Lisa Mainier, D.O. of Salus Integrative Medicine, PC

2545 West 26th St., Erie, PA 16506

(P) 814-923-4025 and **(P) 724-740-4572**

(F) 814-746-4684

drlisamainier.com

Adult Health History

Name:	
Date of Birth:	**Age:**
Preferred Phone:	
Today's Date:	

Please answer the following questions as candidly and completely as possible. This will facilitate an open discussion of your wellness goals at your approaching appointment.

List two (present) concerns that you wish to address at your appointment:
1.
2.

Problem #1

Symptoms:				
Prior Treatments:				
Results of Treatments (circle):	Excellent	Good	Fair	Poor
What makes it better?				
What makes it worse?				

Problem #2

Symptoms:				
Prior Treatments:				
Results of Treatments (circle):	Excellent	Good	Fair	Poor
What makes it better?				
What makes it worse?				

What was the trigger for your health change?

Prescribed Medications (Please check medication bottles for correct name and dose of medication).

Name of Drug and dose	Times taken Each day	Diagnosis (reason for taking)	When did you start taking this drug?	Are you still taking this medication?

Over the Counter (OTC) Medications

Name of Drug and dose	Times taken Each day	Diagnosis (reason for taking)	When did you start taking this drug?	Are you still taking this medication?

Supplements/Vitamins/Herbs

Name of Drug and dose Include Brand	Times taken Each day	Diagnosis (reason for taking)	When did you start taking this drug?	Are you still taking this medication?

Please list all allergies and reactions to medications:

Drug/Medication/Supplement:	Reaction (in detail)

Please list all allergies and reactions to substances/foods etc.:

Substance, food, etc.:	Reaction (in detail)

Vaccines

Are you up to date on all vaccines?	YES NO
Do you get a yearly flu vaccine?	YES NO
Would you like to be tested for hepatitis C?	YES NO
Were you breastfed?	YES NO Not sure
Were you born vaginal delivery?	YES NO Not sure

Injuries:

Please list any injuries, treatments and outcomes.

Injury:	Date:	Treatment	Treating Physician	Past	On-going

Check Box If you have:	**Medical History** Please check/circle all that apply:
	Metabolic Syndrome or Pre-Diabetes
	Type 2 Diabetes Mellitus
	Type 1 Diabetes Mellitus
	Hypothyroidism (low thyroid)
	Hyperthyroidism (over-active thyroid
	Polycystic Ovarian Syndrome (PCOS)
	Infertility
	Weight issues (gain)
	Eating disorders (bulimia/anorexia)
	Eating disorder ________________________
	Endocrine disorder ____________________
	Heart attack
	Heart disease (angina, CVD)
	Peripheral Vascular disease
	Abnormal heart rhythm
	Hypertension (high blood pressure)
	Stroke or TIA (mini stroke)
	Elevated cholesterol
	Mitral valve prolapse/valve issues
	Varicose veins/phlebitis
	Cancer: (type)
	GERD (esophageal reflux)
	Irritable bowel syndrome (IBS)
	Inflammatory bowel disease (IBD) Crohn's or Ulcerative Colitis
	Celiac disease
	Other GI condition
	Osteoarthritis
	Rheumatoid arthritis
	Fibromyalgia
	Chronic pain
	Other musculoskeletal condition (please describe)
	Gout
	Kidney stones
	Interstitial cystitis
	Frequent bladder/kidney infections
	Frequent yeast infections

	Erectile dysfunction/sexual dysfunction (describe)
	Chronic Fatigue syndrome
	Autoimmune disease (diagnosis)
	Lupus/SLE
	Multiple Sclerosis
	Immune deficiency
	Herpes-Genital
	Communicable disease (HIV, Hepatitis etc.)
	Food allergies
	Environmental allergies
	Multiple chemical sensitivities
	Other allergies:
	Chronic sinusitis (frequent sinus infections)
	Asthma
	Bronchitis
	Emphysema (COPD)
	Pneumonia
	Sleep Apnea (Use of CPAP or BiPAP?)
	Eczema
	Psoriasis
	Acne
	Skin cancer (diagnosis)
	Urticaria (hives)
	Other skin condition
	Blood clots
	Bleeding disorder (diagnosis)
	Depression
	Anxiety
	Bipolar disorder
	Schizophrenia
	Headaches
	Migraines
	ADD/ADHD
	Autism
	Memory problems
	Mild cognitive impairment (diagnosis)

	Parkinson's disease (or tremor disorder)
	Head injury/post-concussion syndrome
	Loss of libido/sex drive (men/women)
	Fibrocystic breast (women)
	Uterine fibroids (women)
	Endometriosis (women)
	Osteoporosis
	Other:

Women's Medical History: Please indicate (circle or check) below:

Are you or do you think you may be pregnant? YES NO	**Do you use birth control? YES NO Type: ___________________________**
Age of Menarche (first period) __________ Age at Menopause ____________	Number of pregnancies _________ Number live births ____________
Number of Miscarriages/abortion: _________	Regular Menses? YES NO
Days of bleeding ________ Days between periods ________	Check symptoms that you may have during or before your period:
Check symptoms that you may have if you are menopausal: ○ Hot flashes ○ Mood swings ○ Concentration or memory issues ○ Vaginal dryness ○ Painful intercourse ○ Incontinence	○ Cramping ○ Blood clots ○ Breast tenderness ○ PMS ○ Bloating ○ Nausea ○ Diarrhea/constipation ○ Heavy flow
Indicate Last Menstrual Period:	
Do you use hormone therapy? YES NO	How long?
Last Mammogram (date):	Normal? Yes No Breast biopsy?
Last PAP (date):	Normal pap Abnormal pap
Obstetrical complications: YES NO	
Check if you have ever had complications during pregnancy/childbirth:	○ C-section ○ Large baby (over 8lbs) ○ Gestational Diabetes ○ Miscarriage ○ Post-partum depression

Surgical History:

Please indicate whether you have ever had a medical problem and/or surgery/procedure related to each of the following by checking the appropriate boxes. If you have had a medical condition, please note diagnosis, type of surgery, and year of surgery/procedure and complications, if any.

Condition	**Check If "yes"**	**Year**	**Describe surgery procedure/treatment**	**Complications/ Comments**
Eyes Cataract/Lens?				
Ear, nose, sinus Tonsils				
Thyroid (cancer, condition, surgery, biopsy, etc.)				
Heart valves/ablation				
Heart attack, stent, clip				
Arteries (aorta, head, neck, Limbs, bypass etc.)				
Veins, blood clots, varicosities (DVT/PE)				
Lung				
Appendix, esophagus, stomach.				
Intestine (large/small), anus				
Liver/gallbladder				
Hernia				
Kidney/bladder				
Bones, joints, muscles				
Back, spine				
Brain				
Skin				
Breast				
Female: uterus, tubes, ovary, cervix				
Male: prostate, penis, testes				
Other surg/procedure/treatment				

Medical History:

Please list any other medical illness or conditions, including the year of onset, hospitalizations, treatments and other details.

Diagnosis or Condition	Year of Onset	Details of Diagnosis (treatments, physician, hospitalizations etc.)

Dental History:

Please list dental conditions and treatments:

Diagnosis/Condition	Treatment	Ongoing/ Past

Social History:

Answer/Circle

Have you ever used tobacco in any form? Yes No
If yes, what type of tobacco product:
Do you vape? Yes No Type:
Illegal drugs? Yes No Marijuana use? Yes No
When was the last use of any tobacco product?
If you drink alcohol: glasses day/week type of alcohol:
Do you feel you should cut down on alcohol or tobacco? Yes No
What is your occupation? _______________ years
Previous occupation? _______________ years
Education: Highest level achieved:
Marital status: single married divorced separated live-in
How many years in your relationship? ______________ years.
Do you feel safe in your relationship? Yes No
Are you sexually active? Yes No Homosexual? Yes No
Are you experiencing problems with sexual functioning? Yes No
Please explain:

Family History: Please answer to the best of your ability:

Please check family members with all medical conditions listed.	Mother	Father	Mat GM	Mat GF	Pat GM	Pat GF	Sibling	Sibling	Sibling	Sibling	Child	Child	Other:	Other:	Other:
Birth year															
Age at death:															
Alcohol abuse															
Anemia															
Asthma, Atopy or chronic allergies.															
Bleeding disorder															
Blood clots (DVT or PE)															
Cancer*															
Chemical or drug dependency															
Cardiac Disease: cardiovascular, heart attack, congestive heart failure, peripheral vascular disease, valves etc.*															
Diabetes															
Epilepsy/seizures															
Gallbladder															
Glaucoma															
Gastro-intestinal issues*															
Hepatitis/jaundice/liver disease															
High blood pressure (hypertension)															
Immune disorder*															
Kidney disease/failure															
Lung issues (COPD, emphysema) *															
Lupus (SLE)															
Migraines (headaches)															
Osteoarthritis															
Psychiatric disorder															
Rheumatoid arthritis															
Stroke (or mini stroke)															
Thyroid disease															
Other (list):															
Other (list):															
***List:**															
***List:**															

Activity and Nutrition: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

What is your water source?	Well Public bottled filtered
Caffeine Intake: How many cups of coffee/soda/caffeine/chocolate	______________ per day __________days per week
What type of artificial sweetener?	Aspartame Splenda Equal Stevia Truvia NutraSweet Other ___________
What type of sugar?	Table sugar Coconut sugar Agave honey Raw honey other _____________
Soda/juice/iced tea/sweetened drinks? YES NO	List: How many ounces _____________per day.
Deep Fried foods? YES NO	How often? ________/day ________/week
Red Meat? YES NO	Grass Fed? YES NO How often? ________/day _______ /week
Vegetables daily? YES NO	How many servings? ________/day______/week
Fruit daily? YES NO	How many servings? _______/day ______/week
What percent of your produce is organic?	______________% Do you wash your produce? YES NO
Do you eat fish? YES NO	How often? __________/week
Types of fish (please list):	Wild caught? YES NO
Sweets? YES NO	How often? ________/day _________week
Bread/pasta/white potatoes/rice? YES NO	How often? ________/day _________week
Do you eat processed/frozen/pre-packaged foods?	How often? _________/day _________/week Please list examples:
How often do you eat out?	_________________days per week.
Describe a typical diet in a day:	Breakfast:
Lunch:	Dinner:
Snacks:	Beverages/other:
Are you responsible for shopping/cooking?	YES NO
What are your diet/nutritional goals?	List:

Exercise History: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

Do you exercise daily? YES NO	How often? ________________days/week
Would you like to start an exercise program?	YES NO
Have you had cardiac testing in the past?	YES NO
Please list testing and results:	Type of test: Results:
Do you feel physically fit? YES NO	Explain:

Environmental History: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

List brands/types of Cleaning products in your home:	Cleaning products:
List brands/types of Cosmetics used:	
List brands/types of Personal products used:	
Do you have any knowledge of chemical/toxic exposures? YES NO	Please list:

Spiritual History: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

List sources of JOY in your life:
What are some DISAPPOINTMENTS in your life?
What are some of your greatest CHALLENGES in your life?
What are your spiritual beliefs and/or religious affiliation:
What are your health and wellness concerns?
What are your health and wellness goals?

Most importantly, who referred you to this practice?

Name:	Phone:
Address:	
May I communicate a "Thank you" to this person?**	YES NO

**Client medical information is NEVER shared with referral source unless he/she is your treating physician.

Review of Symptoms
Circle symptoms. Feel free to add a brief comment .
Weight gain/loss (circle)
Fever/chills/sweats
Night sweats
Appetite increase/decrease
Fatigue
Generalized weakness
Generalized pain/ache/discomfort/spasm
Head/Eyes/Ears/Throat
Head injury (anytime in life) Date: ______________________
Headache or Migraine (circle)
Hearing changes. Describe:
Ear pain/discharge/bleeding/trauma (circle) Date: ____________________
Ringing in ears. Date started: _______________________
Vision or eye changes/trauma/conditions/blindness/dryness/redness. Please describe:
Nasal/sinus congestion/pain/frequent infections
Nose bleeds
Gum bleeding/disease/dry mouth
Sore throat (frequent)
Difficulty swallowing
Chronic hoarseness
non-healing mouth sores
cold sores
thrush
nasal polyps
hearing aid
grinding teeth
Neck
pain/stiffness/reduced movement/swollen glands (circle)
Respiratory
Asthma/COPD/emphysema/chronic bronchitis (circle)
Cough/wheezing/phlegm/sputum/blood
Frequent pneumonia
Cardiovascular (Heart and blood vessels)
Chest pain/tightness/discomfort/palpitations (circle)
Difficulty breathing while laying flat. How many pillows at night? ________________
Sleep with fan on or window open
Leg swelling/varicose veins/phlebitis/cramping/calf pain (circle and/or describe)

Irregular heartbeat
Peripheral vascular disease
Blood clots/DVT/PE Date:____________ Treatment:__________________
Are you on blood thinners? Name of blood thinner: __________________________
Anemia. Type: ______________________________________
Easy bleeding/bruising
Gastrointestinal (Digestive Tract)
Difficulty swallowing
Easily full
Abdominal pain after meals
Irritable bowel with constipation/diarrhea (Circle)
frequent constipation/diarrhea (Circle)
Blood in stool: dark tarry/bright red/brown or black blood (Circle)
Rectal pain/bleeding/hemorrhoids/fistula (Circle)
Stomach ulcer/bleed (Circle)
Yellow eyes/skin
Liver/Gallbladder problems
Neurologic (Nervous system)
Dizziness/fainting/seizures/brain injury/stroke/LOC (Circle all that apply)
Limb weakness/tremor/numbness/tingling (Circle all that apply)
Paralysis. Describe: _______________________________________
Facial droop/numbness/pain/weakness
Endocrine (Hormone)
Excessive thirst/hunger (Circle)
Heat/cold intolerance (Circle)
Urinary
Urination that is frequent/urgent/painful/burning/blood/pressure/fullness (Circle)
Incontinence. Describe: __________________________________
Nocturia. How many times each night: ____________________
Incomplete bladder empty or weak stream (Circle)
Frequent urinary tract infections.
Psych/Mental
Grief/depression/apathy/irritable/restless/sad/quick temper (Circle all that apply)
Difficulty concentrating/poor memory/frequent forgetfulness/foggy brain
Social Phobia/Poor relationships Thoughts of Suicide?
Stress/nervousness/anxiety/panic attacks/post-traumatic (Circle all that apply)
Sleep
Difficulty falling/staying asleep (Circle)
Snoring/restless legs/nightmares Sleep apnea/Use CPAP or BiPAP

Notice

Please note that communication via email, over the Internet, is never entirely secure. While improbable, it is still possible that information you include in an email could be intercepted and read by other parties besides the person for whom it is intended.
Please mail or fax completed documents to the following address at least one week prior to your meeting:

Lisa Mainier, D.O.
Salus Integrative Medicine, PC
2545 West 26th St., Erie, PA 16506
(Pittsburgh Clients: Please use FAX)
(P) 814-923-4025 – Erie, PA
(P) 724-740-4572 – Pittsburgh, PA
(F) 814-746-4684

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Client Demographics

Name:
Mailing Address:
Cell Phone:
Home Phone:
Email Address:
Age: DOB:
(circle) Gender: M F
Appointments, reminders and some confidential messages may be left on my (circle ALL that apply) Voicemail Text Email
Emergency Contact Name and relationship to client:
Client Signature/date:

Employer

Employer:

PCP/Pharmacy

PCP Name:	PCP Phone:
PCP Address:	
Pharmacy Name and Address:	
Pharmacy Phone:	Pharmacy Fax:

Other Treating Physician/Services

Physician Name:	
Address:	
Phone:	Fax:
Diagnosis:	
Treatment:	

Permissions

May your PCP call me so that I may discuss lab findings and other pertinent information, if needed? Y N
Please initial and date: Date:

Acknowledgement of Receipt of Privacy Notice

Client Name (printed)
I acknowledge that I have received a copy of the office's "Notice of Privacy Practices", read and understood them: Client (or client's Legally Authorized Person) Signature: Date:
Printed Name of Client's Legally Authorized Person:
Relationship to Client:

Providing Information

Salus Integrative Medicine, PC will not give anyone information about your healthcare without your permission. There are some circumstances where you may desire assistance in receiving healthcare information such as providing copies of records, labs, prescriptions to family members (i.e. spouse) or confirming appointments. Below, please list name and relationship to those who you choose to have permission to receive information regarding your health:

Please print legibly and state relationship to you:
Name: Relationship:
Client (or client's Legally Authorized Person) signature:
Printed name of Legally Authorized Person:
Relationship to Client: Date:

Communication Policies

Please read and initial the policies listed below:

- ___ Dr. Mainier and client does not use email for direct communication regarding sensitive healthcare information.
- ___ Clients should call 814-923-4025 to discuss healthcare issues
- ___ I agree to receive email notices of workshops or events or simple communication regarding articles of interest and other general information from Salus Integrative Medicine, PC

OR

- ___ I wish NOT to receive emails from Salus Integrative Medicine, PC regarding workshops and events or even articles of interest.

AGREEMENTS, AUTHORIZATIONS,
ACKNOWLEDGEMENTS, NOTICE AND CONSENT

Please Initial each statement where indicated:

1. I, _________________________________, authorize Dr. Lisa Mainier*, licensed medical physician in the state of Pennsylvania, to provide medical and health care treatment for myself, or my minor child (____). I understand that I am seeking medical advice from Lisa Mainier, D.O., medical physician, for consultation purposes only. Her practice focuses on overall wellness, nutrition, and lifestyle modifications that may include functional, holistic, complementary and integrative approaches.
2. ________ I understand that Dr. Mainier is NOT my primary care physician (PCP) and is not responsible for the diagnosis and treatment of any particular disorder, but instead is offering medical guidance for my medical condition(s) and overall health, regarding nutrition, wellness and soundness of mind and body. I understand that I must maintain a PCP to continue with all available conventional measures to attend to any medical condition for which I require continued monitored medical care. I will update Dr. Mainier regarding the identity of my referring physicians or PCP using the attached PCP and Specialist Information Form. If desired, I will complete the attached Authorization Form to authorize my referring health care provider or PCP to release my medical records to Dr. Mainier at Salus Integrative Medicine, PC.
3. _________I understand that although Dr. Mainier is trained in traditional medicine practices and is Board Certified in both Family Medicine and Integrative Medicine, her services and recommendations are based on non-traditional, or non-conventional services, often referred to as complementary, alternative, holistic or integrative medicine. This approach to healing and health may entail the use of other services that may not be offered or recognized by those physicians in the medical community who practice solely, traditional medicine. Many of these services may include, but are not limited to, nutrition, health counseling, herbal consultation, and mind-body approaches, that may not be recognized as customary medical practices. Many of these approaches have been practiced for many years, but may be considered investigational, experimental and may not be approved by the Food and Drug Administration and other regulatory agencies.
4. _______I understand that herbs, botanical products and supplements are available over the counter and are generally considered safe, based on their long history of use by many cultures, but many have not been tested using conventional study designs. Although rare, any product can be detrimental, particularly if I am allergic to them, and this could lead to serious consequences. Interactions, both commonly known and some unknown, between conventional drugs, other herbs or supplements, and some medical conditions, exist. This could result in reduced or increased effects of other medications or other negative effects. It is therefore vital, that I reveal all medications, herbs and supplements that I am taking and inform all of my treating physicians, including Dr. Mainier of all of my medical conditions and treatments.
5. __________Dr. Mainier will use mind–body approaches such as meditation, guided imagery, breathing techniques, biofeedback and the like, to facilitate my ability to achieve wellness, handle stress, gain a positive perspective, and perform successfully in maintaining a healthy lifestyle. I understand that this approach is effective in reversing

the influence of stress on healthful living because we now understand that stress impacts many medical conditions.

6. ________ I understand that should I have an adverse reaction, and if it is serious, I will seek emergency care immediately. I understand that Dr. Mainier does not treat urgent or emergent conditions and that I should seek help at a qualified medical facility or my own doctor. I will also report to her, any and all unfavorable reactions that occur. I understand that Dr. Mainier is completely office-based and she does not admit to a hospital, is not affiliated with any hospital or insurance company, and she does not provide emergency, on-call services.
7. _________I understand that the services provided by Dr. Mainier, may be considered non-conventional and therefore, may not be reimbursed by my health insurance. Many insurance companies will not pay for physician consultations regarding wellness, herbal medicine, nutritional counseling, or other alternative services. Laboratory testing that pertain to wellness and insurance companies do usually not cover nutrition, including test kits sent to special laboratories. *Payment is due at time of service.* On the occasion that I have an outstanding balance owed Dr. Mainier, I agree to pay for all costs and expenses, including, but not limited to, court costs, attorney fees, and interest, if it is necessary to secure such payment.
8. __________I also understand that Dr. Mainier does not participate in any insurance plans, including Medicare, her services may NOT be billed to OR submitted for reimbursement by Medicare, and that I am responsible for payment, prior to each service. I am also responsible for all charges for treatment, including procedures and laboratory tests, even if my insurance company determines that her services are (i) not covered, (ii) excluded, (iii) unreasonable, or (iv) not medically necessary. I may request a super bill from Dr. Mainier, outlining the cost and nature of services. Regardless of whether the services are covered under my insurance, it is my responsibility, NOT Dr. Mainier's or her office staff, to submit any and all claims to my insurer.
9. _________ I understand that it is my responsibility to understand and refer to my plan benefits for appropriate information regarding reimbursement. Dr. Mainier may respond to insurance requests for information but is not obligated to take action on my behalf, against my health insurance company for collecting or negotiating my claim. I understand Dr. Mainier may charge a fee for responding to requests for claim information. By way of this Agreement, I also authorize release of information to any payer of my care, including my insurance company or managed care program, upon their specific request.
10. __________ I understand there is a cancellation fee of $25 for missed appointments that are not cancelled more than 24 hours in advance. *This fee must be paid prior to next appointment.* I also agree that multiple cancellations and schedule changes (greater than 3 in a one-year time frame) may incur a fee of $25 regardless of membership status.
11. _________ I understand that there is no guarantee of results or outcomes of any diagnosis or treatments rendered by Dr. Mainier, as the practice of medicine is not an exact science. I agree that I will take responsibility for my health and well-being by following my personal treatment plan suggested by Dr. Mainier. I will also discuss the advice and ideas of Dr. Mainier during my sessions. Her treatment plans are meant to further my own health, and not for the purpose of treatment or anything else. I may not benefit from the treatment plan designed for me, especially if I do not follow the

recommendations. I do not hold Dr. Mainier responsible for less than satisfactory results.

12. _________ I understand that electronic medical records, secure video messaging and other forms of electronic information use, storage and communication will be utilized during my care. Although these electronic services are strongly protected and HIPAA compliant, I realize that no matter how well the information is protected, there is always a chance of corruption, although highly unlikely. With that understanding, I give permission for the use of such electronic services.
13. _________ I have read and understand the nature of the services provided by Dr. Mainier. It is my prerogative to revoke, in writing, at any time the authorizations contained in this document. Such revocation, does not affect my financial responsibility to pay for services already provided to me by Dr. Mainier and her staff. I also declare that I am here to receive health care only, and for no other reason.

*"Dr Lisa Mainier" refers to :Dr. Lisa Mainier ***of Salus Integrative Medicine, PC***

Receipt of Notice of Privacy Practices

Acknowledgement of Receipt of Salus Integrative Medicine HIPAA Privacy Notice and Consent to Medical Clinic Privacy Practices

This Notice of Privacy Practice (Notice) provides information about how we may use and disclose health information about you and how you can access this information. You have the right to review our Notice before signing this consent.

The terms of our notice may change. If we change our Notice, you may obtain a revised copy from us. If you have any questions concerning the Notice, please submit your questions in writing to Dr. Lisa Mainier at the above address.

By signing this form, you acknowledge that you have received, read, understand and consent to the terms of our use and disclosure of health information about you as set forth in the Notice. If consent is not earlier revoked, it shall, without revocation, terminate 180 days after your care is completed and you are discharged from care.

I acknowledge receipt of a copy of the Salus Integrative Medicine's HIPAA notice of Privacy Practices. I further acknowledge that I have read or have had read to me in a language that I understand, the notice, understand its terms and consent to the terms set forth therein.

Client (or client's Legally Authorized Person) signature:	
Printed name of Legally Authorized Person: **Relationship:**	 **Date:**

In-Office Supplement Explanation and Agreement

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, individualized recommendations regarding use of these substances, is provided based on medical evaluation and subsequent counseling. The goal is to upgrade the quality of foods in a client's diet and to supply nutrition that supports the physiologic and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

You are under no obligation to purchase nutritional supplements at Salus Integrative Medicine, PC

As a service to you, nutritional supplements are available in office. These products are purchased only from manufacturers who have gained the confidence through considerable research and experience. Quality is determined by considering the: (1) quality of science behind the product; (2) quality of the ingredients themselves; (3) quality of the manufacturing process; and (4) synergism among product components. The brands of supplements that are carried by Salus Integrative Medicine, PC, are those that meet high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason these products are available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have any other questions, thoughts or concerns, please feel free to discuss them further with Dr. Mainier.

Client (or client's Legally Authorized Person) signature:	
Printed name of Legally Authorized Person:	
Relationship to Client:	**Date:**

Authorizations, Agreements, Consents

By signing below, I admit to receiving, reading, understanding all agreements, authorizations and consents. In addition, I have asked all questions regarding these items and have received explanations in simple, easy to understand language. (see AGREEMENTS, AUTHORIZATIONS, ACKNOWLEDGEMENTS, NOTICE AND CONSENT)

Client (or client's Legally Authorized Person) signature:	
Printed name of Legally Authorized Person: Relationship:	 Date:

Lisa Mainier, D.O.

Salus Integrative Medicine, PC

2820 West 23rd St., Erie, PA 16506

(P) 814-923-4025

www.drlisamainier.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government

requests.
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Complete the following form if you have Medicare:

Lisa Mainier, D.O.
Salus Integrative Medicine, PC
2545 West 26th St., Erie, PA 16506 and Pittsburgh, PA
(P) 814-923-4025 * (P) 724-740-4572

This agreement is between Lisa A. Mainier, D.O., whose principal place of business is 2545 West 26th St. Erie, PA 16506, and

Beneficiary: ________________________________
Who resides at: ________________________________
____
Medicare ID #: ________________________________

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Dr. Lisa Mainier has informed Beneficiary or his/her legal representative that she has opted out of the Medicare program effective on July 1, 2016 for a period of at least two years. Dr. Mainier is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 of the Social Security Act.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

Please Initial:
_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare.

_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by *other* physicians or practitioners who have not opted out.

_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Client (or client's Legally Authorized Person) signature:
Printed name of Legally Authorized Person:
Relationship to Client: **Date:**
Dr. Lisa Mainier (physician):
Initial when you have received a copy of this agreement:

Green highlighted areas to be signed in office.

Lisa Mainier, D.O.
Salus Integrative Medicine, PC
2545 West 26th St., Erie, PA 16506 and Pittsburgh Office.
(P) 814-923-4025 – Erie, PA
(P) 724-740-4572 – Pgh., PA

Please be advised that there will be an *enforced* $25 cancellation or re-schedule fee for any, and all appointments that are not cancelled prior to **24 hours-notice** advanced notice. This applies to new clients, members and follow up appointments. Cancellation via phone, please. Please contact me if you have any questions or concerns. I appreciate your assistance regarding this matter. Thank you.
Dr. Lisa Mainier

Client (or client's Legally Authorized Person) signature:
Printed name of Legally Authorized Person:
Relationship to Client: **Date:**

Please sign and return to Dr. Lisa Mainier at your next visit or mail to above address.

Dr. Lisa Mainier
SALUS INTEGRATIVE MEDICINE

SALUS INTEGRATIVE MEDICINE, PC COMMUNICATION POLICY

Fax: 814-746-4684

How I would love to accommodate each client with all my time and energy. All clients are so important and special. Unfortunately, my time is finite and communication for reassurance, new questions, thoughts or encounters must be limited.

While all clients and her/his questions are important, many can be handled in a *scheduled* appointment. As always, any urgent, emergent or serious concern requires a phone call at any and all times. Most clinical thoughts, concerns, questions or clarifications should take place face to face in the office, a scheduled secure video or phone call to better serve your needs and to give you the attention necessary. If you have questions following an appointment, please feel free to email through your ChARM account or call if the question is urgent, otherwise, please book an appointment with Dr. Mainier. No emergent/urgent issues should be emailed but should be phoned.

From this date forward, the following phone/email policies will be implemented:

- Phone and Email communication *between visits* will be limited to 4.
- Emails should take place through your ChARM account to allow for secure communication.
- Emails via drmainier@drlisamainier.com will no longer be accepted for clinical questions, thoughts or concerns as this is not completely secure.
- Emails should be limited to straight-forward questions, clarifications or thoughts to be considered at next appointment.
- A $25 fee will be charged for each phone call (excluding emergent/urgent) or email over 4 per time period between appointments.

Any email or phone call that results in new orders (labs, Imaging etc.) change in Care Plan, lab reviews, amended note, other action or requires phone follow up, will incur an "Encounter " charge based on fees outlined below, *regardless* of number of emails/phone calls between visits. These types of "communications" are truly *encounters* and are documented as such.

The following charges will be implemented **beginning June 1, 2018:**

	Yearly Membership*	**6-Month and Non-Membership****
Email/Phone greater than 4 (requiring less than 15 minutes of time) between scheduled appointments. *This is the same fee for cancellations, missed appointments and re-scheduling more than 2 times.*	$25	$25
ANY 15-Minute Phone/Email (regardless of number)	$30	$60
ANY 30-Minute Phone/Email (regardless of number)	$60	$95
ANY 60-Minute Phone/Email (regardless of number)	$125	$190

*Includes only active Single/Couple **Yearly** Memberships.

**6-month, Mini-Memberships and Non-Members

A bill for services will be mailed to you and placed in your ChARM account and will be due as soon as it is posted. No new appointments will be made until payment is made in full.

I sincerely apologize for any inconvenience and I continue to welcome all thoughts, questions and concerns in a manner that respects everyone's time and resources. Be well. Dr. Mainier

Please sign below:

Client (or client's Legally Authorized Person) signature:	
Printed name:	**DATE:**