



Wellness Consultation Policies

Cancellation Policy: There is a \$50 charge for cancellations of less than 24 hours or failure to show up for a scheduled appointment.

Email Policy: Email may be used for answering brief clarifying questions at your practitioner's discretion. If you are emailing about a new or more detailed concern, you will be asked to schedule a phone or office consultation to ensure effective communication and comprehensive care.

Costs of any laboratory tests are paid directly to the lab and do not include the fee for follow-up consultation to discuss the results.

Consultation Fees:

Practitioner	90 minutes	60 minutes	30 minutes	15 minutes
PharmD, DC, or ND	\$195	\$145	\$85	\$30
Classical Homeopath, CCN, L.Ac., MS, RD, or RN	N/A	\$110	\$75	N/A
ACN, Ayurvedic, Certified Herbalist, NA, or LMT	N/A	\$85	\$55	N/A
Chiropractic Adjustment	\$40 per visit			



HIPAA 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.

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.

1. Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office 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 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 of 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 to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that 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 care 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 are 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 indicated your 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 Diseases; 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 purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes 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 in 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 may 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 disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and 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 filing 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.



Privacy Notice Acknowledgement Form

The Federal Health Insurance and Portability and Accountability Act (HIPAA) regulates how health care providers may use and disclose health information, and also requires that patients be notified of the provider's privacy practices.

I, _____ (Printed Name of Patient or Patient's Representative), acknowledge receipt of the "Privacy Notice Acknowledgement Form" and "Wellness Consultation Policies".

Signature (Patient or Patient's Representative)

Date



Wellness Consultation Consent Form

I hereby understand, agree, and attest to the following:

1. I fully understand that the Wellness Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.
2. Since the Wellness Consultant is not a medical doctor or primary care physician, it is recommended that I continue services with my primary care physician.
3. The services offered by the Wellness Consultant are at all times restricted to helping me gain a better understanding of 'health' (not disease), so that I will have greater self-awareness and be able to use a self-care plan for daily living.
4. The wellness plan offered (which may include discussion and or sale of nutritional supplements, nutrition and lifestyle modifications, homeopathic remedies, vitamins, minerals, food grade herbs, and other dietary supplements) pertains to the whole body concept of nutrition rather than addressing a specific ailment or condition.
5. The Wellness Consultant does not provide emergency or after-hours care. In the event of an emergency, I will dial 911 or proceed to the nearest emergency room.
6. Laboratory testing may be conducted for screening purposes only and does not constitute a diagnosis of any medical condition. It is my responsibility to follow up with a medical doctor if any of the lab results are abnormal.
7. Women who are pregnant or planning pregnancy must inform their Wellness Consultant, as this will likely alter the recommendations that are made.
8. Since they are not prescribing physicians, the Wellness Consultants will not be able to advise me to discontinue or change doses of my medications. I am advised to consult with my prescribing physician concerning any modifications of my pharmaceutical medications.
9. Potential benefits of following a wellness plan include health optimization, symptomatic relief, and disease prevention. Potential risks include rare allergic reactions, paradoxical reactions to supplements (example: valerian is a relaxing herb for most people, but it is stimulating in some people), and drug-supplement interactions. Although there is a growing body of information regarding such interactions, I understand that not all drug-supplement interactions are known at this time.
10. There are wide individual differences in response to a wellness plan, and no guarantees are made that I will gain any benefit nor suffer any adverse consequences.
11. While I may experience immediate benefits from the wellness plan, I understand that the most effective results will occur when I make a long-term commitment to rebuild my health, which will likely involve some lifestyle modifications.

Signature of Client or Client's Representative:

Printed Name of Client or Client's Representative:

Phone Number:(_____)_____-_____

Date: _____

Referred By: _____

Blood and/or urine test in last year: YES NO If no, most recent date: _____

Please bring a copy of the results to your first visit. Testing may be required if you have not had recent testing.

Current Medical Doctor: _____ Office Phone: _____

Condition	Yourself	Age at Diagnosis	Family Members Diagnosed	Age at Diagnosis/Indicate if deceased
High blood pressure				
Heart Disease/attack High Cholesterol				
Per. Vascular Disease				
Stroke				
Thyroid				
Adrenal Fatigue				
Diabetes (specify type)				
Asthma/Lung Disorders				
Tuberculosis				
Arthritis (please specify)				
Lupus				
Drug or alcohol addiction				
Mental illness (please specify)				
Dementia or Alzheimer's				
Parkinson's Disease				
Multiple Sclerosis				
Other neurological diseases				
Lung Cancer				
Breast Cancer				
Ovarian Cancer Colorectal Cancer				
Celiac or Food Allergies				
Communicable Diseases/STDs (please specify)				
Other:				
Other:				
Other:				
Other:				

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INSTRUCTIONS: Place a check mark by each of the following items that apply.

medications you take:

- Acetaminophen
- Antacids
- Antibiotic/Antifungal
- Antidepressant
- Antidiabetic/Insulin
- Aspirin
- Chemotherapy
- Cortisone/ NSAIDs/
Anti-inflammatories/
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Prostate
- Radiation
- Recreational Drugs
- Specify _____
- Relaxants/Sleeping Pills
- Thyroid
- Ulcer Medications
- Other (list) _____

you eat, drink, or use:

- Carbonated Beverages
- Tea, caffeinated
- Water, distilled
- Water, tap
- Meat with Nitrates/Nitrites
- Margarine
- Saccharin
- Aspartame
- Chew Tobacco
- Smoke Pipe
- Antiperspirants with
aluminum
- Hair dyes containing lead

you:

- Diet often
- Do not exercise
regularly
- Salt food without tasting
- Are under excessive
stress
- Are exposed to
chemicals at work
- Are exposed to
cigarette smoke
- Live within 10 miles of
an industrial plant
- Live in an area high in
EMFs (within 1/4 mile
of an electrical
transformer or
distribution center)

In the following categories, please indicate symptoms, and intensity:

Issue	Symptoms	Mild	Moderate	Severe
Energy				
Sleep				
Skin Issues				
Gastrointestinal/Digestion				
Pain				
Focus/Memory				
Neurological				
Hormonal (i.e. hot flashes, vaginal dryness, low libido, dry skin/hair)				
Emotional (anxiety, apathy)				
Other:				

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Nutrition Assessment

Sex: ___ male ___ female

Pregnant: ___ no ___ yes **Nursing:** ___ no ___ yes

Dietary & Nutritional Information

How often do you eat the following foods? (indicate daily (D), weekly (W), occasionally (O) (Rarely (R))

___ Fast food	___ Caffeine
___ processed meats (lunch meats)	___ Refined sugars/sweets
___ Refined flour (breads/baked goods)	___ Fried foods
___ High-fat dairy products	___ Red meat
___ Alcoholic beverages	

How many servings of the following foods do you consume daily?

___ fruits (½ cup canned, 1 cup raw or 1 med size fruit)
___ vegetables (½ cup cooked or canned, 1 cup raw)
___ whole grain products (whole wheat, whole grain oats, brown rice, etc)
___ dairy products (milk, cheese, yogurt)
___ water

Please indicate always (A), sometimes (S), never (N) to the following items:

___ I eat when I'm hungry
___ I eat when I'm stressed
___ I eat when I'm bored
___ I have a difficult time deciding what to eat
___ I'm not certain if some foods I'm eating are healthy
___ I usually overeat
___ I don't eat enough
___ I don't feel that I get enough food
___ I feel physically hungry
___ I wake at night to eat
___ I consume 50% or more of my calories during the evening

Foods allergies or intolerances: (Please indicate food and reaction to that food)

Food dislikes: (please list foods that you do not like to eat)

What is your typical day's food and beverage intake (please indicate time of meal, foods eaten and serving size):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Weekly exercise regimen, if any (describe): _____

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Uses and Disclosures of Protected Health Information

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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 Diseases; 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.



Austin's Favorite Pharmacy

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:

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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 may 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 disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and 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 filing 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.



Austin's Favorite Pharmacy



Austin's Favorite Pharmacy

Acknowledgement of Receipt of Privacy Practices

By signing this document, I acknowledge that I have read the copy of the Peoples Wellness Center and affiliated entities notice of privacy practices posted at the front desk.

Print Name

Signature

Date: _____

I hereby give my consent for Peoples Wellness Center and Affiliated Entities to release my protected health information to the following family members.

_____	Relationship to Patient	_____
_____	Relationship to Patient	_____
_____	Relationship to Patient	_____
_____	Relationship to Patient	_____
_____	Relationship to Patient	_____

Print Name

Signature

Date: _____

OFFICE USE ONLY

Date Acknowledgement Received: _____

-OR-

Reason acknowledgement was not obtained: _____



Austin's Favorite Pharmacy

Integrative Health and Medicine Wellness Consultations Waiver

I fully understand the attending consultants are not allopathic doctors (M.D.'s) and do not pretend to be, but are health and wellness consultants. I fully understand the difference between the practice of allopathic medicine and wellness consulting.

I fully understand the services provided by the attending consultants are not allopathic, but holistic or naturopathic in nature. I fully understand the attending consultants perform their services within the parameters of a natural health care and wellness system.

I fully understand the attending consultants do not offer allopathic drugs, surgery or chemical stimulants or radiation therapy. I understand, too, that illness is not being diagnosed nor treated and that my wellness is being measured and increased.

I have solicited the attending consultants' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.

I presently seek counsel, advice, opinions, points of view and/or programs within the scope of the attending consultants' wellness practice. However, should I desire any services not provided by nor within the scope of the attending consultant's wellness practice, which is my prerogative, I fully understand I should seek them elsewhere.

I fully understand the attending consultants are in no way encouraging me to terminate any previous and or current therapies other doctors have started.

I understand these consultants are not diagnosing, nor treating diseases, but are providing information and supplements to restore natural balance and optimum function for health and wellness.

If I am accompanied by and am signing for a minor or incompetent, I give full faith that I am legally and totally responsible.

I understand the ZYTO technology does not diagnose or treat. It is a screening tool designed to gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.

I give full faith that I have read and understand this document entirely and that I have received a verbal explanation of the same from the attending consultants and they have satisfactorily answered all of my questions and or doubts.

I am willing and prepared to declare and repeat under oath all of the above statements at the attending consultants' request.

Client's Name: _____
(please print)

Client/Responsible Party Signature: _____



Austin's Favorite Pharmacy

Office Policies

Dear Patients:

In order to make your experience here as enjoyable and easy as possible we are implementing the following policies, effective immediately:

1) **Appointment Cancellation:** 24-hour notice of appointment cancellation is necessary to serve you in the most efficient way possible and to make sure that appointments are available when you need them. To help with this situation, we are instituting a \$25.00 "No Show Fee" for which you will be billed, should you fail to cancel your appointment within 24 hours.

2) **Return phone calls:** Our providers are seeing numerous patients during the day so it can be difficult for them to return phone calls during regularly scheduled patient hours. We ask that you allow up to 24 hours for us to return your phone calls with the exception of weekends and emergencies. If you are experiencing a life-threatening situation, please call the emergency room for immediate assistance.

3) **Late arrivals:** Patients arriving late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first.

4) **Test kits:** The cost of testing goes to the laboratories and does not include the follow-up visit, which is necessary to interpret results and adjust your plan moving forward. This visit will be billed at your practitioner's regular rates. Testing may or may not be covered by insurance. Any insurance questions should be directed to your insurance carrier. We do not offer any insurance billing services. Test kits are only sold to current patients to ensure proper care and follow up.

5) **Meet & Greet Visits:** Meet & Greet appointments are a great way to see if you are a good fit with a practitioner before you pay for an initial visit. This visit does not make you a patient and will not include any suggestions or plans for your condition, although testing may be recommended before scheduling your initial consultation.

If you have any questions, please address them to our staff during regular office hours. Thank you for your cooperation and patience.

I, _____, have read and understand the above policies.

Signature

Date

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Austin, Texas 78750
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www.peoplesrx.com