New Allergy Health Questionnaire (Age 18 years or older)

First Name: _____ Middle: _____ Last: _____

Preferred Name (and Title): _____ ☐ Female ☐ Male

Date of Birth: _____ Place of Birth: _____

Genetic History:

☐ African ☐ Asian ☐ European

☐ Mediterranean ☐ Middle Eastern ☐ Native American

☐ 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: _____ Phone Number: _____

City: _____

Compounding Pharmacy: _____ Phone Number: _____

City: _____

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

_____

_____

What medicines do you take currently? **(Please list: name, dosage, route and routine)**

_____

_____

What vitamins, herbs, and supplements do you take? **(Please list: name, dosage, route and routine)**

_____

_____

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 your ill health has anything happened to make matters significantly better?

What do you do that makes you feel worse? _____

What do you do that makes you feel better? _____

Birth History

Did your mother have pregnancy complications?

Were there birth complications?

Did anything else of significance occur around the time of your birth? _____

Childhood and Adolescent History

What illnesses did you have as a child?

_____

Please explain any significant health problems (<18 years old), including injuries, hospitilizations, and any use of medications longer than 3 months:

_____

_____

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? What Material?

_____

Please list hospitalizations and dates:

_____

_____

Environmental Exposure History

Where have you lived in the past?

_____

Have you traveled outside of the United States? ☐ Yes ☐ No

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?

☐ Yes: When and where? _____

☐ No

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? (By whom, what, when?)

Please list all previous bites, reactions, and dates:

Diet and Nutrition History

Current height in inches: _____ Current weight in pounds: _____

Heaviest weight since age 18: _____ Lightest weight since age 18: _____

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 regularly 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? ☐ Yes ☐ No

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)?

☐ Yes – Please Explain: _____

☐ No

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

☐ Yes – Please Explain: _____

☐ No

Are you under excessive stress and what are the sources of your stress? ☐ Yes ☐ No

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 – Please Explain: _____

☐ No

Please list ways you have learned to cope with stress:

_____

_____

Other Social History

Do you currently smoke?

☐ Yes – How much? _____

☐ No– When did you quit (if applicable)? _____

Did you live with someone who smoked?

☐ Yes – For How long? _____

☐ No

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?

☐ Yes – Please Explain: _____

☐ No

Do you consume alcoholic beverages?

☐ Yes – What type, how much & how often?

_____

☐ No

Do alcoholic beverages help you to feel better? ☐ Yes ☐ No Feel worse? ☐ Yes ☐ No

Do you take any non-prescribed recreational drugs?

☐ Yes – What type, how much & how often?

_____

☐ No

If you do is it in order to feel better or get relief of symptoms? ☐ Yes ☐ No

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Family History (Please check all conditions occurring in your family)

☐ ADD/ADHD ☐ Addiction Disorder/Alcoholism ☐ Allergies ☐ Arthritis ☐ Asthma

☐ Autistic Spectrum ☐ Auto Immune Disease ☐ Bleeding Disorder ☐ Cancer ☐ Celiac Disease

☐ Chronic Fatigue ☐ Depression/Anxiety ☐ Diabetes ☐ Dementia/Alzheimer's

☐ Digestive Disorder ☐ Dizziness/Vertigo ☐ Eczema/Psoriasis ☐ Fibromyalgia

☐ Food Allergy ☐ Headache/Migraine ☐ Heart Disease ☐ High Blood Pressure

☐ Hormone Balance ☐ Immune Deficiency ☐ Inherited/Metabolic Disorder

☐ Inflammatory Bowel Disease ☐ Irritable Bowels ☐ Memory Loss ☐ Mitochondrial Disorder

☐ Multiple Sclerosis ☐ Nerve Disorder ☐ Overweight ☐ Parkinson's ☐ Psychiatric Disorder

☐ Seizures ☐ Skin Disease ☐ Sleep Apnea ☐ Sleep Loss ☐ Thyroid Problems

List of Symptoms In Past 60 Days

Digestive: ☐ Abdominal Pain ☐ Belching ☐ Bloating ☐ Change in appetite

☐ Constipation ☐ Diarrhea ☐ Flatulence ☐ Heartburn ☐ Nausea ☐ Reflux

☐ Vomiting ☐ Upset Stomach

Endocrine: ☐ Acne ☐ Adrenal problem ☐ Change in hair ☐ Change in skin/nails

☐ Change in urine ☐ Diabetes/High blood sugar ☐ Eating disorder ☐ Excess Sleepiness

☐ Excessive sweating ☐ Fatigue ☐ Feeling cold/Chills ☐ Feeling Hot/Hot flashes

☐ Fluid retention ☐ Food cravings ☐ Hair loss ☐ Increased urination ☐ Low blood sugar

☐ Night sweats ☐ Not sweating ☐ Pituitary disorder ☐ Sleeplessness/Insomnia

☐ Thyroid problem ☐ Undesired hair growth ☐ Unusual body odor ☐ Weight gain

☐ Weight loss ☐ Other hormone disorder: _____

Nervous System: ☐ Absence spells ☐ Amnesia ☐ Burning/Tingling

☐ Change of muscle tone ☐ Concussion ☐ Confusion ☐ Facial pain ☐ Fainting episodes

☐ Faintness ☐ Hallucinations ☐ Head injury ☐ Headaches ☐ Hoarseness

☐ Loss of Coordination/Dropping things ☐ Migraines ☐ Muscle loss ☐ Numbness

☐ Problems with focus/attention ☐ Problems with memory ☐ Problems multitasking

☐Problems with speech

Problems with sensitivity to: ☐ Odors ☐ Sights ☐ Smells ☐ Sounds ☐ Tastes

☐ Seizure-like activity ☐ Tremors ☐ Uncontrolled movements ☐ Voice change

☐ Weakness

Vision: ☐ Blurred vision ☐ Change in colors ☐ Dark spots/tunnel vision

☐ Dry eye ☐ Itchy eyes ☐ Loss of vision ☐ Visual hallucinations/spots/flashes

Hearing/Balance: ☐ Disequilibrium ☐ Ear discharge ☐ Ear itching ☐ Ear pain

☐ Loss of hearing ☐ Motion sickness ☐ Positional vertigo ☐ Ringing in ears ☐ Spinning

☐ Vertigo

Nose/Sinuses: ☐ Nasal blockage ☐ Nasal discharge ☐ Nasal itching

☐ Nosebleed ☐ Post-nasal drip ☐ Sinus pain ☐ Sneezing ☐ Sinus infection

Mouth/Throat: ☐ Dry mouth ☐ Growth or sore ☐ Mouth pain/burning

☐ Mouth swelling ☐ Trouble swallowing

Mood/emotions: ☐ ADD/ADHD ☐ Addiction ☐ Anxiety Panic attacks

☐ Autism ☐ Bipolar Psychiatric diagnosis ☐ Compulsive ☐ Depression

☐ Emotionality Schizophrenia ☐ Excess fear/Phobia ☐ Impulsive ☐ Obsessive

☐ Mood swings ☐ Tantrums/Rages ☐ Trouble with transitions

Immune/Inflammatory: ☐ Auto Immune Disorder (Please list): _____

☐ Frequent illness ☐ Food allergy ☐ History Mononucleosis ☐ HIV

☐ Lyme ☐ Parasites ☐ Seasonal Allergy/Hay fever ☐ Shingles

Respiratory: ☐ Asthma ☐ Bronchitis ☐ Cough ☐ Coughing up blood ☐ Emphysema

☐ Pneumonia ☐ Shortness of breath ☐ Sleep apnea ☐ Tuberculosis

Skin: ☐ Eczema ☐ Hives ☐ Excessive bruising ☐ Rash

☐ Persistent sore/growth/mark

Cardiovascular: ☐ Blood clot ☐ Chest pain ☐ Cholesterol/Lipid disorder

☐ Cold extremities ☐ Exercise intolerance ☐ Exertion pain ☐ Heart attack

☐ High blood pressure ☐ Irregular heart beat ☐ Lightheadedness

☐ Low blood pressure ☐ Mitral valve prolapsed ☐ Pain with exercise ☐ Rapid heart beat

☐ Slow heart beat ☐ Sudden vasospasm ☐ Stroke ☐ TIA

Joints and Extremities: ☐ Joint pain ☐ Joint redness ☐ Joint stiffness

☐ Joint swelling ☐ Hot joints ☐ Muscle pain ☐ Muscle spasm

☐ Muscle swelling ☐ Muscle tenderness to touch

GenitoUrinary: ☐ Bedwetting ☐ Blood in urine ☐ Burning urination

☐ Change in urine smell ☐ Change in urine appearance ☐ Frequent/Urgent urination

☐ Nighttime Urination ☐ Uncontrolled urination/Incontinence

Dental: ☐ Bleeding gums ☐ Broken teeth ☐ Dental cavities

☐ Gum disease ☐ Mercury fillings ☐ Metal crowns/Implants ☐ Pain with chewing

☐ TMJ disorder/pain ☐ Tooth pain

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 patients' 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, or another third party payer. For example, a lab company may contact us for billing information such as a phone number to contact patient which we will provide.

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

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.

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 law 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 patients 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.

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 or 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.texasintegrative.com.

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.

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

V. 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 patients.

VI. FOR FURTHER INFORMATION

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact us at 512-800-5309.

VII. 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 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 may charge a reasonable fee for our costs in copying and mailing your requested information.

Revised form approved March 16, 2017

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 maintain 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 benefits 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 April 6, 2017

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

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. There are no "one size fits all protocols" that are appropriate for the conditions that we evaluate and treat. To facilitate this, we ask that you complete, as thoroughly as possible, a very detailed general health survey that includes your environmental exposures, your family tendencies, your individual sensitivities, and your current symptoms. It is also important for us to have access to your current medications and supplements, both prescription and nonprescription, in addition to any recent medical evaluations and tests including labs that you have had in the past. Please let us know about any other treatments that are on-going.

Since our fees are based on direct provider contact, the more that our clinicians can prepare in advance the more time that can be spent on educating you on your recovery process and the better value for you. Dr. Taylor's physician professional fee is calculated based on a quarter hour rate of $100. Megan Miller FNP-C's professional fee is calculated based on a quarter hour rate of $75. It is very important to stress that this integrative model of patient care is "process-care" and not "episode care" as is typical of modern Western medicine. There is no "quick fix". There is no "magic pill". Results take time to achieve and achieving the best result requires the dedication and commitment of you, the patient, and your support group or family if applicable. The clinician 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 your unique, individual circumstances we will order any additional studies that are deemed to be necessary to diagnose and appropriately monitor your condition upon obtaining your consent. These studies are not included in the office clinician fee. Some labs are billed through the office and other labs are billed by the laboratory directly. This will be discussed when the labs are ordered or obtained with your consent, of course. Your condition and our recommendations for treatment will then be discussed with your provider.

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 exclude it from reimbursement. This is very unfortunate but does require that we not participate in any form of medical insurance including Medicare and Medicaid. The Federal government requires that 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 (example labs) 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. 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 an "out of network provider". 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. We are not able to arrange "prior authorization" for the tests and treatments that we recommend. 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 informing you of any additional charges. Our clinicians provide consultative service and do 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.

A deposit of $200.00 will be collected in order to schedule an appointment for initial consultation with one of our clinicians which will be applied to your service when provided. As a courtesy to patients who are waiting to be seen by us and to avoid cancelled appointment charges, we ask that you provide us two complete business days if you must cancel or reschedule your new patient appointment so that your allotted time can be used to help another guest. (Example: A Monday appointment would need to be cancelled before close of business the Wednesday prior.) Please observe this cancellation policy to avoid forfeiture of your deposit. Your return appointment will be scheduled in a suitable time frame for us to review your lab studies or to assess your response to recommended treatments. Due to increased demand for the services of our clincians, it is necessary to request two full business day's advance notice for rescheduling or cancelling any follow-up provider visit or treatment service at our facility. (Example: A Monday follow-up service appointment would need to be cancelled or rescheduled before the close of business the Wednesday prior.) This includes clinician visits, IV treatments, EWOT sessions and Thor cold laser treatments. We will accept a written excuse from a licensed medical provider in the event of illness. Late cancellation fee of $75 will be assessed for failure to adhere to this policy. The interpretation of laboratory reports is a very important part of your care and should be done during a visit with the clinician. We will notify you via the contact information you have provided us 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 further 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 need to be handled with a clinician appointment (either by phone or in person). We will attempt to schedule "impromptu" appointments as the schedule permits. As a reminder, we do not act as primary care providers but provide consultation medical and wellness services. 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.
You may be contacted between visits by one of our Patient Advocates between service appointments. The role of the Advocate is to assist you with issues related to your care with us and to assure that we are providing you with the service that you expect from us.

Revised October 12, 2017.

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 16, 2017**

☐ **MEDICARE PRIVATE CONTRACT**

☐ **INTEGRATIVE & COMPLEMENTARY MEDICINE DISCLOSURE AND CONSENT REVISED APRIL 6, 2017**

☐ **DISCLOSURE AND CONSENT TO T.I.M. OFFICE POLICIES AND PROCEDURES REVISED OCTOBER 12, 2017**

_____ _____

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 Medicine 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 Medicine

Attn: Dr. Wallace Taylor

4107 Medical Parkway Suite 100

Austin, TX 78756-3735

FAX: 512-367-5975 Phone: 512-800-5309 email: info@texasintegrative.com

Please send medical records no later than: _____

Please Include: ☐ History & Physical Test Reports ☐ Progress Notes
☐ NeuroSensory ☐ Imaging Test Reports
☐ Lab Test Reports ☐ Operative Reports

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

_____

Date: _____

Patient (or Legal Guardian)