SEBRING Clinic
feel better

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Wimberley, TX 78676
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www.sebringclinic.com

Lane Sebring, MD
Board Examiner American Academy of Anti-Aging Medicine

Patient Name: _____

Date: _____

In an attempt to improve patient flow through the clinic and reduce waiting time, we ask that you list the health problems you would like addressed during your visit beginning with the one you feel is most important and needs immediate attention. **Please note that if your list is long or complicated, you may be asked to schedule a follow-up visit to address the issues for which there was not time to cover during this visit.**

1. (Most important) _____
2. _____
3. _____
4. _____
5. _____

Dr. Sebring does NOT accept insurance. All patients treated by Dr. Sebring are responsible for payment in full at the time of the appointment. Dr. Sebring specializes in Alternative and Anti-Aging Medicine, which is viewed as elective and is therefore not covered by health insurance policies. You will be provided with a **cash receipt**.

Do you understand and accept the terms of our payment policy? _____

Why are you seeking healthcare outside of your regular healthcare provider? _____

How did you hear about us? _____

Have you ever entered litigation, claimed damage, or sued anyone because of injuries to or effect on your health? _____

Sebring Clinic Patient Profile

Last Name	First	Middle	Race	Sex	Primary Care Physician

Street Address	Email Is it ok to correspond with you via email? Yes No

City	State	Zip	County	Home Phone OK to leave message? Yes No

Social Security Number	Marital Status	Cell Phone OK to leave message? Yes No	Work Phone OK to leave message? Yes No

Place of Employment	Occupation	Birthplace	Date of Birth

Person Responsible For Payment

Last Name	First	Middle	Relationship to Patient	Social Security Number

Address	Home Phone	Date of Birth

City	State	Zip	Cell Phone	Work Phone

Person To Notify In Case Of Emergency

Last Name	First	Middle	Relationship to Patient	Home Phone

Address	Cell Phone	Work Phone

City	State	Zip		

Initials

_____ **Insurance and Medicare: Dr. Sebring does NOT accept any form of insurance. All patients treated by Dr. Sebring are responsible for payment in full at the time of the appointment.** Dr. Sebring specializes in Alternative and Anti-Aging Medicine, which is viewed as elective and is therefore not covered by health insurance policies or Medicare. **You will be provided with a cash receipt.**

_____ **What to expect in terms of cost:** Your first visit with Dr. Sebring is very important. You will have a comprehensive evaluation performed including a complete history and physical and extensive education addressing your specific problems and focused lab work(if necessary). This is to help establish a base line of your body chemistry with which Dr. Sebring will work to develop a personalized health and wellness strategy specifically tailored to your needs.

The initial consultation fee is $294.00. Labs are often necessary and will be determined during your consultation. Lab costs can range anywhere from $150.00 - $500.00 depending on your condition, as well as your health care goals. Please keep this in mind in preparation for your visit.

Follow-up consultations range between $137.00 and $218.00. Any labs that may be necessary during your follow-up are separate and will be added to your consultation cost.

I understand and accept the terms of Sebring Clinic's Payment Policy. I am seeking Alternative or Anti-Aging Medical treatment, which is not covered by insurance.

_____ _____/_____/_____

Patient signature (or Representative) Date

_____ _____

Name of Patient Name of Representative and Description of Authority

Medical History

Patient Name: _____

Have you had any history of the following?

	Yes	No	If yes, please elaborate
Allergies or Reactions to Medication	☐	☐	_____
Allergies (other: seasonal, food, etc)	☐	☐	_____
Anemia	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Back Trouble	☐	☐	_____
Bronchitis	☐	☐	_____
Cancer	☐	☐	_____
Cataracts	☐	☐	_____
Chest Pain	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Gall Bladder	☐	☐	_____
Heart Attack	☐	☐	_____
Hepatitis	☐	☐	_____
Hernia	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney/Bladder	☐	☐	_____
Blood Disorders	☐	☐	_____
Liver Disease	☐	☐	_____
Pneumonia	☐	☐	_____
Prostate Problems	☐	☐	_____
Seizures	☐	☐	_____
Stroke	☐	☐	_____
Swelling	☐	☐	_____
Ulcers	☐	☐	_____

Females: When was your last PAP Smear? _____ Mammogram? _____

Males over 40: When was your last prostate exam? _

Date of last immunizations: Tetanus_____ Flu_____ Pneumonia _____

Medical History

Patient Name: _____

Doctors who are currently treating you or have treated you within the last three years

Treatment Started	Treatment Stopped	Doctor's Name	Specialty / Reason you see this Doctor / Comments	Phone Number

Major Surgeries / Injuries / Procedures

Date	Surgery / Injury / Procedure	Complications / Comments

Family History
Have any family members had any history of the following?

	Yes	No	If yes, please elaborate
High blood pressure	☐	☐	_____
Cancer	☐	☐	_____
Heart Attack	☐	☐	_____
Diabetes	☐	☐	_____
Stroke	☐	☐	_____
Psychiatric	☐	☐	_____
Other	☐	☐	_____

Social Information

	Yes	No	If yes, please elaborate
Do you smoke?	☐	☐	_____
Do you drink?	☐	☐	_____
Do you use drugs?	☐	☐	_____

LifestyleQuestions

Energy Metabolism

How would you rate your energy and vitality level? _____
Are you a morning person? (Do you wake up ready to go in the morning?) _____
Do you drink coffee in the morning, if so how many cups? _____
At time during the day do you feel your day is over (energy wise)? _____
Do you enjoy an alcoholic beverage after work? _____
Are you slow in the morning? _____
Do you have a hard time shutting off the day? _____

Nutrition

How many meals do you have during a typical day? _____ How many snacks do you have during a typical day? _____
Do you feel you eat healthy most of the time? _____
Describe your typical breakfast _____ How often do you eat vegetables? _____ How often do you eat bread and pasta? _____ How often do you drink milk and eat cheese including cottage cheese? _____
Do you crave carbohydrates in the evening? _____
Do you crave carbohydrates all day long? _____
Do you frequently suffer from constipation? _____
Do you frequently suffer from diarrhea? _____
Do you suffer from alternating constipation and diarrhea? _____

Stress

Do you feel stress is a big part of your life? _____
Do you find yourself trying to avoid stress? _____ Have you dealt with very stressful situations early in your life? _____ Have you dealt with very stressful situations lately or in the last few years? _____
Do you suffer from panic attacks? _____
(If I knew what a panic attack was I might say yes to the previous question. A panic attack is experiencing a rapid or pounding heartbeat associated with feelings of anxiety and occasionally accompanied by shortness of breath.)

Exercise

In the past year, how often have you been engaged in physical activity?

- ☐ Regularly (3-4 times per week).
- ☐ Occasionally (1-2 times per week).
- ☐ Sporadically (several times per month).
- ☐ None.

What are your personal barriers or challenges with exercising? _____
How much time are you willing to seriously commit to an exercise program?
_____ minutes per day, _____ days per week
By how much would you like to change (gain or loose) from your current weight? _____
Have you ever had rheumatic fever? _____
Have you ever taken nitroglycerine or any other medication for chest pain? _____
Please summarize exercise and/or sports history in your life. _____

Libido

Rate your libido (sex drive) from 0 to 10 (with 10 being the highest) _____
My sex drive was highest when I was_____years old.
Do you never initiate sex but after some coaxing by your partner then become interested? _____

Women Only

My last period was (date):_____Have you
been suffering from hot flashes? _____
Have you been suffering from night sweats? _____
Have you been suffering from mood swings? _____
I'm getting a little irritated at answering all these questions about my personal life. _____
Have you had trouble keeping your weight under control?_____Have
your breasts gotten smaller? _____
Have your breasts gotten larger over time? _____
Do your breasts swell and become tender with coming periods? _____
Is intercourse painful? _____
Do you believe it is mainly due to vaginal dryness? _____

Medication List

Patient Name: _____

Prescription Medications

Date Started	Date Stopped	Drug Name	Dosage (#	Frequency/Directions (how often)	Prescribing Dr.

Vitamins, Supplements, and OTC

Date Started	Date Stopped	Drug Name	Dosage (#	Frequency/Directions (how often)	Prescribing Dr.

Updated:									

Authorizations, Consents, and Agreements

Initials

_____ **New Patients:** We look forward to meeting with you for your first Initial Consultation. This consult schedules for 45-60 minutes, therefore we ask for credit card information to hold your appointment. If you are unable to make your scheduled appointment please provide 48 hours' notice, otherwise you will be charged half of the initial consultation fee.

Financial Agreement: I hereby guarantee payment for services rendered at Sebring Clinic. I understand that the patient and other responsible parties will be held responsible for court costs, legal fees, or agency fees which may be incurred in the collection of the account.

_____ **No Show/Late Cancellation Appointments**: We have set times for you in our schedule and possibly turned away other patients needing to be seen, so we ask for at least a 48 hour notice for appointment cancellation. If you do not show up for an appointment without proper notice 3 or more times you may be discharged from the practice. **There is a $75.00 fee for no show/late cancellations.**.

_____ **Arriving Early or Late:** Dr. Sebring sees patients according to the appointment schedule. If you arrive early please expect to wait behind those patients whose scheduled times are before yours and may arrive after you, but on time for their appointment. If you arrive more than 30 minutes late for your appointment, you will be asked to reschedule.

_____ **Confirmations:** As a courtesy we usually call the day before your appointment to confirm. However, there are times when staffing is low, we are too busy to call, or are otherwise unable to contact you to confirm your appointment. We provide cards as an appointment reminder.

_____ **Answering Service:** Our office hours are 8:00 to 12:00 and 1:30 to 5:00 Monday through Thursday and 8:00 to 12:00 on Friday. We do have an answering service that is available after hours for emergency calls only. **Please do not call the answering service for refills, lab or x-ray results, or to schedule or cancel an appointment**. We ask that you call for the above requests during office hours.

_____ **Telephone Calls:** Please do not expect phone calls to be lengthy when talking with the Doctor or staff. Lengthy conversations should be reserved for your next office visit or scheduled phone consultation.

_____ **I have read the Notice of Privacy Practices (HIPAA)**, which explains how my medical information will be used and disclosed. I have received a copy of this document.

_____ **Release of Medical Information:** In addition to medical information disclosures permitted per our Notice of Privacy Practices, I hereby authorize Sebring Clinic to release medical information via: phone, fax, and email (cross out any you do not authorize) to:

_____

Name of Person(s) you authorize us to release your Medical Information to

Alternative and Anti-Aging Medicine

We at the Sebring Clinic work hard to provide our patients with the finest care available. This means we must step out of the confines of traditional allopathic medicine and incorporate knowledge from discipline such as nutritional, natural and herbal medicine. Given the responsibility of the State Board of Medical Examiners and that most of the Board members are practicing physicians that are aware they cannot be experts in all aspects of healthcare and know all the possible safe and effective treatments for all health problems, the Board requires those physicians who offer care to a patient that the majority of physicians do not offer to get a signed acceptance by the patient before offering such treatment options.

☐ I wish to be offered and informed by Dr. Lane Sebring of the treatment methods he believes are best suited to me and my health needs even if they are not practiced by most physicians.

☐ I do not wish to be offered any treatment methods that most other physicians do not offer.

I have read the authorizations, consents, agreements, office policies, and Notice of Privacy Practices, and I fully understand and accept all terms as described. I have received a copy of these documents for my records.

_____ _____/_____/_____

Patient signature (or Representative) Date

_____ _____

Name of Patient (Print) Name of Representative and Description of Authority

Authorizations, Consents, and Agreements

Initials

_____**Consent to Treatment:** As a patient at Sebring Clinic I consent to care and treatment only after the recommended Treatment is explained to me. I understand that while a patient at Sebring Clinic I am under the care of Dr. Sebring.

_____**Prescriptions:** To refill a prescription always contact your pharmacy when you have about a week of medication remaining. Please do not wait until the last minute. If authorization is required the pharmacy will contact us and we will usually reply within 72 hours.

_____**Consent and Credit Card Information for New Patient Appointments:** I hereby authorize Sebring Clinic to charge my credit card in the event that do not give sufficient notice in cancelling my new patient appointment.

_____ ____/_____/_____

Patient Signature (or Representative) Date

_____ _____

Name of Patient Name of Representative and Description of Authority

Sebring Clinic Notice of Privacy Practices (HIPAA)

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.

Sebring Clinic uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact Sebring Clinic.

A. Treatment, Payment, Health Care Operations

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will share some or all of your medical information with that physician to facilitate the delivery of care.

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide you. Fore example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support Sebring Clinic and ensure that quality care is delivered. For example, we may engage the services of a professional to aid in compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and deaths), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court or the administrative decision-maker or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstance provided: the information is released pursuant to legal process, such as a warrant or subpoena; the information pertains to a victim of crime and you are incapacitated; the information pertains to a person who has died under circumstances that may be related to criminal conduct; the information is about a victim of crime and we are unable to obtain the person's agreement; the information is released because of a crime that has occurred on these premises; or the information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lesson an imminent threat to the health or safety of a person.

We may disclose your medical information as required by workers' compensation law.

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by authorized military or other command officers if you are in the military or other government security agency.

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. You also may request that

we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: the information to be restricted, what kind of restriction you are requesting, and to whom the limits apply. Send the request to the address and person listed at the end of this document.

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: the information is psychotherapy notes, the information reveals the identity of a person who provided information under a promise of confidentiality, the information is subject to the Clinical Laboratory Improvements Amendments of 1988, or the information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decisions on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable fee. **Currently, this fee is $25 for up to 50 pages and $50 for 51 pages or more, but is subject to change without notice.**

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: the information wasn't created by this practice or the physicians in this practice, the information is not part of the designated record set, the information is not available for inspection because of an appropriate denial, or the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed at the end of this document. Your first accounting of disclosures within a twelve month period will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. **Currently this charge is $25, but is subject to change without notice.**

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by telephone, mail, and/or email to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed at the end of this document. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:
Sebring Clinic
16811 Ranch Road 12
Wimberley TX 78676
Phone: 512-847-5618
Fax: 512-847-8746

This notice is effective January 1, 2015.