# PATIENT INFORMATION DEMOGRAPHICS

## PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Sex: M F • Married: Y N • Partner: Y N

City: _____ State: _____ Zip: _____ Marital/Partners Name: _____

Occupation: _____ _____

Employer: _____ Email: _____

Employers Address and Phone#: _____ Social Security #: _____

_____ Driver's License #: _____ State: _____

Pharmacy Name and Address: _____ Mobile Phone: _____

_____ Home Phone If Different: _____

Pharmacy Phone: _____ Work Phone: _____

## RESPONSIBLE PARTY INFORMATION (If different)

Name: _____ Relationship To Patient: _____

Address: _____ Mobile Phone: _____

City: _____ State: _____ Zip: _____ Home Phone If Different: _____

Email: _____ Work Phone: _____

## HEALTH INSURANCE (Please give your insurance cards to the receptionist)

Insurance Co: _____ Policyholder's Name: _____

Address: _____ Relationship To Patient: _____

City: _____ State: _____ Zip: _____ Policyholder's DOB: _____

Effective Date: _____ Through: _____ Policyholder's SSN: _____

Phone: _____ Policyholder's Employer: _____

Plan Name: _____ Copay: $_____ Policy #: _____

Group #: _____

## ADDITIONAL SECONDARY INSURANCE

Insurance Co: _____ Policyholder's Name: _____

Policyholder's Employer: _____ Relationship To Patient: _____

Policy #: _____ Policyholder's DOB: _____

Group #: _____

## IN CASE OF AN EMERGENCY

Notify: _____ Relationship To Patient: _____

Home Phone: _____ Work Phone: _____

## SIGNATURE

The undersigned verifies that the above information is true and correct:

Signature: _____ Date: _____

(If the patient is a minor – signature of parent or guardian)

# Patient Communication Authorization

Date: _____ Patient

Patient's Date of Birth: _____

Patient's Name: _____

We must call on occasion to discuss confidential, protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

Mobile Phone Number _____

- Can we text your mobile phone about appointments
  e.g., appointment reminders, changes made to your appointment time, etc.? Yes ❑ No ❑
- Can we text your mobile phone about the account
  e.g., unpaid statements, balance due, etc. Yes ❑ No ❑
- Can we call this number and leave a message concerning your health? Yes ❑ No ❑

Email Address _____

- Can we email you about appointments,
  e.g., appointment reminders, changes made to your appointment time, etc.? Yes ❑ No ❑
- Can we email you about the account
  e.g., unpaid statements, balance due, etc. Yes ❑ No ❑
- Can we email you with information concerning your health? Yes ❑ No ❑

Home Phone Number _____

- Can we call this number and leave a message concerning your health? Yes ❑ No ❑

Work Phone Number _____

- Can we call this number and leave a message concerning your health? Yes ❑ No ❑

❑ I give permission to the individual(s) listed below to receive protected health information:
❑ You may also call these individuals on my behalf at the phone number(s) listed below:

_____

_____

- This authorization can be revoked or modified by notifying us IN WRITING at any time.

_____ _____
Patient's Signature Date

Todays Date: _____

# PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____ Sex _____ S. M. LTP. W. D.

Address _____ Tel. No. _____

Insurance Co. _____ ☐HMO ☐PPO Copay $ _____ Copay $ _____ Primary care Physician _____ Occupation _____

Mail Claim To _____ Policy No. _____

Instructions: Put ☑ In Those Boxes Applicable To You And In The "Yes" Or "No" Space. If Lines Are Provided Write In Your Answer.

## Family History

| | Father | Mother | Brother 1 | Brother 2 | Brother 3 | Brother 4 | Sister 1 | Sister 2 | Sister 3 | Sister 4 | Spouse/ Partner | Children 1 | Children 2 | Children 3 | Children 4 | Children 5 | Children 6 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age (if Living) | | | | | | | | | | | | | | | | | |
| Health (G) Good (B) Bad | | | | | | | | | | | | | | | | | |
| Cancer | | | | | | | | | | | | | | | | | |
| Tuberculosis | | | | | | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | | | | | | |
| Epilepsy | | | | | | | | | | | | | | | | | |
| Nervous Breakdown | | | | | | | | | | | | | | | | | |
| Asthma, Hives, Hay Fever | | | | | | | | | | | | | | | | | |
| Blood Disease | | | | | | | | | | | | | | | | | |
| Age (At Death) | | | | | | | | | | | | | | | | | |
| Cause Of Death | | | | | | | | | | | | | | | | | |

## Personal History

| Have You Ever Had . . . | No | Yes | Have You Ever Had . . . | No | Yes | Have You Ever Had . . . | No | Yes |
|---|---|---|---|---|---|---|---|---|
| ☐Scarlet Fever | | | Jaundice | | | ☐Broken Bones ☐Cracked Bones | | |
| Diphtheria | | | Epilepsy | | | Recurrent Dislocations | | |
| Smallpox | | | Migraine Headaches | | | ☐Concussion ☐Head Injury | | |
| Pneumonia | | | Tuberculosis | | | Ever Been Knocked Unconscious | | |
| Pleurisy | | | Diabetes | | | ☐Food ☐Chemical ☐Drug Poisoning | | |
| ☐Rheumatic Fever ☐Heart Disease | | | Cancer | | | Explain | | |
| ☐Arthritis ☐Rheumatism | | | Colonoscopy / Sigmoidoscopy | | | Latex Sensitivity | | |
| ☐Bone Disease ☐Joint Disease | | | ☐High ☐Low Blood Pressure | | | Chronic Fatigue Syndrome | | |
| ☐Neuritis ☐Neuralgia | | | Nervous Breakdown | | | Any Other Disease | | |
| ☐Bursitis ☐Sciatica ☐Lumbago | | | ☐Hay Fever ☐Asthma | | | Explain | | |
| ☐Polio ☐Meningitis | | | ☐Hives ☐Eczema | | | | | |
| ☐Gonorrhea ☐Syphilis ☐HIV | | | Frequent ☐Colds ☐Sore Throat | | | Weight: Now One Yr. Ago | | |
| Anemia | | | Frequent ☐Infections ☐Boils | | | Maximum When | | |

## Allergies

| Are You Allergic To . . . | No | Yes | Are You Allergic To . . . | No | Yes | Are You Allergic To . . . | No | Yes |
|---|---|---|---|---|---|---|---|---|
| ☐Penicillin ☐Sulfa Drugs | | | Any Other Drugs | | | Any Foods | | |
| ☐Aspirin ☐Codeine ☐Morphine | | | Explain | | | Explain | | |
| ☐Mycins ☐Other Antibiotics | | | Iodine Or Radiologic Dye | | | | | |
| ☐Tetanus ☐Antitoxin ☐Serums | | | Adhesive Tape | | | ☐Nail Polish ☐Other Cosmetics | | |

## Surgery

| Have You Had Removed . . . | No | Yes | Have You Had Removed . . . | No | Yes | Have You . . . | No | Yes |
|---|---|---|---|---|---|---|---|---|
| Tonsils | | | ☐Ovary ☐Ovaries | | | Had Hernia Repaired | | |
| Appendix | | | Hemorrhoids | | | Had Any Other Operations | | |
| Gall Bladder | | | Ever Have A Transfusion | | | Been Hospitalized For Any Illness | | |
| Uterus | | | ☐Blood ☐Plasma | | | Explain | | |

## X-Rays

| Ever Have X-rays Of . . . | No | Yes | Date | Disease Present |
|---|---|---|---|---|
| Chest | | | | |
| ☐Stomach ☐Colon | | | | |
| Gall Bladder | | | | |
| Extremities | | | | |
| Back | | | | |
| Mammogram | | | | |
| Sigmoidoscopy / Barium Enema | | | | |
| Other | | | | |

Print Name: _____ Todays Date: _____

## Review Of Systems

| Do You Now Have Or Have You Ever Had . . . | No | Yes | Do You Now Have Or Have You Ever Had . . . | No | Yes |
|---|---|---|---|---|---|
| ☐ Eye Disease ☐ Eye Injury ☐ Impaired Sight | | | Kidney ☐ Disease ☐ Stones | | |
| ☐ Ear Disease ☐ Ear Injury ☐ Impaired Hearing | | | Bladder Disease | | |
| Any Trouble With ☐ Nose ☐ Sinuses ☐ Mouth ☐ Throat | | | Blood In Urine | | |
| Fainting Spells | | | ☐ Protein ☐ Sugar ☐ Pus ☐ Other In Urine | | |
| Convulsions | | | Difficulty In Urination | | |
| Paralysis | | | Narrowed Urinary Stream | | |
| Dizziness | | | Abnormal Thirst | | |
| Headaches: ☐ Frequent ☐ Severe | | | Prostate Trouble | | |
| Enlarged Glands | | | ☐ Stomach Trouble ☐ Ulcer | | |
| Thyroid: ☐ Overactive ☐ Underactive ☐ Enlarged | | | Indigestion | | |
| Enlarged Goiter | | | ☐ Gas ☐ Belching | | |
| Skin Disease | | | Appendicitis | | |
| Cough: ☐ Frequent ☐ Chronic | | | ☐ Liver Disease ☐ Gall Bladder Disease | | |
| ☐ Chest Pain ☐ Angina Pectoris | | | ☐ Colitis ☐ Other Bowel Disease | | |
| Spitting Up Blood | | | ☐ Hemorrhoids ☐ Rectal Bleeding | | |
| Night Sweats | | | Black Tarry Stools | | |
| Shortness Of Breath ☐ Exertion ☐ At Night | | | ☐ Constipation ☐ Diarrhea | | |
| ☐ Palpitation ☐ Fluttering Heart | | | ☐ Parasites ☐ Worms | | |
| Swelling Of ☐ Hands ☐ Feet ☐ Ankles | | | ☐ Any Change In Appetite ☐ Eating Habits | | |
| Varicose Veins | | | ☐ Any Change In Bowel Action ☐ Stools | | |
| Extreme ☐ Tiredness ☐ Weakness | | | Explain | | |

## Immunization - EKG

| Have You Had . . . | No | Yes | Have You Had . . . | No | Yes |
|---|---|---|---|---|---|
| Smallpox Vaccination (Within Last 7 Years) | | | Polio Shots (Within Last 2 Years) | | |
| Tetanus Shot (Not Antitoxin) | | | An Electrocardiogram When | | |
| Hepatitis Vaccination | | | | | |

## Social History

| Do You . . . | No | Yes | Do You Use . . . | Never | Occ. | Freq. | Daily |
|---|---|---|---|---|---|---|---|
| Exercise Adequately | | | Laxatives | | | | |
| How? | | | Vitamins | | | | |
| Awaken Rested | | | Sedatives | | | | |
| Sleep Well | | | Tranquilizers | | | | |
| Average 8 Hours Sleep (Per Night) | | | Sleeping Pills | | | | |
| Have Regular Bowel Movements | | | Aspirins | | | | |
| Sex - Entirely Satisfactory | | | Cortisone | | | | |
| Like Your Work ( Hours Per Day) ☐ Indoors ☐ Outdoors | | | Alcoholic Beverages | | | | |
| Watch Television ( Hours Per Day) | | | Tobacco: Cigarettes ( Pks Per Day) | | | | |
| Read ( Hours Per Day) | | | ☐ Cigars ☐ Pipe ☐ Chewing Tobacco | | | | |
| Have A Vacation ( Weeks Per Year) | | | ☐ Snuff | | | | |
| Have You Ever Been Treated For Alcoholism | | | ☐ Other Drugs | | | | |
| Have You Ever Been Treated For Drug Abuse | | | Appetite Depressants | | | | |
| Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week? | | | Thyroid Medication: ☐ No ☐ Yes, In Past ☐ None Now ☐ Now On Gr. Daily<br>Have You Ever Taken:<br>☐ Insulin ☐ Tablets For Diabetes ☐ Hormone Shots ☐ Tablets ☐ No | | | | |

## Women Only

| Menstrual History . . . | No | Yes | | No | Yes |
|---|---|---|---|---|---|
| Age At Onset | | | Are You Regular: ☐ Heavy ☐ Medium ☐ Light | | |
| Usual Duration Of Period Days | | | Do You Have ☐ Tension ☐ Depression Before Period | | |
| Cycle (Start To Start) Days | | | Do You Have ☐ Cramps ☐ Pain With Period | | |
| Date Of Last Period | | | Do You Have Hot Flashes | | |
| Pregnancies . . . | No | Yes | Cervical & Vaginal Cancer Risk Assessment: | No | Yes |
| Children Born Alive (How Many ) | | | **1) Did you have sexual intercourse before the age of 16?** | | |
| Cesarean Sections (How Many ) | | | **2) Have you had more than five partners in your lifetime?** | | |
| **Have you had a Pap test in the past 7 years?** | | | **3) Have you ever had a sexually transmitted disease?** | | |

## Emotions

| Are You Often . . . | No | Yes | Are You Often . . . | No | Yes |
|---|---|---|---|---|---|
| Depressed | | | Jumpy | | |
| Anxious | | | Jittery | | |
| Irritable | | | Is Concentration Difficult? | | |

# Clinic Policies

## Acknowledgement & Consent

Patient name:_____Date of birth: _____

I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to the physician(s) or medical clinic for any services furnished to me: (a) Granting an irrevocable assignment of your patient's right and or my right to reimbursement for covered services rendered ("Covered Services"); and (b) Granting you a power of attorney to submit, negotiate, and appeal that claim in the patient's name.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I understand that all inactive medical records are destroyed after six years; and that if I want them I need to claim them before six years. I also authorize the release of any information required to process insurance claims including any information relating to drug or alcohol abuse, and AIDS/HIV.

**Financial Arrangements**:
For your convenience, our clinic participates with most insurance plans. Our list of plans may change periodically. You are responsible for making sure that we are currently participating with your carrier. You are responsible to notify us which diagnostic testing laboratory your insurance is contracted with, otherwise you may be liable for non-contracted laboratory services.

We offer the following methods of payment: Cash, Personal Check, Visa, and MasterCard. If you do not have insurance, we require full payment at the time of service. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance prior to your appointment.

Forms are completed free of charge on or before the day of surgery or during your 30-day post-operative checkup. At any other time, I agree to pay for any letter; note; forms required for a return to work, disability, insurance, DMV, or for legal purposes; that I request to be completed and signed at $50/page and $25 each additional page. I agree to pay a $6.00 rebilling fee for each month that I carry a balance beyond 60 days. I agree to pay $60 for a missed appointment or $600 for a missed surgery if cancelled with less than 16 hours' notice.

**Acknowledgment of Receipt of Privacy Notice**:
I have been presented with a copy of the clinics "Notice of Privacy Policies", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I place no additional restriction(s) concerning my personal medical information:_____.
This authorization regarding how my information may be used and disclosed, in order to maintain my privacy, may be revoked in writing by me at any time.

Signed: _____ Date: _____
(If patient is a minor - signature of parent/guardian)

# TERZEPATIDE AND SEMAGLUTIDE CONSENT

**Terzepatide and Semaglutide** is a human-based glucagon-like peptide receptor agonist prescribed as an adjunct to a reduced calorie diet and exercise for chronic weight management in adults with an initial body mass index (BMI) that is considered outside a healthy range. Terzepatide and Semaglutide can help your body regulate blood sugar and decrease how much food you eat. Studies have shown that Terzepatide is more effective than Semaglutide for weight loss, but only Semaglutide is approved for weight loss.

**While using Terzepatide or Semaglutide, it is highly recommended that you:**

- Eat a fibrous diet. Focus on fruits and vegetables that are high in fiber.
- Eat small high-protein meals as digestion is slowed down while on this medication.
- Avoid foods high in fat as they take longer to digest.
- Limit alcohol intake to prevent side effects of nausea.
- Drink at least 32 oz of water a day to avoid constipation.

**Do not take this medication if:**

- You have a personal or family history of follicular thyroid carcinoma (Thyroid Cancer)
- Multiple Endocrine Neoplasia syndrome type 2
- You are pregnant or plan to become pregnant while taking this medicine.
- You are diabetic and taking medication that lowers your blood sugar levels. Taking Terzepatide or Semaglutide with your diabetes medication may increase your risk of hypoglycemia (low blood sugar).
- You have a history of acute/chronic pancreatitis.
- You have a history of kidney failure.
- You have a history of diabetic retinopathy and diabetic macular edema.
- You have a history of severe anxiety, depression, or suicidal thoughts.
- You are allergic to Terzepatide or Semaglutide or any other GLP agonist such as Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegoby®;
- If you have other allergies. This product may contain inactive ingredients, which can cause allergic reactions or other problems. Talk to your pharmacist for more details. Before using this medication, tell your doctor/pharmacist your medical history.

**Possible drug interactions:**

Anti-diabetic agents, specifically Insulin and Sulfonylureas (e.g., glyburide, glipizide, glimepiride, tolbutamide) due to the increased risk of hypoglycemia (low blood sugar). Do not take with other GLP agonist medicines such as: Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegoby® (THIS IS NOT AN ALL-INCLUSIVE LIST). For other medications used in diabetes, please tell your provider about any medications that may lower your blood sugar.

**Possible side effects:**

Severe stomach problems that won't go away. Severe stomach problems have been reported with Terzepatide and Semaglutide. A delay in stomach emptying can cause severe vomiting, dehydration, and constipation. Tell your healthcare provider if you have stomach problems that are severe or will not go away.

Gastrointestinal Side Effects: Because Terzepatide and Semaglutide slow down the digestive process, it can cause gastrointestinal side effects that you might not be used to. Some of the most common side effects of Terzepatide and Semaglutide include nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distension, belching, hypoglycemia, flatulence, mild gastroenteritis, and gastroesophageal reflux disease. In studies, most nausea, vomiting, and diarrhea events occurred while the dose of Terzepatide and Semaglutide was being increased. These events decreased over time.

To Reduce Gastrointestinal side effects: Eat smaller meals. Avoid fat or fatty foods. Stop eating when you feel full. Try eating bland foods like toast, crackers, or rice. Over-the-counter medicines like Pepcid-AC for reflux or Lomotil for diarrhea can be helpful.

Low Blood Sugar (Hypoglycemia): Signs and symptoms of low blood sugar may include dizziness or light-headedness, sweating, confusion or drowsiness, headache, blurred vision, slurred speech, shakiness, fast heartbeat, anxiety, irritability, or mood changes, hunger, weakness, and feeling jittery. If you have hypoglycemia symptoms, do the following: Eat or drink 15 to 20 grams of fast-acting carbohydrates. These are sugary foods or drinks without protein or fat that are easily converted to sugar in the body. Try glucose tablets or gel, fruit juice, regular (not diet) soda, honey, or sugary candy.

Thyroid Cancer: Tell your healthcare provider if you get a lump or swelling in your neck, hoarseness, trouble swallowing, or shortness of breath. These may be symptoms of thyroid cancer.

Inflammation of your pancreas (pancreatitis): Stop using Terzepatide or Semaglutide and call your healthcare provider immediately if you have severe pain in your stomach area (abdomen) that will not go away, with or without vomiting. You may feel the pain from your abdomen to your back.

Subcutaneous Injections: common injection site reactions characterized by itching and burning at the administration site with or without skin thickening (welting). If you notice other side effects not listed above, contact your doctor or pharmacist.

Gallbladder problems. Gallbladder problems have happened in some people who use Terzepatide and Semaglutide. Tell your healthcare provider immediately if you get symptoms of gallbladder problems, including pain in your upper stomach (abdomen), fever, yellowing of skin or eyes (jaundice), and clay-colored stools.

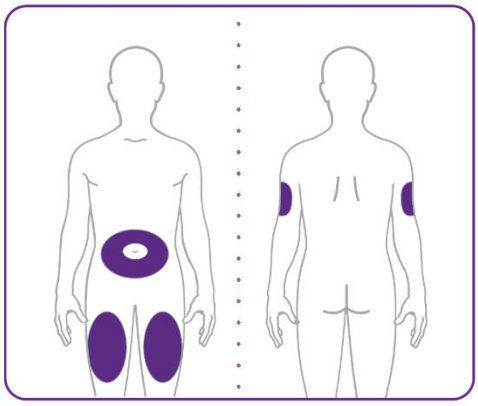
Kidney problems (kidney failure). In people with kidney problems, diarrhea, nausea, and vomiting may cause a loss of fluids (dehydration), which may cause kidney problems to get worse. You need to drink fluids to help reduce your chance of dehydration.

A severe allergic reaction to this drug is rare. However, get medical help immediately if you notice any symptoms of a severe allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), and very rapid heartbeat, severe dizziness, feeling faint, trouble breathing. Report adverse side effects to your doctor or pharmacist. In the event of any emergency, call 911 immediately.

I agree to obtain and be cared for by a primary care physician during my treatments and to report to him or her any side effects, physical and emotional.

I understand that all Terzepatide and Semaglutide medication delivered to the clinic by me or on my behalf becomes the property of the clinic.

Choosing the injection site:



• Your healthcare provider can help you choose the injection site that is best for you.
• You or another person can inject the medicine into your stomach or thigh.
• Another person should give you the injection in the back of the upper arm.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THIS TREATMENT OR QUESTIONS CONCERNING THIS TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK THE STAFF NOW BEFORE SIGNING THIS CONSENT FORM.

By signing, I certify that I have read and understand the contents of this form. I know the possible side effects and drug interactions and consent to treatment. I have informed the medical staff of any known allergies to drugs or other substances and any past adverse reactions I've experienced. I have informed the medical staff of all medications and supplements I'm currently taking. I understand other ways and programs can assist me in my desire to decrease my body weight and acknowledge that no guarantees have been made to me concerning my results.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree, in the event of non-payment, to bear the cost of collection or Court costs, and reasonable legal fees, should this be required.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions. I consent to the Semaglutide/Terzepatide cosmetic treatment today and for all subsequent treatments.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

# EATING DISORDER AND CONSENT TO TREAT

I read the pamphlet "EATING DISORDERS, Guidance for Patients, Families, and Friends" published by the American Psychiatric Association (APA) and available for download on my provider's website. I have a binge eating disorder - ICD10 F50.81, and possibly other specified feeding or eating disorders (OSFED) - ICD10 F50.89, as defined by the APA.

Signs of a Binge Eating Disorder to look for to look out for might include:

- Eating past the point of satisfaction and to the point of discomfort.
- Eating too fast to notice how much you eat or how it feels.
- Eating large amounts of food when you're not hungry or after recently finishing a meal.
- Eating in response to emotional stress (emotional eating).
- Eating alone and in secret and avoiding social eating.
- Organizing your schedule around binge eating sessions.
- Hoarding and stashing food in hidden places to access later.
- Hiding eating from others because you're embarrassed about how much you're eating.
- Obsessive thinking about food and specific food cravings.
- Frequent dieting, which may cause weight fluctuations or no weight loss.
- Guilt, remorse, shame, and self-esteem issues related to binge eating.

Signs of OSFED to look out for might include:

- Overly focused on and/or secretive behavior around food
- Self-consciousness when eating in front of others
- Low confidence and self-esteem
- Poor body image
- Irritability and mood swings
- Tiredness
- Social withdrawal
- Feelings of shame, guilt, and anxiety
- Difficulty concentrating

I understand that psychotherapy is a crucial element in treating an eating disorder and that weight loss medications, like tirzepatide, semaglutide, or lisdexamfetamine, may help control my obsessive thinking about food. I have been counseled and strongly encouraged to attend psychotherapy counseling for my condition.

Off-label use of tirzepatide and semaglutide for cosmetic weight loss and/or eating disorders has not been proven safe and effective in long-term clinical studies. It is, therefore, not approved by the U.S. Food and Drug Administration (FDA) and can carry certain risks and potential side effects. I have signed a consent form acknowledging these risks.

I understand that medications, like tirzepatide, semaglutide, or lisdexamfetamine, may be contraindicated if I have a history of severe anxiety, depression, or suicidal thoughts, and I will not take any if this is the case.

_____ _____

Patient Signature Date

# EATING DISORDERS

## Guidance for Patients, Families, and Friends

AMERICAN PSYCHIATRIC ASSOCIATION

# INTRODUCTION

- Eating disorders are medical conditions characterized by frequent and problematic eating behaviors as well as distressing thoughts and emotions about food.
- Behaviors commonly associated with eating disorders include restrictive eating or avoidance of certain foods, binge eating, purging by vomiting or laxative misuse, and compulsive exercise.
- Eating disorders are serious conditions that can reduce overall quality of life. Also, if left untreated, the physical and mental side effects of eating disorders can last for decades, or even a lifetime.
- Types of eating disorders include: anorexia nervosa (anorexia), bulimia nervosa (bulimia), binge-eating disorder, avoidant/restrictive food intake disorder (ARFID), pica, rumination disorder, and other specified feeding and eating disorders. This guide will focus on three of the most common: anorexia, bulimia, and binge-eating disorder.
- Current estimates show eating disorders will affect between 2 to 3 out of every 100 people in the United States at some point during their lifetime (roughly 6 to 10 million people). Many other people may have features or symptoms of an eating disorder but not have an official diagnosis.
- Eating disorders are more common in women, and often appear in teenage years and early adulthood. However, eating disorders can affect any person at any time, regardless of age, gender, race, ethnicity, weight, size, or body shape.
- Recovery from eating disorders is a gradual process unique to each person. When identified and treated, patients are able to change their relationship with food, have improved health, and enjoy a good quality of life.
- This guide will help patients and their families understand how eating disorders are diagnosed, the treatment options that are available, and what can be done to achieve the best possible outcomes.

**Seeking medical help is the first step in the care process and the path to recovery.**

- **Early intervention greatly increases the chances of recovery from eating disorders. The problem is that it is not always easy to identify when someone has an eating disorder.**
- **To help identify issues as early as possible, primary care clinicians and mental health professionals may ask screening questions that explore a person's relationship with food, weight, and self-image.**
- **One questionnaire that can be used to help identify an eating disorder is the *Eating Disorder Screen for Primary Care* (pictured below; answers marked with an asterisk suggest a possible eating disorder).**

| | |
|---|---|
| Are you satisfied with your eating patterns? | **Y** / **N*** |
| Do you ever eat in secret? | **Y*** / **N** |
| Does your weight affect the way you feel about yourself? | **Y*** / **N** |
| Have any members of your family suffered with an eating disorder? | **Y*** / **N** |
| Do you currently suffer with or have you ever suffered in the past with an eating disorder? | **Y*** / **N** |

Source: Eating Disorder Screen for Primary Care (Cotton et al. 2003)

- **If the answers to screening questions suggest that an eating disorder may be present, the clinician will ask for more information to determine the type of eating disorder that is present and its severity.**

- **Other information that may be asked as part of an assessment includes:**
  - » Height and weight history, including any recent weight changes.
  - » Eating habits, including foods that are typically eaten or avoided, binge eating, or other eating behaviors.
  - » Efforts to control weight by eating less food, self-inducing vomiting after eating, compulsive exercising, or taking medications to affect weight.
  - » Preoccupations with food, weight, or body shape.
  - » Effects of eating behaviors and body image concerns on school or work functioning and relationships with family and others.
  - » Family history of eating disorders or other medical conditions, including mental health.
  - » Previous treatment including psychotherapy and any medications currently or recently taken, including prescriptions and over the counter medications, such as laxatives.
- **Individuals struggling with eating disorders are often dealing with other physical and mental health challenges as well. Mental health conditions such as depression, anxiety, or substance use can be present along with an eating disorder and can affect treatment choices and outcomes. For this reason, it is important for patients to mention any stresses and psychological or physical health concerns that they may be experiencing.**
- **A physical exam will also be done that includes measuring height, body weight, pulse, blood pressure, temperature, and looking for other physical changes that can occur as part of an eating disorder. Depending on the results of the history and physical exam, the clinician may suggest laboratory tests and an electrocardiogram (ECG) to monitor the heart.**

## What Will Treatment Include?

- Every person's situation is different, so choosing the best treatment options will be a shared decision between the patient and treating clinicians, with adjustments in the plan made as treatment progresses.
- Often family members or others in the person's support network will give input on decisions about treatment.
- Typically, treatment of an eating disorder will be given by a team of individuals with medical, psychiatric, psychological, and nutritional expertise.
- Psychotherapy is a crucial element in the treatment of an eating disorder.
- Medications may be suggested in some circumstances.

## Determining the Best Level of Care

- There are multiple levels of care and care settings available to help patients with eating disorders.
- The most common levels of care include outpatient, intensive outpatient, residential, and hospital-based care.
- Within a level of care, some programs may have additional capabilities, such as staff and facilities for managing serious physical health complications.
- Because the right setting and level of care will depend on multiple factors, the patient and family should discuss the most appropriate level of care with the clinician.

## Identifying Goals of Treatment

- **Goals of treatment will usually include:**
  - » Providing education to the patient and family about eating disorders and their treatment.
  - » Reducing the severity of symptoms.
  - » Promoting healthy behaviors and addressing any physical health issues.
  - » Improving the patient's level of functioning and quality of life.
- **Patients will often have their own goals for treatment related to issues such as school or employment, living situation, past experiences, and personal, family, or other intimate relationships.**
- **Other goals will depend on the patient's specific eating disorder.**

## Anorexia Nervosa

- **Anorexia is characterized by self-starvation and weight loss resulting in low weight for height and age. It is usually driven by an intense fear of gaining weight.**

- **There are two subtypes of anorexia:**
  - » Restricting type, in which individuals lose weight primarily by dieting, fasting, or excessively exercising.
  - » Binge eating/purging type in which persons also engage in intermittent binge eating and/or purging behaviors, such as vomiting or taking laxatives.

- **Patients with anorexia will require renourishment and weight restoration to assist with recovery.**

- **Individualized goals will be set for each patient that include target weight and weight gained for each week.**

- **Psychotherapy is another essential treatment for anorexia to help in normalizing eating and weight-related behaviors. In addition to treating symptoms of the disorder, it will focus on addressing any underlying fears or concerns that contributed to the disorder, such as a fear of weight gain or other body image concerns.**

- **A number of different psychotherapies are effective in treating anorexia, including cognitive-behavioral therapies, focal psychodynamic psychotherapy, interpersonal psychotherapy, the Maudsley Model of Anorexia Nervosa Treatment for Adults, and specialist supportive clinical management.**

- **For adolescent and young adult patients, family-based treatment is recommended and teaches family members to help the patient normalize eating and weight control behaviors.**

## Bulimia Nervosa

- Individuals with bulimia have frequent episodes of binge eating that are followed by behaviors to try to prevent weight gain from the binge-eating episode.
- Binges occur at least weekly and are typically secretive and associated with feelings of shame or embarrassment. Behaviors that follow binges can include purging through self-induced vomiting, excessive exercising, or use of laxatives, diuretics (i.e., water pills), or other medications to influence weight.
- If untreated, bulimia can lead to physical complications including esophageal tears, gastric rupture, and dangerous cardiac arrhythmias.
- Treatment with cognitive-behavioral therapy (CBT) is recommended for adults with bulimia.
- CBT focuses on examining and changing beliefs and behaviors about food and weight. There can also be a focus on changing beliefs that contribute to eating disorders such as perfectionism and low-self-esteem.
- Family-based treatment is suggested for adolescent and young adult patients with bulimia.
- In addition to psychotherapy, adults with bulimia may be prescribed a type of medication called a serotonin reuptake inhibitor (e.g., fluoxetine). When a serotonin reuptake inhibitor is used, it can be started at the very beginning of treatment or if there is minimal or no improvement after 6 weeks or more of therapy alone.

## Binge-Eating Disorder

- Similar to bulimia, people with binge-eating disorder have frequent episodes of binge eating in which they consume large quantities of food in a brief period, experience a sense of loss of control over their eating, and are distressed by the binge behavior. The main difference from bulimia is that patients with binge-eating disorder do not usually try to counteract the effects of the binge episode by inducing vomiting, exercising, or misusing laxatives or other medications.
- Binge-eating disorder can lead to health complications, including diabetes, hypertension, and cardiovascular diseases.
- Patients with binge-eating disorder should be treated with eating disorder-focused CBT or interpersonal therapy.
- Adults with binge-eating disorder who prefer medication or have not responded to psychotherapy alone may be treated with either an antidepressant medication or lisdexamfetamine.

## Path to Recovery

- An active support system often plays a key role in recovery. Family and friends can encourage their loved ones to stay in therapy, eat regular meals, and use new coping skills. They can also provide support during difficult meals and help build a healthy life.
- Involvement of a caregiver or family member is especially important for adolescent or young adult patients.
- Relapse can occur when struggling with eating disorders. This is why regular monitoring and ongoing therapy are important stepping stones on the path to recovery.
- Each person's recovery is unique. Recovery is not a straight line but rather a winding road that may include bumps and potholes as well as smooth sailing.
- It's important to remember and recognize that the first step is reaching out and seeking help.

- **What are the warning signs of an eating disorder?**

  » Warning signs of an eating disorder can differ for each person, but some of the most common signs include:

  - Constant focus on weight, food, calories, dieting, and/or body image.
  - Development of unusual, secretive, extreme, or ritualized eating habits.
  - Evidence of binge eating, such as the disappearance of a large amount of food.
  - Evidence of purging behaviors, including frequent trips to the bathroom after meals and/or laxative, diet pill, or diuretic use.
  - Compulsive or excessive exercising.
  - Discoloration or staining of the teeth.
  - Other changes in mood and behavior such as depression, anxiety, irritability, or withdrawal from friends and activities.

- **Can someone who looks healthy still have an eating disorder?**

  » YES! This is a very common misconception. People can look healthy yet still be experiencing an eating disorder.

- **What causes eating disorders?**

  » The exact cause of eating disorders is unknown. Current research shows eating disorders are caused by a complex interaction of factors. These include genetic, biological, behavioral, psychological, and social factors. There is no single factor to determine whether someone will develop an eating disorder.

- **What is ARFID and how is it different from anorexia?**

  » Avoidant/restrictive food intake disorder (ARFID) is associated with dramatic restriction in the types or amounts of food that is eaten, and it can cause slowed growth in children or weight loss in older individuals. Individuals with ARFID, unlike those with anorexia, do not have concerns about body image or fear of weight gain. Instead, they avoid food based on fears of choking or vomiting or because they are distressed by food related sensations such as textures, colors, smells, or other features of food.

- **Do only women get eating disorders?**

  » While eating disorders are more common in women, eating disorders can affect anyone. People of all ages, genders, socioeconomic statuses, shapes and sizes, sexual orientations, abilities, races, and ethnicities can experience an eating disorder.

# FREQUENTLY ASKED QUESTIONS

- **Why can't someone with an eating disorder just eat more or less food?**

  » Simply put — eating disorders are not fads, phases, or lifestyle choices that can be addressed by trying to eat more or less food. Rather, they are serious, and sometimes life-threatening medical conditions.

- **How long does treatment take?**

  » Initial therapy may last anywhere from a few months to multiple years. Every person and situation are different. Ongoing therapy may be needed for many years after that. Slips, backslides, and relapse are common. Re-learning normal eating habits and coping skills can take a long period of time and often requires lots of support from professionals, friends, and family.

- **Can someone with an eating disorder make a full recovery?**

  » Early detection and intervention are extremely important, and recovery from eating disorders is a gradual process that is unique to each person — but full recovery is absolutely possible.

# ADDITIONAL RESOURCES

**In the links below you can find additional resources such as:**

Signs and symptoms of eating disorders, healthcare provider locators, support groups, meal plans, resources for special and underserved populations, and so much more.

- **National Center of Excellence for Eating Disorders**
  - » https://www.nceedus.org/
- **American Psychiatric Association**
  - » https://www.psychiatry.org/patients-families/eating-disorders
- **National Institute of Mental Health**
  - » https://www.nimh.nih.gov/health/topics/eating-disorders
- **National Eating Disorders Association**
  - » https://www.nationaleatingdisorders.org/
- **National Association of Anorexia Nervosa and Associated Disorders**
  - » https://anad.org/
- **Families Empowered And Supporting Treatment for Eating Disorders**
  - » https://www.feast-ed.org/

**If you or someone you know may be struggling with an eating disorder, please seek help immediately.**

In addition, the 988 Suicide & Crisis Lifeline (https://988lifeline.org/) provides 24/7, free and confidential support for people in distress by calling or texting 988 or chatting through the website (https://988lifeline.org/chat/). If you suspect a medical emergency, seek medical attention or call 911 immediately.

## — Other Specified Feeding or Eating Disorder (OSFED)

According to the *DSM-5*, the category of other specified feeding or eating disorder (OSFED) is applicable to individuals who are experiencing significant distress due to symptoms that are similar to disorders such as anorexia, bulimia, and binge-eating disorder, but who do not meet the full criteria for a diagnosis of one of these disorders.

Examples of experiences that fall within the OSFED category include:

- *Atypical anorexia nervosa* – The individual meets the criteria for anorexia and has sustained significant weight loss as a result, but they remain within or above the weight range that is considered normal for their height and gender.
- *Bulimia nervosa (of low frequency and/or limited duration)* – The individual meets the criteria for bulimia, with the exception that they engage in bingeing and compensatory behaviors less than one time per week or for a duration of fewer than three months.
- *Binge-eating disorder (of low frequency and/or limited duration)* – The individual meets the criteria for BED, except that they average no more than one bingeing episode per week or have been experiencing symptoms for fewer than three months.
- *Purging disorder* – The individual engages in purging behaviors such as self-induced vomiting or laxative misuse, but they do not experience eating binges.
- *Night eating syndrome* – The individual experiences recurring episodes of eating after awakening at night, or of eating excessively after their evening meal. These episodes cause significant distress or impaired functioning.

## Source

American Psychiatric Association: Practice Guideline for the Treatment of Patients With Eating Disorders, Fourth Edition. Washington, DC, American Psychiatric Publishing, 2023.

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## Disclaimer

*This pocket guide attempts to define principles of practice that should produce high-quality patient care. It is applicable to specialists, primary care, and providers at all levels. This pocket guide should not be considered exclusive of other methods of care reasonably directed at obtaining the same results. The ultimate judgment concerning the propriety of any course of conduct must be made by the clinician after consideration of each individual patient situation. Neither IGC, the medical association, nor the authors endorse any product or service associated with the distributor of this clinical reference tool.*

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# 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.**

Effective Date September 23, 2013

**A. PURPOSE OF THIS NOTICE.**

This medical office is committed to preserving the privacy of your health information. In fact, we are required by law to do so for any health information created or received by us. We are required to provide this Notice of Privacy Practices ("Notice") to you. The Notice tells you how we can and cannot use and disclose the health information that you have given to us or that we have learned about you when you were a patient in our system. It also tells you about your rights and our legal duties concerning your health information.

We are required to abide by this Notice and any future changes to this Notice or law at all of our locations, including medical schools, medical residency programs, hospitals, skilled nursing facilities; numerous primary care and specialty clinics; multiple research institutes and centers; and several community service and outreach programs. This Notice applies to the practices of:

- All of our employees, volunteers, students, residents and service providers, including clinicians, who have access to health information.
- Any health care professional authorized to enter information into your health record.
- Any clinicians who might otherwise have access to your health information created or kept by us, as a result of, for example, their on-call coverage for our clinicians.

For the rest of this Notice," we" and "us" will refer to all services, service areas, and workers on our staff. When we use the words "your health information," we mean any information that you have given us about you and your health, as well as information that we have received while we have taken care of you (including health information provided to us by those outside of our facilities).

We will have a copy of the current Notice with an effective date in clinical locations and on our website.

**B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND FOR OUR HEALTH CARE OPERATIONS.**

1. Treatment, Payment and Health Care Operations.

The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. For each of those categories, we explain what we mean and give one or more examples. Not every use or disclosure will be noted and there may be incidental disclosures that are a byproduct of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

a. For Treatment. We may use your health information to provide you with medical or dental treatment or services. We may disclose your health information to staff physicians, staff dentists, post-graduate fellows, midwives or nurse practitioners, and other personnel involved in your health care. We may also disclose your health information to students and resident physicians who, as a part of their educational programs (and while supervised by physicians or dentists), are involved in your care. Treatment includes (a) activities performed by nurses, office staff, hospital staff, technicians and other types of health care professionals providing care to you or coordinating or managing your care with third parties, (b) consultations with and between our providers and other health care providers, and (c) activities of other physicians or other medical providers covering our practice by telephone or serving as the on-call provider.

   For example, a physician or dentist treating you for an infection may need to know if you have other health problems that could complicate your treatment. That provider may use your medical history to decide what treatment is best for you. They may also tell another provider about your condition so that he or she can decide the best treatment for you.

b. For Payment. We may use and disclose your health information so that we may bill and collect payment from you, an insurance company, or someone else for health care services you receive from us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

   For example, we may need to give your health plan information about surgery you received at any facility so that your health plan will pay us or reimburse you for the surgery.

c. For Health Care Operations. We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance and business functions at our facility. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about patients to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective. Or we may give health information to doctors, nurses, technicians, or health profession students for review, analysis and other teaching and learning purposes.

2. Fundraising Activities. As a part of our healthcare operations, we may use and disclose a limited amount of your health information internally, or to other charitable foundations to allow them to contact you to raise money. The health information released for these fundraising purposes can include your name, address, other contact information, gender, age, date of birth, dates on which you received service, health insurance status, the outcome of your treatment at our facility and your treating physician's name and department at our facility. Any fundraising communications you receive from us or our Foundations will include information on how you can elect not to receive any further fundraising communications from us or them.

3. Uses and Disclosures You Can Limit

a. Hospital Directory. Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital. Specifically, your name, location in the hospital and your general condition (e.g., good, fair, serious, critical) may be released to people who ask for you by name. In addition, your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name.

b. Family and Friends. Unless you notify us that you object, we may provide your health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your health information with these people and you don't stop us from doing so. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the exam room during treatment.

   Also, if you are not able to approve or object to disclosures, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care. For example, we may tell someone who comes with you to the emergency room that you suffered a heart attack and provide updates on your condition. We may also make similar professional judgments about your best interests that allow another person to pick up such things as filled prescriptions, medical supplies and X-rays.

**C. OTHER PERMITTED USES AND DISCLOSURES OF HEALTH CARE INFORMATION.**

We may use or disclose your health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

1. Required By Law: As required by federal, state, or local law.
2. Public Health Activities: For public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, school immunizations under certain circumstances or problems with products.
3. Victims of Abuse, Neglect or Domestic Violence: To a government authority authorized by law to receive reports of abuse, neglect or domestic violence when we reasonably believe you are the victim of abuse, neglect or domestic violence and other criteria are met.
4. Health Oversight Activities: To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
5. Lawsuits and Disputes: In response to a subpoena, discovery request or a court or administrative order, if certain criteria are met.
6. Law Enforcement: To a law enforcement official for law enforcement purposes as required by law; in response to a court order, subpoena, warrant, summons or similar process; for identification and location purposes if requested; to respond to a request for information on an actual or suspected crime victim; to report a crime in an emergency; to report a crime on our premises; or to report a death if the death is suspected to be the result of criminal conduct.
7. Coroners, Medical Examiners and Funeral Directors: To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.
8. Organ and Tissue Donation: To organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.
9. Research: For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your health information for research purposes until the particular research project, for which your health information may be used or disclosed, has been approved through this special approval process.
10. Serious Threat to Health or Safety; Disaster Relief: To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to your health and safety or that of the public or another person, or (ii) to notify your family members or persons responsible for you in a disaster relief effort.
11. Military: To appropriate domestic or foreign military authority to assure proper execution of a military mission, if required criteria are met.
12. National Security; Intelligence Activities; Protective Service: To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.
13. Inmates: To a correctional institution (if you are an inmate) or a law enforcement official (if you are in that person's custody) as necessary (a) to provide you with health care; (b) to protect your or others' health and safety; or (c) for the safety and security of the correctional institution.
14. Workers' Compensation: As necessary to comply with laws relating to workers' compensation or similar work-related injury program.

**D. WHEN WRITTEN AUTHORIZATION IS REQUIRED.**

Other than for those purposes identified above in Sections B and C, we will not use or disclose your health information for any purpose unless you give us your specific written authorization to do so. Special circumstances that require an authorization include most uses and disclosures of your psychotherapy notes, certain disclosures of your test results for the human immunodeficiency virus or HIV, uses and disclosures of your health information for marketing purposes that encourage you to purchase a product or service, and for sale of your health information with some exceptions. If you give us authorization, you can withdraw this written authorization at any time. To withdraw your authorization, deliver a written revocation to us. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

**E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.**

You have certain rights regarding your health information which we list below. In each of these cases, if you want to exercise your rights, you must do so in writing. You can get information about how to exercise your rights and about any costs that we may charge for materials by contacting us directly.

1. Right to Inspect and Copy. With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in our electronic health record, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically (unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.
2. Right to Amend. You have the right to amend your health information maintained by us, or used by us to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.
3. Right to an Accounting of Disclosures. You have the right to request a list and description of certain disclosures by us of your health information.
4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service for which we have been paid out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a surgery you had, a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in 4(c) above, we are not required to agree to your request. Any time we agree to such a restriction, it must be in writing and signed by our Privacy Officer or his or her designee.
5. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain place. We will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.
6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, whether or not you may have previously agreed to receive the Notice electronically.
7. Right to be Notified of a Breach. You have the right to be notified if there is a breach – a compromise to the security or privacy of your health information – due to your health information being unsecured. We are required to notify you within 60 days of discovery of a breach.

**F. REVISIONS TO THIS NOTICE**

We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. We will post the revised Notice at our clinical locations and on its website and provide you a copy of the revised notice upon your request.

**G. QUESTIONS OR COMPLAINTS**

If you have any questions about this Notice, please contact us directly. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with us, begin the process by contacting our practice manager by calling the office. You will not be penalized for filing a complaint.

This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.