HIPAA Notice of Privacy Practice

Repower Medical Clinic, LLC
3651 E. Baseline Rd., Ste. E121 Gilbert, AZ 85234
4110 N. Scottsdale Rd., Ste 215 Scottsdale, AZ 85251

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEAE REVIEW IT CAREFULLY.

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

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office and other staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health office care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate our physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.
Other Permitted and Required Uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any of your protected health information.

We reserve the right to change the terms of this notice wand will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____Signature:_____ Date:_____

REPOWER
medical clinic

Consent for Investigational Treatments

Dr. Worden owner of Repower Medical Clinic, LLC is a Naturopathic Physician licensed as a primary care doctor whose scope of practice includes prescriptive privileges and minor surgery. She uses western diagnostic methods including a thorough history, physical exam, labwork and imaging studies. Dr. Worden is also licensed in clinical nutrition, acupuncture, spinal manipulation, botanical medicine, counseling, homeopathy, therapeutic injection and other natural healing modalities. She uses her knowledge of both systems of medicine to integrate the best treatment for the individual patient for their physical and/or emotional ailments. The following treatments may be helpful for certain patients. If Dr. Worden decides that one of these treatments are appropriate she will fully explain the details about the treatment and get your verbal consent.

These therapies include such therapies as Apitherapy (Bee Venom), IV Therapy, Neural Therapy, Bio Puncture, Cold Laser Therapy, Homeopathic Trigger Point Injections, , Prolotherapy, Bio-Identical Hormones and Bioenergetic techniques that have been in used throughout the world and some have been documented as safe and effective in respected medical journals. Repower Medical Specialties conducts research in some of these areas. Additionally, the Arizona Board of Naturopathic Medical Examiners has given its approval to conduct some of these therapies.

I understand that I have been fully informed of the therapeutic protocols and possible side effects of the treatments. I understand that it is my prerogative to terminate participation in this program at any time and for any reason without prejudice.

I understand some of the therapies that I am requesting and agreeing to undergo are considered investigational and the data collected from my participation in this program may be used to further the understanding and treatment of the disease with those therapies. This includes, but is not limited to, publishing data, presenting paper in public or private journals, or sharing this information with other professionals. I understand data collected from my treatment, if presented, will be kept anonymous and that my confidentiality will be protected at all times.

I have been informed and understand that this protocol may or may not be recognized or approved by the FDA as a standard therapy. I therefore, hereby release Repower Medical Specialties and Dr. Worden, staff or owners from any liability arriving out of the status of the approval or lack of approval of this therapeutic process.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT, BY SIGNING THIS VOLUNTARY CARE PATIENT CONSENT FORM, I AM GIVING INFORMED CONSENT TO THE PROVISION OF DIAGNOSIS, CARE, AND/OR TREATMENT BY DR. DONESE WORDEN AND CANNOT BRING A TORT OR OTHER SIMILAR ACTION, INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC, OR OTHER HEALTH-RELATED CLAIM, AGAINST DR. DONESE WORDEN UNLESS THE ACTION OR OMISSION OF DR. DONESE WORDEN CONSTITUTES WILLFUL OR WANTON MISCONDUCT.

Patient Name (print):_____Date:_____

Patient/legal guardian Signature: _____

REPOWER
medical clinic

Financial Policy

Dear Patient:

Thank you for choosing Repower Medical Clinic, LLC. We realize that questions may arise about our payment and collection policies and this notice is designed to provide an overview of these policies. Our goal is to provide quality medical care for our patients and it is important that we work together. Our office manager will be happy to discuss these policies with you.

INSURANCE:

1. You are directly responsible for payment of your medical care and you are expected to pay for any services, supplements, and lab fees at the time of service.
2. Repower Medical Clinic **accepts no insurance**. You will be provided with a statement with all of your charges and your diagnosis. It is then your responsibility to submit this to your insurance for reimbursement. Your insurance company may or may not pay for all of your health care costs. Please keep in mind that your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover.
3. Please expect to pay in full at the time of the office visit for services rendered.

BILLING:

1. Delinquent accounts will be transferred to a collections agency or our attorney when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years.

Please understand that maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare that you deserve and expect.

I UNDERSTAND AND ACKNOWLEDGE THIS FINANCIAL POLICY.

_____	_____	_____
Patient Signature	Patient Name (Printed)	Date

REPOWER
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Donese Worden, N.M.D.

PLEASE REMEMBER TO BRING SUPPLEMENTS/MEDICATIONS AND LAB WORK/DOCTOR'S NOTES TO YOUR FIRST VISIT

Health History Summary

Today's Date: _____

Name _____Age _____ DOB_____
Blood-Type_____
Address_____City_____State_____Zip_____
Email Address _____
Preferred method of contact (please circle one): **email / mail / fax**
Phone Numbers: (home)_____(work)_____(cell)_____
(fax)_____
Occupation_____ (full-time/part-time)
Years Employed: _____
Employer_____
Insurance Co. _____
Policy #_____SSN#_____
Address_____
City_____ State_____ Zip_____

Nearest Relative_____Relationship_____Phone_____
Emergency Contact _____Relationship_____Phone_____

Last physician or health practitioner seen?_____
When? _____
Do you currently have a primary care physician? **(yes/no)**
If yes, who?
_____
Most recent blood test and kind:
_____
Who referred you to our office or how did you find us?
_____

Your Current Health Problems

What is your **main** reason for coming in?

_____

_____

If you have a specific health condition please describe in detail.

_____

_____

_____

_____

_____

_____

_____

When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation?

_____

_____

_____

_____

_____

List in order of importance other health problems that are troubling you:

1. _____Length of time_____
2. _____Length of time_____
3. _____Length of time_____
4. _____Length of time_____

How long has your main problem been troubling you?

_____

Is your current "main problem" getting **(better / worse / unchanging)** and for how long? Additional Details:

_____

_____

_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, or other alternative health practitioner for your current problem? **(yes/no)**
What was the therapy and what were the results?

_____

_____

_____

_____

General Health History

The general state of your health is **[excellent, good, average, fair, poor]**
On average describe your energy level from 1-10 _____ (10 is highest, 1 is lowest)
When during the day is your energy the best? _____ Worst?

_____

What is your current approximate weight (lbs)? _____ height? _____

Weight 1yr ago? _____
As an adult, what has been your max weight (not including pregnancy) _____
Minimum _____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Please circle the most significant one.

1. _____Date_____
2. _____Date_____
3. _____Date_____
4. _____Date_____
5. _____Date_____

Are you currently working with a professional counselor, psychologist, social worker, pastor, or other therapist?

_____

Have you in the past?

_____

Are you currently working with a doctor of conventional medicine? **(MD/DO)**
Name, location, phone number:

_____

What are your current conventional treatments?

_____
_____
_____

Mark any childhood illnesses have you had?

Measles_____ Mumps_____ Chickenpox_____ Whooping cough_____
Polio_____ Diphtheria_____ Rheumatic fever_____ Scarlet fever_____
Smallpox_____ Typhoid fever_____ Tuberculosis_____Mono_____ How long? _____

Previous surgeries and hospitalizations, including dates:

Surgery Date

1._____
2._____
3._____
4._____
5._____

Which of the following do you currently use? (Amount, how often, how much and how long, etc.)

Alcohol_____
Tobacco_____
Hormones_____
Coffee_____
Cortisone_____
Laxatives_____
Sedatives_____
Antacids_____

Do you have any allergies to any drugs, herbs, foods, animals or other?
(yes/no/unknown) Please describe:

_____
_____
_____

Medications (Please give full name, dosage and how long you have been taking the medication)

Name	Dose	When / How Often	Purpose

Vitamins / Herbs

Name	Dose	When / How Often	Purpose

Family History

Please list ages, health problems and if deceased, cause of death:

	Living (age)	Died (age)	Health Problems	Cause of Death
Your Mother				
Your Father				
Your Brothers				
Your Sisters				
Grandma & Grandpa				
Mother's Mom				
Mother's Dad				
Father's Mom				

Father's Dad

_____ _____ _____ _____

What is your nationality? (Please list all backgrounds and give approximate %)

_____

_____

You currently live with? **(spouse / partner / friends / children / alone)**
Are you? **(married / divorced / widowed / single / in a relationship)**
Is your relationship supportive? **(yes/no)**
What is your current level of education? _____
Are you satisfied with this? **(yes/no)**
Do you have any children? **(yes/no)**
How many? ____ Ever had Toxemia during pregnancy? **(yes/no)**
Do your children have any health problems?_____
Do you have any relatives (aunt, uncle or grandparents) who have had any of the following?

___allergies ___arthritis ___asthma ___cancer ___skin disease
___anemia ___depression ___diabetes ___heart attack ___genetic

___high BP ___stroke ___ulcers ___thyroid problem ___(STD)

___seizures ___sickle cell ___cataracts ___hypoglycemia

What is your weakest organ system and why?

_____

Personal Habits

What do you enjoy most in your life?

_____

What are your main interests or hobbies?

_____

What do you worry most about in life?

_____

Do you exercise? **(yes/no)** If yes, what kind, how much and how often?

_____

Do you have spiritual beliefs? **(yes/no)** If yes, what?_____
On a scale of 1-10, how would you rate the quality of your sleep? (10 being great)_____
Do you have problems falling asleep? **(yes/no)** or problems staying asleep? **(yes/no)**
How many hours do you sleep at night?_____
Do you awake at night? **(yes/no)**
If yes, what time do you usually wake?_____
Do you ever sweat at night while sleeping? **(yes/no)**
How frequently and how much?_____
Do you wake feeling refreshed? **(yes/no)**
Do you nap/rest horizontally during the day? **(yes/no)** Length____

Do you usually feel **(warmer/cooler)** compared to others around you?
Are your hands/feet usually **(cold/hot)?**
Do you enjoy your work? **(yes/no)**
Do you take vacations? **(yes/no)**
Are you currently in a happy, satisfying relationship with someone?**(very / mostly / somewhat / no)**
How often do you get colds, flues, sore throats, yeast infections during the year?

_____

When you rise quickly from sitting or lying do you ever get dizzy? **(yes/no)** How often?

_____

Female Reproduction

***If post menopausal please fill in this section according to symptoms experienced before menopause**

Age of first menses _____
If periods have stopped, at what age did they stop? _____
If periods have stopped, did you go through menopause naturally or have a hysterectomy? _____
Are you cycles regular? **(yes/no)** Period begins every _____ days.
How many days are you periods?_____
Are your periods **(heavy / medium / light)**
What color is the blood? **(light red/ medium red /dark red)**
Are there any clots? **(yes/no)**
Do you have any spotting or bleeding between periods? **(yes/no)**
Any cramps with period? **(yes/no)**
Circle any premenstrual symptoms: **(water retention / breast tenderness / irritability / depression / headaches / mood swings / food cravings)**
What do you crave? **_____**
Additional Notes:

_____

Number of pregnancies_____
Number of abortions_____
Number of live births_____
Number of miscarriages_____
Any problems getting pregnant? **(yes/no)**
Do you get yearly PAP smears? **(yes/no)**
Any abnormal PAPs? **(yes/no)**
Breast lumps? **(yes/no)**
Are you currently sexually active? **(yes/no)**
How often? _____ Is this **(more/less)** than 1 year ago?
Do you experience vaginal dryness? **(yes/no)**
Do you leak urine when you cough, sneeze or laugh? **(yes/no)**
Do you experience painful intercourse? **(yes/no)**
Do you use birth control? **(yes/no)**
What type of birth control do you currently use? _____
Were you ever **(physically / sexually / emotionally / verbally)** abused? **(yes/no)**
How old and how often?

_____
_____

Male Reproduction

How often do you have to get up at night to urinate? _____
Is this more than a few years ago? **(yes/no)**
Any problems with impotency? **(yes/no) (getting / maintaining an erection)**
Decreased libido? **(yes/no)**
Any abnormal discharge from penis? **(yes/no)**
Any venereal (sexually transmitted) diseases? **(yes/no)**
Sores on penis? **(yes/no)**
Any prostate problems? **(yes/no** and **past/now)**
Last prostate exam? _____PSA? _____
Do you experience any leakage of urine? **(yes/no)**
Do you have a weak urine stream? **(yes/no)**
Do you have trouble starting urination? **(yes/no)**
Are you currently sexually active? **(yes/no)** How often? _____
Is this **(more/less)** than 1 year ago?
Were you ever **(physically / sexually / emotionally / verbally)** abused? **(yes/no)**
How old and how often?

_____
_____

Digestions and Elimination

Do you have any problems with **(gas /bloating / fullness)** after eating? **(yes/no)**
How often? **(often / sometimes / never)** How severe? _____
Gas in? **(upper abdomen / lower abdomen / both / neither)**
How long have you had this problem? _____
Number of bowel movements per day? _____
Do you ever have **(blood / mucus / undigested food / black)** stools?
Any rectal itching? **(yes/no)**
Do your stools tend to be **(formed/loose)?**

****Please answer the questions below based on the following: A normal bowel movement occurs 2-3 times a day, should be medium brown in color, should be as wide as a half dollar, and should be the length of the area from your wrist to forearm.**

How often do you have diarrhea? _____
Do you ever have alternating constipation and diarrhea? **(yes/no)**
How often do you have thin, long and narrow stools? **(often / sometimes / never)**
How often do you have small and hard stools? **(often / sometimes / never)**
Do you ever have yellow or light colored stools? **(often / sometimes / never)**
How often do your stools have a strong disagreeable odor? **(often / sometimes / never)**
Have you ever fasted? **(yes/no; juice or water)**
For how long have you fasted?

_____
How did you feel while you were fasting?

_____

Have you traveled outside the US in the past 5 years? **(yes/no)** Where?

_____

_____

Have you gone camping in the last 5 years? **(yes/no)** Where?

_____

Kidneys and Bladder

Have you had recurrent bladder infections? **(yes/no)**
How were they treated?_____
How many bladder infections have you had in the past 3 years?

_____

Do you have any burning sensation during or after urination? **(yes/no** and **past/present)**
Is your urine? **(dark yellow / bright yellow / cloudy / pale / clear**)
Does your urine have a strong odor to it? **(yes/no)**
Do you have difficulty starting or stopping when urinating? **(yes/no)**
Do you have difficulty perspiring? **(yes/no)**
Do you perspire when you exercise? **(light / moderate / heavy)**
Do you perspire other times than when exercising? **(yes/no)**
When? _____
Does your perspiration have a strong smell? **(yes/no)**

Occupational / Household / Environmental Exposures

How long have you lived at your present address? _____
What state did you previously live in? _____
Please describe current location, if old or new place, ie: new construction, damp or moldy, near power lines or industrial buildings, etc.

_____

_____

_____

New carpet or flooring? **(yes/no)**
Recent painting or remodeling? **(yes/no)**
New furniture? **(yes/no)**
Do you have specialized air filtration at home? **(yes/no)**
Last time air filters were changed? _____
Do you live in the city? **(yes/no)**
Do you live next to a golf course? **(yes/no)**
Do you live next to any orchards or farms? **(yes/no)**
Do you work in an office building? **(yes/no)**
Do the windows open? **(yes/no)**
Do you have specialized air filtration at work place? **(yes/no)**
Do you work in the presence of toxic fumes or chemicals? **(yes/no)**
Do any of your hobbies involve toxic materials? Ie: painting, building models, working with metals, yard care, working on cars, etc. **(yes/no) Please describe:**

_____

Are you exposed to second hand smoke currently? **(yes/no)**
Were you in the past? **(yes/no)**

What do you use for your drinking water? **(bottled / filtered / tap)**
As far as environmental exposures, do you have anything else you would like to comment
on?_____
_____
_____
_____
_____

REPOWER
medical clinic

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be sent TO:

Name: **Dr. Donese Worden, NMD**
Address: **3651 E BASELINE RD., STE E121 GILBERT, AZ 85234**
Phone: **(480)588-2233**
Fax: **(480)588-2235**

Requesting records FROM:

Physician's Name: _____
Address: _____
Phone: _____
Fax: _____

I authorize the release of records, including those that may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug use. Please release the following records:

- Lab Reports
  Date of Service _____
- Operative/Path. Report
  Date of Service _____
- Gynecological Reports
  Date of Service _____
  Full Medical Report
  Date of Service _____
- Other
  Date of Service _____

Patient Name (Printed): _____

Patient Date of Birth: _____

This consent will expire automatically TWELVE MONTHS from the date signed below.

Patient: _____ _____
(Sign) **(Date)**

Witness: _____ _____
(Sign) **(Date)**

To be signed & returned to office if Patient authorizing release to other individual

Relationship to Patient: _____ **if the patient is a minor, the parent or legal guardian must sign.**

REPOWER
medical clinic

As a partner in your health care, it is important that you prepare for your appointment and bring the items necessary to make your appointment successful.

Plan to arrive 15 minutes early for your appointment to allow time for our registration process. If you cannot fill out this paperwork before your appointment, please arrive 45 minutes early to receive a copy in the office. This is important to maintain appointment scheduling and ensure that you obtain the full duration of your visit with Dr. Worden. We make every effort to respect your time by staying on schedule.

What you should bring:

- Medical Records
  - ✓ Please bring them with you or arrange for them to be sent/faxed prior to your appointment.

- Personal Medical History
  - ✓ In order to provide the best care, your medical provider needs specific information about the medications/supplements you are taking. Please bring in a record of all current prescription and non-prescription medications. **(Please bring the bottles)**

- Your completed Health History Summary Form

- Payment
  - ✓ Please be prepared at the time of service to pay the office visit. We accept cash, checks, and credit/debit cards. (Visa, MasterCard, American Express, Discover)

Acknowledgement of Receipt of Notice of Privacy Practices

Practice Name: Repower Medical Clinic, LLC Contact Person: Donese Worden, NMD
Contact Phone, Email and Fax: 480-588-2233 (o), 480-588-2235 (f)
info@drworden.com

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.
Our Office Policies contains important information regarding payment, insurance, collections, cancellations, returns, refunds and other important information.
By signing this form, I acknowledge that I have received a copy of this office's Notice of Privacy Practices, and Office Policies. You may refuse to sign this acknowledgment, if you wish.

Patient Name / Relationship:
_____

Print your Name:
_____
_

Signature:
_____
_____

Date: _____

For Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Policies from this patient but it could not be obtained because:
___ The Patient refused to sign ___ We were not able to communicate with the Patient
___ Due to an emergency situation it was not possible to obtain a signature
Other (please provide details):
_____
_____
_____
_____

Employee Signature: _____ Date: _____