New Adult Health Questionaire (Age 18 years and older)

Name: First _____ Middle _____ Last _____

Preferred Name (and Title) _____

Female _____ Male _____ Date of Birth _____

Place of Birth_____

Genetic History European ____ Mediterranean ___ African____ Native American ____ Asian ____ Middle Eastern____ Other_____

Current Job _____

Nature of Job _____

Primary Address Street/Apartment No.

_____

City _____State_____ Zip _____

Best Phone to Reach You _____Alternate Phone _____

Preferred email address to discuss your health _____

How did you hear about our services?

_____

Who should we contact if there is an emergency?

Name_____ Relationship _____

Phone number _____

Preferred Pharmacy: Name _____ Phone Number _____
City _____

Compounding Pharmacy:Name _____Phone Number_____
City_____

What Allergies or Intolerances do you have to medications, airborne, foods, chemicals?

_____

What medicines do you take currently? _____

What vitamins, herbs, and supplements do you take? _____

What treatments have you tried in the past? _____

When did you first not feel well? _____

Was anything associated with the onset of your health problem? _____

What are your top 5 health concerns (symptoms) now?

_____

Since the start of your ill health has anything happened to make matters significantly worse?

_____

Since the start of you ill health has anything happened to make matters significantly better?

_____

What do you do that makes you feel worse? _____

What do you do that make you feel better? _____

Birth History-Did your mother have pregnancy complications?

_____

Were there birth complications? _____

How many days were you in the hospital when you were born? _____

Childhood and Adolescent History-What illnesses did you have as a child?

_____

Did you receive vaccinations as a child? _____

What were they for? _____

About how many times did you take antibiotics as a child? _____
What were they for? _____

What regular medicines did you take as a child? _____

What were they for? _____

Please explain any hospitalizations as a child (<18 years old). _____

Please explain any health problems you experienced in high school. _____

Please explain any health problems while at school after high school (College/Professional School) _____

Please explain any other health issues as an adult that you feel are important for us to know _____

Please list Surgeries and dates_____

Do you have any surgical implants_____

Please list hospitalizations and dates_____

_____
_____

Environmental Exposure History Where have you lived in the past?
_____

Have you traveled outside of the United States? _____
When and where? _____

Do you or did you smoke? Yes___ No___

Did you live with a regular smoker? Yes___ No____

Have you lived where you drank well water? _____ When and where? _____

Have you had any exposure to man-made chemicals that you know of (cleaning chemicals, toxic metals, farm chemicals, hair care products, insecticides, paints and solvents, auto chemicals, welding, etc)? Please explain _____

How many times do you go to the dry cleaners in a month?_____

Currently are you bothered by any exposures like chemicals, fumes, cigarette smoke, perfumes, car exhaust, etc? Please explain._____

Have you had any head injury (unconscious, amnesia, concussion, headaches, seizures)? Please explain _____

Have you ever lived or worked where there was a musty odor, mildew, water leak or known mold growth? Please explain _____

Have you ever lived somewhere that you believe made you ill? Please explain _____

Have you ever been told you have an ongoing infection or parasite illness?(lymes, etc.) _____

Diet and Nutrition History

Current height in inches_____ Current weight in pounds_____

Highest weight since age 18_____ Lowest weight since age 18_____

What is your desired weight range goal in pounds?_____

Have you ever changed your diet or eating habits due to health concerns? Please explain_____

Are you currently on a special diet or eating program? _____

Do you feel that you have problems with your digestion? Please explain_____

Do you regular perform any digestive “cleanses”?

_____

How willing are you to modify your eating to achieve your wellness goals?

Not willing____ Somewhat willing____ Very willing____

What foods or beverages do you consume the most?

_____

What changes to your eating habits do you think you should make to feel better/_____

Are there any barriers to changing your eating habits?

_____

Exercise and Stress Reduction

Are your health problems made worse by stress?

_____

Please list significant sources of stress in your life.

_____

Do you get regular physical exercise? Please describe (what kind, how often, what duration, when and where). _____

Do you engage in any regular stress reduction activity (meditation, yoga, prayer, etc)? Please explain_____

Have you ever received counseling or special care for your mental health? Please explain.

_____

Would you consider working with a trainer or life coach? Yes____ No____

Are you under excessive stress and what are the sources of your stress? Please grade your stress level

0=no stress 10=most stress imaginable NA=not applicable

Home_____ Spouse_____ Children_____ Parents_____ Job_____ Social Life_____

Girlfriend/Boyfriend_____ School_____ Sexual Relations_____

Have you ever had professional help to cope with stress? Yes/no Please explain_____

Please list ways you have learned to cope with stress_____

Other Social History

Do you currently smoke?_____ How much?_____

When did you quit smoking?_____

Did you live with someone who smoked? _____ How long?_____

If you smoke how likely are you to quit if advised to do so? Not at all likely_____ Somewhat likely_____ Very likely_____ I plan to quit smoking_____

Have you been involved in a program to quit smoking in the past?_____

Do you consume alcoholic beverages?_____
Please explain what type, how much and how often.
_____

Do alcoholic beverages help you to feel better?_____ Make you feel worse?_____

Do you take any non-prescribed recreational drugs? _____

What drugs and how often?_____

If you do is it in order to feel better or get relief of symptoms?_____

For Women Only

Age at first period_____ Date last period started_____ Are your periods regular_____

How many days between periods_____

Periods are: light____ moderate____ heavy____ very heavy____

Do you experience symptoms that seem related to your cycle like PMS (please explain)_____

Have you been pregnant? Yes____ No____ If yes, how many times? _____
Outcome_____

During pregnancy did you feel: better ____ worse____ same____

Did you experience significant problems from pregnancy or delivery (please explain_____

What form of contraception do you employ? None/ Not applicable _____

Please list_____

Do you use oral contraceptives or female hormones?

(please list)_____

Are you experiencing problems with sexual relations?
(explain)_____

For how long?_____ Did you in the past?_____ For how long?_____

When did you have your last female exam?_____

Date of last PAP smear?_____

Date of last mammogram?_____ NA_____

MEN ONLY

Any change in sexual performance? (Please indicate any that apply)

Sex Drive_____ Motivation_____ Erection_____

Climax/Orgasm_____ Pain_____

List any other_____

Any prostate problems or change in
urination?_____

Have you taken anything to assist with sexual performance or prostate health?
_____

Family History Please circle all conditions occurring in your family

ADD/ADHD_____ Addiction Disorder/Alcoholism_____ Allergies _____ Arthritis_____ Asthma_____ Autistic Spectrum_____ AutoImmune Disease_____ Bleeding Disorder_____ Cancer _____ Celiac Disease_____

Chronic Fatigue_____ Depression/Anxiety_____ Diabetes_____ Dementia/Alzheimers_____ DigestiveDisorder_____ Dizziness/Vertigo_____ Eczema/Psoriasis_____ Fibromyalgia_____ FoodAllergy_____

Headache/Migraine_____ HeartDisease_____ HighBloodPressure_____ HormoneBalance_____ ImmuneDeficiency_____

Inherited/MetabolicDisorder_____ InflammatoryBowelDisease _____ IrritableBowel_____ MemoryLoss_____ MitochondrialDisorder_____ MultipleSclerosis_____ NerveDisorder_____ Overweight_____ Parkinson's_____

Psychiatric Disorder_____ Seizures_____ Skin Disease_____ Sleep Apnea _____ Sleep Loss_____ Thyroid Problems_____

List of Symptoms In Past 60 Days

Digestive: Abdominal Pain _____ Upset Stomach_____ Bloating_____ Belching_____ Flatulance_____ Nausea_____ Vomiting_____ Constipation_____ Diarrhea_____ Change in appetite _____ Heartburn_____ Reflux_____

Endocrine: Fatigue _____ Sleeplessness/Insomnia_____ Excess Sleepiness_____ Weight loss_____ Weight gain_____ Hair loss_____

Change in skin/nails_____ Low blood sugar_____ Not sweating_____ Excessive sweating_____ Night sweats_____ Eating disorder_____

Unusual body odor_____ Increase urination_____ Change in urine_____ Fluid retention_____ Feeling Hot/Hot flashes_____

Feeling cold/Chills_____ Change in hair_____ Acne_____ Undesired hair growth_____ Food cravings_____ Thyroid problem_____

Adrenal problem_____ Diabetes_____ Diabetes/High blood sugar _____ Pituitary disorder_____ Other hormone disorder_____

Nervous System: Problems with focus/attention_____ Problems with speech_____ Problems with memory_____

Problems multitasking_____ Problems with sensitivity to Sights_____ Sounds_____ Smells_____ Tastes_____ Odors_____

Headaches_____ Migraines_____ Facial pain_____ Numbness _____ Burning/Tingling_____ Uncontrolled movements_____ Weakness_____

Voice change_____ Hoarseness_____ Tremor_____ Faintness_____
Fainting episodes_____ Amnesia_____ Head injury_____ Concussion _____

Change of muscle tone Muscle loss_____ Absence spells_____ Seizure-like activity_____ Hallucinations_____ Confusion_____

Loss of Coordination/Drop things_____

Vision: Loss of vision_____ Visual hallucinations/spots/flashes_____ Dark spots/tunnel vision_____ Blurred vision_____ Change in colors_____ Dryeye_____ Itchy eyes_____

Hearing/Balance: Loss of hearing_____ Ringing in ears_____ Ear pain_____
Ear itching_____ Ear discharge_____ Dysequilibrium_____

Spinning vertigo_____ Motion sickness_____ Positional vertigo_____

Nose/Sinuses: Sinus pain_____ Nasal itching_____ Sneezing_____ Nasal blockage_____ Nasal discharge_____ Post-nasal drip_____

Nosebleed_____ Sinus infection_____

Mouth/Throat: Growth or sore_____ Dry mouth_____ Mouth pain/burning_____
Trouble swallowing _____

Mouth swelling_____

Mood/emotions: Anxiety Panic attacks_____ Depression_____ Bipolar Pyschiatric diagnosis_____ ADD/ADHD_____ Autism_____

Emotionality Schizophrenia_____ Compulsive_____ Obsessive_____
Impulsive_____ Tantrums/Rages_____ Excess fear/Phobia_____

Mood swings_____ Trouble with transitions_____ Addiction _____

Immune/Inflammatory: Frequent illness_____ Seasonal Allergy/Hayfever_____ Food allergy_____ Parasites_____

Lymes_____ HIV_____ Shingles_____ History Mononucleosis_____
AutoImmune Disorder_____ (Please list)_____

Respiratory: Cough_____ Asthma_____ Shortness of breath_____ Emphysema _____ Tuberculosis_____ Sleep apnea_____

Pneumonia _____ Bronchitis_____ Cough up blood_____

Skin: Persistent sore/growth/mark_____ Rash_____ Hives_____ Eczema_____
Excessive bruising _____

Cardiovascular: Lightheadedness_____ Rapid heart beat_____ Slow heart beat_____ Irregular heart beat_____ Sudden vasospasm_____ Blood clot_____ Stroke_____ TIA_____ Chest pain_____ Exertional pain_____ Pain with exercise_____ Exercise intolerance_____ High blood pressure_____ Low blood pressure_____ Cold extremities_____ Mitral valve prolapsed _____ Heart attack_____

Cholesterol/Lipid disorder_____

Joints and Extremities: Joint stiffness_____ Joint swelling_____ Joint redness_____ Hot joints_____ Joint pain_____ Muscle pain_____

Muscle spasm_____ Muscle tenderness to touch_____ Muscle swelling_____

GenitoUrinary: Burning urination_____ Frequent/Urgent urination_____ Blood in urine_____ Change in urine smell_____

Change in urine appearance Nighttime Urination_____ Bedwetting_____ Uncontrolled urination/Incontinence_____

Dental: Dental cavities_____ Tooth pain_____ Gum disease_____ Bleeding gums _____ Pain with chewing_____ TMJ disorder/pain_____

Broken teeth_____ Mercury fillings_____ Metal crowns/Implants_____

MEDICARE PRIVATE CONTRACT
IN COMPLIANCE WITH 42 U.S.C. §1395a; 42 C.F.R. § 405, SUBPART D

This contract is entered into by and between Wallace Taylor MD "physician", whose principal medical office is located at 4107 Medical Parkway Suite 100; Austin, Texas and the medicare beneficiary whose name appears on the accompanying signature page and shall become effective on the date of the signature sheet and shall expire on the 30th day of September, 2016 (the "opt out period"), unless otherwise renewed in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.

Physician Obligations

The physician acknowledges that [he or she] [is or is not] excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician acknowledges that [he or she] must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that [he or she] must enter into a contract for each opt-out period.

Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would

be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

[Optional provision, not required by Medicare to be included in the affidavit]: I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.
Revised September 26, 2014

_____
Name of Physician (printed)

_____ _____
Signature of Physician Date

_____ _____
Principal Office Address Telephone Number

_____
National Provider Identifier

_____
Name of Beneficiary (printed) or His/Her Legal Representative

_____ _____
Signature of Beneficiary or Date
His/Her Legal Representative

_____ _____
Home Address Telephone Number

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.

We respect the privacy of your personal health information and are committed to maintaining our residents' confidentiality. This Notice applies to all information and records related to your care that our facility has received or created. It extends to information received or created by our employees, staff, volunteers and physicians. This Notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and obligations regarding your personal health information.

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your personal health information; and
- Abide by the terms of the Notice that are currently in effect.

I. WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT. PAYMENT AND HEALTH CARE OPERATIONS

For Treatment: We will use and disclose your personal health information in providing you with treatment and services. We may disclose your personal health information to facility and non-facility personnel who may be involved in your care, such as nurses, physicians, nurse aides, and physical therapists. For example, a nurse caring for you will report any change in your condition to your physician. We may also disclose personal health information to individuals who will be involved in your care after you leave the facility.

For Payment: We may use and disclose your personal health information so that we can bill and receive payment for the treatment and services you receive at the facility. For billing and payment purposes, we may disclose your personal health information to your representative, an insurance or managed care company, Medicare, Medicaid or another third party payer. For example, we may contact Medicare or your health plan to confirm your coverage or to request prior approval for a proposed treatment or service.

For Health Care Operations: We may use and disclose your personal health information for facility operations. These uses and disclosures are necessary to manage the facility and to monitor our quality of care. For example, we may use personal health information to evaluate our facility's services, including the performance of our staff.

II. WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES

Facility Telephone Directory. Unless you object, we will include certain limited information about you in our facility directory. This information may include your name, your location in the facility, and your phone number. Our directory does not include specific medical information about you. We may release information in our directory to people who ask for you by name.

Clergy Information: We may provide your name, location, phone number, general condition and religious affiliation, to any member of the clergy.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your personal health information to a family member or close personal friend, Including clergy, who is involved in your care.

Disaster Relief: We may disclose your personal health information to an organization assisting in a disaster relief effort.

As Required by Law: We may disclose your personal health information when required by law to do so.

Public Health Activities: We may disclose your personal health information for public health activities. These activities may include, for example

- reporting to a public health or other government authority for preventing or controlling disease, injury or disability, or reporting child abuse or neglect; reporting to the federal Food and Drug Administration (FDA) concerning adverse events or problems with products for tracking products in certain circumstances, to enable product recalls or to comply with other FDA requirements;
- to notify 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 or
- for certain purposes involving workplace illness or injuries.

Reporting Victims of Abuse. Neglect or Domestic Violence: if we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your personal health information to notify a government authority if, required or authorized by law, or if you agree to the report.

Health Oversight Activities: We may disclose your personal health information to a health oversight agency for oversight activities authorized by law. These may include, for example, audits, investigations, inspections and licensure actions or other legal proceedings. These activities are necessary for government oversight of the health care system, government payment or regulatory programs, and compliance with civil rights laws.

Judicial and Administrative Procedures: We may disclose your personal health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may disclose your personal health information for certain law enforcement purposes, including, as required by lay to comply with reporting requirements;

- to comply with a court order, warrant, subpoena, summons, investigative demand or similar legal process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- when information is requested about the victim of a crime if the individual agrees or under other limited circumstances;
- report information about a suspicious death;
- to provide information about criminal conduct occurring at the facility;
- to report information in emergency circumstances about a crime; or
- where necessary to identify or apprehend an individual in relation to a violent crime or an escape from lawful custody.

Research. We may allow personal health information of Resident/Client/Members from our facility to be used or disclosed for research purposes provided that the researcher adheres to certain privacy protections. Your personal health information may be used for research purposes only if the privacy aspects of the research have been reviewed and approved by a special Privacy Board or Institutional Review Board, if the researcher is collecting

information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Coroners. Medical Examiners. Funeral Directors. Organ Procurement Organizations: We may release your personal health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an, organization involved in the donation of organs and tissue.

To Avert a Serious Threat to Health or Safety: We may use and disclose your personal health information when necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces, we may use and disclose your personal health information as required by military command authorities. We may also use and disclose personal health information about foreign military personnel as required by the appropriate foreign military authority.

Workers' Compensation: We may use and disclose your personal health information to comply with laws relating to workers' compensation or similar programs.

National Security and Intelligence Activities: Protective Services for the President

and Others: We may disclose personal health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.

Fundraising Activities: We may use certain personal health information to contact you in an effort to raise money for the facility and its operations. We may disclose personal health information to a foundation related to the facility so that the foundation may contact you in raising money for the facility. In doing so, we would only release contact information, such as your name, address and phone number and the dates your received treatment or services at the facility. The money raised will be used to expand and improve the services and programs we provide the community and our residents.

Appointment Reminders. We may use or disclose personal health information to remind you about appointments.

Treatment Alternatives: We may use or disclose personal health information to inform you about treatment alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose personal health information to inform you about health-related benefits and services that may be of interest to you.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF PERSONAL HEALTH INFORMATION

We will use and disclose personal health information (other than as described in this Notice or required by law) only with your written Authorization. You may revoke your Authorization to use or disclose personal health information in writing, at any time. If you revoke your Authorization, we will no longer use or disclose your personal health information for the purposes covered by the Authorization except where we have already relied on the Authorization.

IV. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights regarding your personal health information at the facility:

Right to Request Restrictions: You have the right to request restrictions on our use or disclosure of your personal health information for treatment, payment or health care operations. You also have the right to restrict the personal health information we disclose about you to a family member, friend or other person who is involved in your care or the payment of your care.

We are not required to agree to your requested restriction (except that while you are competent you may restrict disclosures to family members or friends). If we do agree to accept your requested restrictions, we will comply with your request except as needed to provide you with emergency treatment.

Right of Access to Personal Health Information: You have the right to inspect and obtain a copy of your medical or billing records or other information that may be used to make decisions about your care, subject to some limited exceptions. We may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain limited circumstances. If you are denied access to personal health information, in some cases you will have a right to request review of the denial. This review would be performed by a licensed health care professional designated by the facility who did not participate in the decision to deny.

Right to Request Amendment: You have the right to request the facility to amend any personal health information maintained by the facility for as long as the information is kept by of for the facility. You must make the request in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information.

- Was not created by the facility, unless the originator of the information is no longer available to act on your request;
- is not part of the personal health information maintained by or for the facility.
- is not part of the information to which you have a right of access; or
- is already accurate and complete as determined by the facility.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of our disclosures of your personal health information. This is a listing of certain disclosures of your personal health information made by the facility or by others on our behalf, but does not include disclosures for treatment, payment and health care operations or certain other exception.

To request an accounting of disclosures, you must submit a request in writing, stating a time periods beginning after April 13, 2003 that is within six years from the date of your request. An accounting will include, if requested; the disclosure date; the name of the person or entity that received the information and address, if known; a brief description of the information disclosed; a brief statement of the purpose of the disclosure or a copy of the authorization or request; or certain summary information concerning multiple similar disclosures. The first accounting period provided within a 12-month period will be free; for further requests, we may charge you our costs.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You may obtain a copy of this Notice at our website, www.hillviewretirement.org.

V. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with the facility or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with the facility, contact Hill View's Privacy Officer/Human Resources Resident Services Director at (740)351-1012.

We will not retaliate against you if you file a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in

this Notice, we reserve the right to change this Notice and to make the revised or new Notice provisions effective for all personal health - information already received and maintained by the facility as well as for all personal health information we receive in the future, we will post a copy of the current Notice in the facility. In addition, we will provide a copy of the revised Notice to all residents. Revised notices shall be distributed to Independent residents and the acknowledgement of receipt shall be filed by the Administrative Assistant. Revised notices shall be distributed to Assisted Living residents and the acknowledgement of receipt shall be filed by the Health Care Admissions Director. Revised notices shall be distributed to Health Care residents and the acknowledgement of receipt shall be filed by the Health Care Admissions Director.

VIII. FOR FURTHER INFORMATION

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact Hill View Privacy Officer/Human Resources/Resident Services Director at 740-351-1012.

IX. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights regarding your personal health information at the facility:

Right to Request Restrictions: You have the right to request restrictions on our use or disclosure of your personal health information for treatment, payment or health care operations. You also have the right to restrict the personal health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care

We are required to agree to your requested restriction unless you are being transferred to another health care institution, the release of records is required by law, or the release of information is needed to provide you emergency treatment.

Right of Access to Personal Health Information: You have the right to request, either orally or in writing, your medical or billing records or other written information that may be used to make decisions about your care. We must allow you to inspect your records within 24 hours of your request. If you request copies of the records, we must provide you with copies within 2 days of that request. We may charge a reasonable fee for our costs in copying and mailing your requested information.

Revised form approved March 3, 2010

INTEGRATIVE AND COMPLEMENTARY MEDICINE DISCLOSURE AND CONSENT

Much of the text of this Disclosure is quoted from a standard form of the Texas Medical Board approved October 15, 1999 TSBME Board meeting. Form Revised 6/7/2001

"(NOTE: The Texas State Medical Board of Medical Examiners ("Medical Board") adopts this form which may be used by a physician on a voluntary basis to inform a patient, or person authorized to consent for the patient, of the possible risks and hazards involved in the integrative and complementary medical treatment named in the form. The Medical Board recognizes that patients have a right to seek integrative and complementary therapies. However, the use of this form shall not be construed as an endorsement by the Medical Board to practice integrative and complementary medicine and shall not pardon or absolve physicians from disciplinary action that may be taken by the Board.)" **TEXAS STATE BOARD OF MEDICAL EXAMINERS**

We are very glad that you have come seeking our services to aid you in your path toward health and wellness. We respect the fact that this is a privilege for us. We are required to tell you and have you acknowledge in advance some special features regarding the care that we provide.

You, the patient, "have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure."(**TSBME**) This office practices in an "integrative style". This means that we combine "standard" also known as "usual and customary" evaluations and treatments along with those that are considered by some to be "not standard" or "not usual and customary". We do this because we have found that "standard" approaches to treatment are often not able to deliver and <u>maintain</u> the good results we are trying to achieve or are associated with undesirable side effects. According to the Texas Medical Practice Act Chapter 200 you are free to receive these "not standard" treatments so long as it is documented that you have been advised of and agree to this direction of care. We will advise you when our recommendations deviate in our opinion from this "standard". Of course it is important to say that this standard is constantly changing. Many previously "not standard" treatments have become or are becoming "standard" (vitamins that are now considered part of a "standard" treatment protocol) and previous "standard" treatments are now considered "not standard" (prescription drugs that have been taken off the market for various reasons).

I voluntarily request Dr. Taylor as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as a chronic metabolic disorder affecting multiple tissues and organ systems as a result of genetic inborn deficiencies of metabolism interacting with harmful environmental factors including but not limited to toxins in the air, food and water, chronic effects of infectious agents, physical and psychological stress, physical injury, dietary nutrient deficiencies, allergic reaction to environmental antigens and harmful environmental physical forces such as electromagnetic fields.

The Standard of Care Treatment: Treat each symptom or set of symptoms with appropriate prescription drugs, surgery or other therapeutic intervention as outlined in existing "treatment guidelines" as presented by various bodies of organized medicine.

Risks of Complimentary Therapy: As with "standard" care may be associated with side effects, adverse or allergic reactions or failure to achieve in a timely fashion the desired treatment results. Integrative therapy may have a slower time course of effect but may result in a more complete and lasting recovery. The need for associated "standard" medicines and therapies may no longer be necessary.

Expected Time Frame for Therapy: It is not unusual to see a period of "regressive healing" which may be associated with a temporary worsening of symptoms which may last days to weeks. Symptom improvement may begin in days to weeks but may take months for results to be seen. Typically continued improvement may be seen over several years. In some cases benefit may not be experienced at all. Once symptom recovery is well underway the emphasis shifts to maintaining wellness, preventing disease, and delaying the effects of the aging process.

"I (we) understand that no warranty or guarantee has been made to me as to result of care."(**TSBME**)

"I (we) realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary procedure planned for me." (**TSBME**)

"I (we) have been given an opportunity to ask questions about my condition, conventional treatment, integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of nontreatment, procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent." (**TSBME**)

"NOTICE: Refusal to consent to the integrative and complementary procedure should not affect your right to future care or treatment." (TSBME)

Our purpose here is to serve you, our guest and patient. We do not work for a payer whether it be an insurance company, pharmaceutical company, diagnostic laboratory, or governmental agency. We simply offer you what we believe to be the best care for your medical condition based on our extensive knowledge of the scientific body of medical evidence and our years of experience in treating these conditions.

Dr. Wally Taylor

Revised September 26, 2014

DISCLOSURE AND CONSENT TO TEXAS INTEGRATIVE MEDICINE
\OFFICE POLICIES AND PROCEDURES

In order for us to be able to serve you best we would like to familiarize you with what you can expect as a new patient in our clinic. We ask that you provide your acknowledgment of understanding and consent for these policies. For us to best understand your health condition and the factors that are contributing to your health disorder it is important for us to have as complete an awareness as possible of all the many factors that contribute. To facilitate this we ask that you complete as thoroughly as possible a very complete general health survey that includes your environmental exposures, your family tendencies and your current symptoms. It is also important for us to have access to your current treatments both prescription and nonprescription in addition to any recent medical evaluations and tests including labs that you have had in the past. Since our fees are based on direct physician contact, the more that the physician can prepare in advance the more time that can be spent on educating you on your recovery process. Physician professional fee is calculated based on a quarter hour rate of $90. Some of the services that we offer are grouped into all-inclusive packages of care that cover an extended period of time and include multiple services normally recommended to address a specific problem area.

It is very important to stress that this Integrative model of patient care is process care and not “episode” or “drive-through” care. There is no “quick fix”. There is no “magic pill”. Results take time to achieve and achieving the best results requires the dedication and commitment of the patient (and family in the case of minor patients).

The doctor will review your medical history with you taking additional information as individually required and will then perform a physical examination and review appropriate reports. Based on each patient’s individual circumstances we will order any additional studies that are deemed to be necessary to diagnose and appropriately monitor your condition. These studies are not included in the office physician fee. Some lab is billed through the office and other labs are billed by the laboratory directly. We do offer in-office lab draws for some tests. Your condition and our recommendations for recovery will then be discussed with the physician. If the complexity of your condition does not allow complete coverage of all information in the time period scheduled, an additional appointment on a different day may be necessary. We try to schedule enough time to cover the majority of the patients we treat.

Since our approach to care is “integrative” and includes both standard and “alternative” approaches to treatment, many insurance companies classify our treatment as “unproven” or “experimental” and therefore excluded from reimbursement. This is very unfortunate but does require that we not participate in any form of medical insurance including Medicare and Medicaid. Medicare patients must complete and sign a Medicare “opt out” contract which we will provide. No claim for reimbursement can be made to Medicare or your Medicare Secondary although approved ancillary services may be covered. Your private insurance may provide partial coverage for our services if “out of network providers” are covered. We also request that you review and sign a consent form indicating your understanding of the alternative nature of some of our recommended treatments and acknowledge your consent for same. Payment for our services is expected at the time of service. We accept cash, personal check and major bank cards. Patients are expected to keep their account paid in full

in order to receive continuing care. Costs for testing, prescriptions and supplements are charged separately. They may be covered by insurance but this varies greatly between carriers and we urge you to discuss this with your insurance company if this is important to you. We are considered “out of network providers”. We will provide you a medical receipt which can be submitted for possible reimbursement. This can also be used as documentation for use of health savings accounts. We do not maintain insurance processing staff. If additional reports are required by your insurance company there may be an additional charge for the time involved to prepare these reports. We will obtain your approval before these additional services are provided.
Our physician provides consultative service and does not function in a primary care role. It is important for you to also maintain the services of a primary care provider. We are not available after hours and do not provide “on call” coverage. We do not maintain hospital admitting privileges. In case of emergency we ask that you call 911.

In order to avoid cancelled appointment charge we ask that you provide us two complete business days if you must cancel or reschedule your appointment so that your allotted time can be used to help another guest. The cancellation fee is assessed at the lesser of the rate of the originally scheduled visit or $200 whichever is less. Some service packages require a non-refundable deposit at the time of scheduling. A method of payment is needed to hold an appointment slot.
Your return appointment will be scheduled in a suitable time frame for us to review your lab studies and assess your response to treatments recommended. Interpretation of laboratory reports is a very important part of your care and should be done during a visit with the physician. We will notify you via the contact information you have provided of any urgent lab results that we feel need your immediate attention. Your treatment regimen will then be modified as appropriate. As recovery proceeds return visits are scheduled farther apart.

We ask that you review any needed prescription refills with your physician during your appointment. If you require refills between appointments we ask that you have your pharmacy FAX the refill request to us with two business days advance for us to authorize your refill.
We are happy to respond to procedural questions between visits as a part of our service to you. Questions that require a clinical opinion are billed at the standard physician rate based on the time required to respond either by phone or email unless they are included in the all-inclusive service package.

Texas Integrative Medicine maintains and protects the privacy of your health care information. We will work to keep your information confidential and secure and to abide by all HIPAA rules and regulations. We cannot release any of your healthcare information to any third party without your expressed written consent.

Revised March 23, 2015

ACKNOWLEDGEMENT OF UNDERSTANDING, AGREEMENT AND CONSENT

I have read the following documents entirely as checked. All my questions regarding these documents have been sufficiently answered. By my signature below I give my acknowledgement of understanding, agree and consent to the information as contained therein.

____NOTICE OF PRIVACY PRACTICES REVISED MARCH 3, 2010

____MEDICARE PRIVATE CONTRACT

____INTEGRATIVE & COMPLEMENTARY MEDICINE DISCLOSURE AND CONSENT REVISED SEPTEMBER 26, 2014

____DISCLOSURE AND CONSENT TO T.I.E.A. OFFICE POLICIES AND PROCEDURES REVISED SEPTEMBER 26, 2014

_____ _____

Patient Name Patient Signature

_____ _____

Legal Guardian's Name Legal Guardian's Signature

_____ _____

Witness Physician's Signature

_____

Patient Address and Phone Number

Name of Physician-Wallace Taylor M.D.

Texas Integrative ENT and Allergy

Authorization for Release of Medical Records

Patient Information (Please Print):

Name:_____DOB:_____

Address:_____

City:_____ State:_____

Zip:_____Phone:_____

Please Release My Medical Records From:

Name:_____

Telephone:_____

FAX:_____

To: Texas Integrative ENT and Allergy

Attn: Dr. Wallace Taylor

4107 Medical Parkway Suite 100

Austin, TX 78756-3735

FAX: 512-420-9390 Phone: 512-420-9300 email: cathy@peoplesrx.com

Please send medical records no later than:_____

Please Include: _____History and Physical _____ Progress Notes _____NeuroSensory Test Reports

_____Imaging Test Reports _____Lab Test Reports_____Operative Reports

BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MEDICAL RECORDS.

_____

Date:_____

Patient (or Legal Guardian)