can't cry even though I want to.
4	**0** I get as much satisfaction out of things as I used to. **1** I don't enjoy things the way I used to. **2** I don't get any real satisfaction out of anything anymore. **3** I am dissatisfied or bored with everything.	11	**0** I am no more irritated by things than I ever am. **1** I am slightly more irritated now than usual. **2** I am quite annoyed or irritated a good deal of the time. **3** I feel irritated all the time now.
5	**0** I don't feel particularly guilty. **1** I feel guilty a good part of the time. **2** I feel quite guilty most of the time. **3** I feel guilty all of the time.	12	**0** I have not lost interest in other people. **1** I am less interested in other people than I used to be. **2** I have lost most of my interest in other people. **3** I have lost all of my interest in other people.
6	**0** I don't feel I am being punished. **1** I feel I may be punished. **2** I expect to be punished. **3** I feel I am being punished.	13	**0** I make decisions about as well as I ever could. **1** I put off making decisions more than I used to. **2** I have greater difficulty in making decisions than before. **3** I can't make decisions at all anymore.
7	**0** I don't feel disappointed in myself. **1** I am disappointed in myself. **2** I am disgusted with myself. **3** I hate myself.	14	**0** I don't feel that I look any worse than I used to. **1** I am worried that I am looking old or unattractive. **2** I feel that there are permanent changes in my appearance that make me look unattractive. **3** I believe that I look ugly.

15	**0** I can work about as well as before. **1!** It takes an extra effort to get started at doing something. **2** I have to push myself very hard to do anything. **3** I can't do any work at all.	19	**0** I haven't lost much weight, if any, lately. **1** I have lost more than five pounds. **2** I have lost more than ten pounds. **3** I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)
16	**0** I can sleep as well as usual. **1** I don't sleep as well as I used to. **2** I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. **3** I wake up several hours earlier than I used to and cannot get back to sleep.	20	**0** I am no more worried about my health than usual. **1** I am owrried about physical problems such as aches and pains, or upset stomach, or constipation. **2** I am very worried about physical problems, and it's hard to think of much else. **3** I am so worried about my physical problems that I cannot think about anything else.
17	**0** I don't get more tired than usual. **1** I get tired more easily than I used to. **2** I get tired from doing almost anything. **3** I am too tired to do anything.	21	**0** I have not noticed any recent change in my interest in sex. **1** I am less interested in sex than I used to be. **2** I am much less interested in sex now. **3** I have lost interested in sex completely.
18	**0** My appetite is no worse than usual. **1** My appetite is not as good as it used to be. **2** My appetite is much worse now. **3** I have no appetite at all anymore.		TOTAL **0**

Name:_____DOB:_____ Date _____

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been affected by that symptom during the past month, including today. If you printed this form, please write the appropriate number for each column in the corresponding circle. In the Column Sum row, write the sum of each column. Finally, sum those four totals and write the result in the Grand Score box. If filling this out on your computer, this table should automatically sum and tally all of the totals for you (if using one of the apps listed).

	Not At All 0	Mildly but it didn't bother me much. 1	Moderately - it wasn't pleasant at times 2	Severely – it bothered me a lot 3
Numbness or tingling	◯	◯	◯	◯
Feeling hot	◯	◯	◯	◯
Wobbliness in legs	◯	◯	◯	◯
Unable to relax	◯	◯	◯	◯
Fear of worst happening	◯	◯	◯	◯
Dizzy or lightheaded	◯	◯	◯	◯
Heart pounding/racing	◯	◯	◯	◯
Unsteady	◯	◯	◯	◯
Terrified or afraid	◯	◯	◯	◯
Nervous	◯	◯	◯	◯
Feeling of choking	◯	◯	◯	◯
Hands trembling	◯	◯	◯	◯
Shaky / unsteady	◯	◯	◯	◯
Fear of losing control	◯	◯	◯	◯
Difficulty in breathing	◯	◯	◯	◯
Fear of dying	◯	◯	◯	◯
Scared	◯	◯	◯	◯
Indigestion	◯	◯	◯	◯
Faint / lightheaded	◯	◯	◯	◯
Face flushed	◯	◯	◯	◯
Hot/cold sweats	◯	◯	◯	◯
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score.

Clear

Grand Score _____

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Monday, Tuesday & Thursday, 8am-4pm.

Before and after our scheduled office hours our answering service is available to answer your calls. The answering service cannot change nor cancel appointments. In the event your call is an emergency, please call 911 for assistance. Patients needing to reach the Physician or nurse during business hours for medication refills or general questions may leave a message on their voicemail. Messages are typically returned within 24 to 48 hours.

APPOINTMENTS– CCMC is committed to providing continuous coverage and quality care to our patients. Please be prepared to provide updated demographic and insurance information when scheduling an appointment and medication count.

All patients must notify the office **830-249-8400** of any appointments/cancellations within **48 hours**of their scheduled appointment. Failure to notify the office will be charged a **fullpayment** assessed to your account. **(Office staff will give a courtesy call – but is not required). $25 for EARLY REFILLS before your schedule appointment.**

(TEXTINGPHYICIANSFORMEDICALQUESTIONSORCONCERNSWILLBE CHARGED $25 TEXT)

TRANSFEROFCARE– We are happy to forward your medical records to your new provider should you choose to seek care with another Physician.

FINANCIAL OBLIGATION: It is our office policy to collect payment from patients at the time services are rendered. This includes any outstanding payment that was required after hours services as stated in your financial contract with our clinic. We accept cash, and credit cards. **We do not accept Insurance or Medicare/Medicaid**. On your behalf as a courtesy, we will provide you with an Invoice to submit for your insurance company for you to file the claim.

FORMS/LETTERS/MEDICAL RECORDS – A minimum of **a $75.00 fee will be applied to the completion of forms or letters requested by our office.**Extra charge over 50 pages (**25¢**). **Paymentisduewhenyoucollectthecompletedforms/letters.**FMLA paperwork or other forms require a 7-business day turnaround for completion**. (NO CHECKS)**

DRUGTESTING:IF YOU ARE SELECTED FOR A DRUG TEST YOU ARE REQUIRED TO COME IN THE SAME DAY! **NO SHOW IS A POSITIVE.**

Signature: _____ Date: _____

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Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ Date of Birth _____ authorize Celebrity Care Medical Clinic at above address

Patient Name (Print) _____ to: Physician Name (Print) Dr. Jeffrey Butts or Providers;

Check all that apply:

☐ **RECEIVE** my treatment information/records from the following physician or treatment provider:
(name, address)_____

(name, address)_____

☐ **RECEIVE** my treatment records from the following therapist:
Therapist (name, address)_____

☐ **RELEASE** my treatment information/records to the following healthcare facility/treatment provider:
(name, address)_____

☐ **RELEASE** my treatment information to the following family member:
(name, address) _____

This information is for the following purposes (any other use is prohibited)
_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. **This consent will expire 365 days after I complete my treatment,** unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

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Note: This page only applies to patients who have a narcotic component to their treatment. If you are not using narcotics you can skip this page.

BUPRENORPHINE (SUBOXONE) TREATMENT AGREEMENT

Name: _____ DOB:_____

Please type your initials after each statement below. Enter letters only. The form will automatically uppercase the initials and add periods.

As a participant in Buprenorphine (Suboxone) treatment for opioid use disorder, I agree to the following:

1. To keep all my scheduled appointments or change the appointment in advance, except in case of emergency. _____
2. I agree not to sell, share, or give any of my medication to another person. _____
3. I agree not to deal or buy drugs at GIMC, or in its parking lots or property. _____
4. I agree that my medication/prescription will only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit. _____
5. I agree that the medication I receive is my responsibility and I agree to keep it safe and secure. I agree that lost/ stolen medication will not be replaced regardless of why it was lost/ stolen. _____
6. I agree not to obtain buprenorphine (Suboxone), other opioids, or benzodiazepines (for example, lorazepam, diazepam/Valium, clonazepam, alprazolam/Xanax, etc.) from any other healthcare providers, pharmacies, or other sources without telling my treating physician. _____
7. I understand that mixing buprenorphine with other medications, especially benzodiazepines (as in #6) can be dangerous. I understand that several deaths have occurred among persons mixing buprenorphine (Suboxone) and benzodiazepines. There is also a risk of overdose death from mixing buprenorphine (Suboxone) with large amounts of alcohol or other types of sedatives, such as barbiturates._____
8. I understand that buprenorphine (Suboxone) by itself is not enough treatment for my addiction, and I agree to participate in counseling/support groups as discussed and agreed upon with my healthcare provider. I understand that if my attendance at these groups is not confirmed then I will not be able to continue to receive buprenorphine (Suboxone). _____
9. I agree to provide random urine samples for drug testing and have my healthcare provider test my blood alcohol level whenever I am asked to do so. _____
10. I agree that my goal is to stop using addictive drugs, and that I will work to stop using all addictive and illegal drugs during my treatment with buprenorphine (Suboxone). _____
11. I agree that violating this agreement may result in my no longer receiving treatment with buprenorphine (Suboxone). _____
12. I understand that if I decrease my use of opioids (stop using heroin, pain pills) or substitute buprenorphine for these drugs, I have a higher risk of dying from an overdose if I relapse. I understand that if I relapse, I need to use small doses of opioids until I learn what my body can tolerate. _____
13. I understand that if I relapse when I have been taking buprenorphine, at first, I may not get high from the other opioids because buprenorphine blocks their effect. I understand that if I keep using larger and larger mounts to try to get high, I could stop breathing and die. _____
14. I understand that buprenorphine (Suboxone) is extremely dangerous for infants and children. They can stop breathing and die after taking in tiny amounts of this medication. I agree to keep my supply of this medication locked securely away from others, especially infants and children. _____

I consent to the above terms and to begin treatment with buprenorphine (Suboxone).

Patient signature:_____ Date:_____

Provider name & signature:_____ Date: _____

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I. Introduction. Texas Law defines Telemedicine as "a health care service delivered by a physician licensed in this state, or a health professional acting under delegation and supervision of a physician licensed in this state, and acting within the scope of a physician's or health professional's license to a patient at a different lo cation than the physician or health professional using telecommunications or information technology."

II. Consent for Treatment. I voluntarily request Celebrity Care Medical Clinic ("CCMC") provider(s) and such associates, technical assistants and others as they may deem necessary ("CCMC Telemedicine Providers") to participate in my medical care through the use of
telemedicine.

- I understand that my healthcare information may be shared with CCMC associates for scheduling and billing purposes. Others may also be present during the consultation in order to operate the telecommunications technology. The above-mentioned people will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the
consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and/or (3) terminate the consultation at any time.

- I understand that a telemedicine consultation is not the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as the CCMC Telemedicine Provider. CCMC providers will not have the opportunity to perform an in-person physical examination, and therefore it is critical for me to provide accurate information. I acknowledge that CCMC Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or inaccuracies of a screening test or procedure. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

- I understand that CCMC Telemedicine are not intended to replace a primary care physician relationship. If CCMC Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in- person medical evaluation. I agree to seek emergency help or follow-up care when recommended by an CCMC provider or when otherwise needed.

An CCMC provider may make arrangements for follow-up care either through my local provider, a health systems partner, or other health care providers.

- In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary.

- If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my CCMC provider and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

III. Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to CCMC Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.
I understand that the disclosure of my medical information to CCMC Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although the electronic systems we use will incorporate networks and software security protocols to protect the privacy and security of health information, in some instances, security protocols may fail and cause a breach of privacy and/or personal health information.

IV. Acceptance of Terms. By signing this form, I certify that:

1. I certify that this consent has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents
2. I fully understand the risks and benefits of the proceure(s).I have been given ample
3. opportunity to ask questions and that any questions have been answered to my satisfaction.
4. I understand that the laws that protect the privacy and security of health information apply to telemedicine.
5. I understand my CCMC Provider, in his or her sole discretion and professional judgment, may determine that telemedicine services are not appropriate for some or all of my treatment needs and, accordingly, may elect not to provide telemedicine services.

_____ _____

Patient's/parent/guardian signature Date

_____ _____

Witness signature Date

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NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. Access to Care. You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable law s and regulations. This is true regardless of race, creed, sex, national origin, religion, disability or handicap, or source of payment for care or services.

2. Respect and Dignity. You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

3. Personal Safety. You have the right to expect reasonable safety regarding the practice's procedures and environment.

4. Identity. You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.

5. Privacy and Confidentiality. You have the right, within the law, to personal and informational privacy. This includes the right to:

- Be interviewed and examined in surroundings that ensure reasonable privacy
- Have a person of your own sex present during a physical examination or treatment
- Not remain disrobed any longer than is required for accomplishing treatment or services
- Request transfer to another treatment room if a visitor is unreasonably disturbing
- Expect that any discussion or consultation regarding care will be conducted discreetly
- Expect all written communications pertaining to care to be treated as confidential
- Expect medical records to be read only by individuals directly involved in care, quality-assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

6. Information. You have the right to obtain complete and current information concerning your diagnosis (to the degree know n), your treatment, and any know n prognosis. This information should be communicated in terms that you understand.

7. Communication. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. Consent. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.

- Consent discussions will include an explanation of the condition, the risks and benefits of treatment, as well as the consequences of no treatment.

- Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.

- You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. Consultation. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. Charges. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

11. Rules and Regulations. You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. Keep Us Accurately Informed. You have the responsibility to provide, to the best of your know ledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

2. Follow Your Treatment Plan. You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.

3. Keep Your Appointments. You are responsible for keeping appointments and, w hen unable to do so for any reason, for notifying this practice in 24 hours or responsible party will be charged for the same day cancellation.

4. Take Responsibility for Noncompliance. You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. Be Responsible for Your Financial Obligations. You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible.

6. Be Considerate of Others. You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

7. Be Responsible for Lifestyle Choices. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

Patient Name (Print): _____ Date: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____