

New Patient Instructions

Life Extension Center

425 Main Street
Ridgefield, Connecticut 06877

Phone (203) 431-6165
Fax (203) 431-6167

2505 Boulevard of the Generals
Norristown, Philadelphia 19403

Phone (203) 431-6165

Please read, fill out and mail or fax back to us ALL information prior to your appointment. If this is not possible, then you may bring paperwork the day of your appointment.

1. Personal Assessment Questionnaire
2. Patient Introduction Card
3. All pages requiring your signature
4. Recent relevant medical records

Doing so will allow the doctor and staff ample time to review your records and set up your patient chart.

Due to our long waiting list of new and current patients, our office policy requires a non-refundable deposit of \$150.00 upon scheduling your appointment. This deposit will be forfeited unless you cancel your appointment 48 business hours or more before your scheduled appointment. If you keep your appointment as scheduled, your deposit will be credited to the charges for your initial visit.

If you decide to have our office review your medical records to verify candidacy for treatment, please enclose a check for \$450.00 made out to Life Extension Center along with all pertinent medical records. This option is only determined by the New Patient Coordinator and the candidate for treatment or his/her family.

Thank you for taking the time to prepare for your appointment. We look forward to meeting you! If you have any questions, please do not hesitate to call the office. We will be happy to answer any questions you may have for our staff.

Sincerely,

Life Extension Center Office Staff

PATIENT INTRODUCTION CARD

(Please Print)

Date _____

Name _____ Phone _____
(last) (first) (middle)

Address _____ City _____ State _____ Zip _____

Birth date _____ SS No. _____ Male Female No. of children _____

Occupation _____ Married Single Divorced Widowed

Employed by _____ Business phone _____

Address _____ City _____ State _____ Zip _____

Name of spouse (name of parent, if minor) _____

Occupation _____ Birth date _____ SS No. _____

Parent's address _____ City _____ State _____ Zip _____

Person responsible for account Self Spouse Parent Other _____

If other, name _____ Phone _____ SS No. _____

Address _____ City _____ State _____ Zip _____

Referred by _____

Have you had chiropractic care before? Yes No When? _____ Dr.? _____

FEES PAYABLE WHEN SERVICE RECEIVED

ATTENTION PATIENTS AND VISITORS:

Please refrain from wearing perfume or cologne in the office. There are many people (both patients and staff) who are chemically sensitive.

Thank you for your understanding and consideration

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OFFICE POLICIES

APPOINTMENTS AT OUR OFFICE

Due to the nature of our practice, there may be a three week wait for a new patient appointment with Dr. Zabrecky. In our effort to accommodate our patients, a new patient may be given an earlier appointment with our associate, Dr. Marcie Wolinsky. This appointment will allow a new patient to begin initial contact with a health care provider in our office. A history, physical exam, blood testing or other laboratory testing will be taken at this appointment. If records are reviewed in advance by our office, therapy may be initiated during this first appointment based on these medical records (*please see Medical Records*). A new patient is typically given a follow-up appointment with Dr. Zabrecky two to three weeks later to allow for all testing to return for his review (*please see Follow-Up Appointments*). The new patient will be charged accordingly for laboratory testing and supplements upon the completion of this visit.

Please initial _____

FEE STRUCTURE

The standard health evaluation for a new patient with the physician runs anywhere from one hour to an hour and a half. Fees are charged at the rate of \$450.00 per hour. A \$150.00 deposit is required at the time the appointment is scheduled. Cancellations must be made 48 business hours prior to your appointment or your \$150.00 deposit will be forfeited. Any lab tests will be billed in addition to the evaluation. We urge patients to bring any previous testing that they have from other health care providers for the physicians to review. We will not repeat lab work that has already been performed to reduce charges for the patient.

If results of testing or symptomatology warrant, further testing will be recommended. This may consist of food allergy testing, cardiac or diabetic risk factor assessment, specific mineral/toxic metal testing, functional vitamin assays for deficiencies, immune system or endocrine systems evaluations, evaluation for malignant/pre-malignant states or suspected chronic infections. The costs of these tests are an additional charge and the necessity will be discussed in detail if recommended to the patient. *The charges for any specific, non-routine tests are in addition to the initial visit cost.* An average new patient visit with lab tests and/or supplements could range from \$650.00 to \$1,200.00.

Please initial _____

TELEPHONE CONSULTATIONS

Telephone consultations are utilized in place of follow-up office visits or to provide an initial assessment of new patients who live long distances from our office in Connecticut.

If you are a new patient and are planning to schedule a telephone consultation with Dr. Zabrecky or Dr. Wolinsky, the following is required for your appointment:

1. All medical records pertinent to the patient's diagnosis or disorder are required to be sent to our offices via fax or mail. An office staff member will instruct a patient on how to obtain your medical records from your other physicians if you do not have copies on hand.
2. The new patient letter must be read thoroughly, signed and sent or faxed back to our offices with the patient's medical records.
3. Fees for a new patient telephone consultation are billed at the rate of \$450.00 per hour. *A prepayment is required for all new patient Telephone Consultations.* An Easy Pay Consent form is to be filled out, signed and returned to our office with a patient's medical records and signed new patient letter.

When the above items are received from the patient, an office staff member will telephone the prospective patient to schedule the telephone consultation date and time that the physician will call.

After a new patient telephone consultation, a patient will be given recommendations and referrals, or this information will be reviewed during a follow-up appointment. A patient may be requested to make a follow-up appointment to come to the Ridgefield office, see one of our associated physicians or attend a treatment session at another medical facility. These options are discussed with the patient during the initial contact and during the telephone consult. All patients are given specific therapies conjunctive to their specific case and diagnosis. Treatment may not be recommended to start before a follow-up appointment. A patient's credit card is charged *after* the appointment date, *not before*.

Please initial _____

FOLLOW-UP APPOINTMENTS

A report of findings and their significance will be given at a subsequent visit. This second visit will be scheduled for two to three weeks after your initial visit with one of our health care providers. This will allow sufficient time for all laboratory testing to be completed and returned to our office for your follow-up visit. Consultation fees for follow-up appointments and telephone consultations are \$225.00 per hour for Dr. Zabrecky and/or Dr. Wolinsky. If you need to cancel your appointment, we require 24 hours notice or there will be a missed appointment fee charged for your allotted scheduled time. Requests for information from an insurance carrier may require additional work, copying of records, etc. and will be billed at the rate of \$30.00 per hour.

Please initial _____

INSURANCE AND BILLING

Our offices do not accept assignment for insurance. Our offices are not affiliated with HMO or Managed Care Networks. Some insurance companies may reimburse for nutritional support, preventative health care, diagnostic testing and chiropractic services. We recommend you contact Member Services at your insurance company. They will be able to provide you with information regarding your eligibility for services performed at our offices. ***All referrals, pre-certification and out-of-network benefits are the responsibility of the patient and NOT this office. MEDICARE DOES NOT COVER OUR SERVICES. If you are covered by Medicare, you must sign the enclosed form regarding our opting out of Medicare.***

Our office will provide a superbill for your submittal, with all information necessary for insurance reimbursement. This is not a guarantee of coverage. In order to keep our services as affordable as possible, our office is on a fee-for-service basis. Payment is expected at the time of the visit.

Please initial _____

MEDICAL RECORDS

If you have been treated in the past by your Primary Care Physician, or any other health care provider, you may obtain copies of your medical records to bring to your first appointment. This may prove to be cost effective. We will not repeat a laboratory test unnecessarily. This may actually lower the cost of your first appointment.

To obtain medical records from another physician or medical facility, we suggest that you contact your physician's office or hospital where the testing was performed and request your medical records. As general office procedure, most offices request a signed medical release form from the patient to protect your confidential records. In some states, a medical office or hospital may require thirty (30) days notice to release your medical records or require records to be sent directly to the physician at the office address. There may be a charge for this service. You may call your physician's office or make a request in writing (via fax or mail) to forward or fax your records directly to Dr. Zabrecky for more immediate results. It is always best to fax a written request to the medical facility or travel to your physician's office to pick-up copies of your records and sign the release. One of our staff members will assist you in obtaining records for an immediate appointment.

You may decide to copy your records for your own personal file. On your first appointment, our office will be happy to copy records, at no charge, that Dr. Zabrecky will keep on file. Copies of your testing performed in our office are available at no charge to the patient. Additional copies of your testing performed in our office are available for a small fee.

After careful review of your records, Dr. Zabrecky reserves the right not to accept a patient for care if he feels this patient cannot be benefited by treatments. A patient may be referred to our medical staff members or a physician outside of this office.

Most patients are accepted for treatment at our facility. If further treatment or medication is required, a patient may be referred to an outside medical facility that handles such critical care

Our offices do not handle emergency situations. If you have a medical emergency, please report to the nearest emergency room.

Please initial _____

FORMS OF PAYMENT

Our offices are on a fee-for-service basis. Payment is expected in FULL at the time of each visit. As stated earlier in this letter, our office does not accept insurance assignment.

Forms of payment are cash, checks, Visa and Mastercard. An Easy Pay Consent Form is available for download via our web site. It is to be filled out and returned with all other paperwork and medical records for your file. This form will allow our offices to charge telephone consultations, supplement orders and any monthly balances that you may incur at our office.

All medical and financial records are kept completely confidential. If you have any questions concerning our office payment policy, please do not hesitate to speak to a staff member.

Please initial _____

PREPARATION FOR YOUR FIRST VISIT

For your first in-office appointment, please do the following:

1. Please read this information CAREFULLY!
2. Children only - do not wash your hair for 24 hours before your appointment.
3. Fasting is not required for any blood testing you may receive on your first appointment.
4. Mail enclosed paperwork, signed forms, laboratory results and medical records pertinent to your diagnosis or major complaint back to this office prior to your scheduled appointment.
5. You may wish to bring a tape recorder. Some patients find it helpful to replay the information at home.
6. Make sure you or anyone that accompanies you does not wear perfume or cologne.

For your first telephone consultation, please do the following:

1. Please read this information CAREFULLY!
2. Please mail all paperwork, i.e. signed forms, laboratory results and medical records pertinent to your diagnosis or major complaint. These must be received prior to your scheduled appointment.

I have read this letter and understand its content. I have been informed that Dr. George Zabrecky utilizes chiropractic, nutrition and other conservative health care measures within the scope of his Connecticut chiropractic license. I understand if prescription medication, intravenous therapy or surgery is needed, I will be referred to the appropriate medical practitioner. I also understand that this facility does not provide insurance services, Medicare coverage, emergency or critical/crisis care.

Patient Name (Print)

Patient Signature

Parent/Guardian Signature

Date

Please remember to sign the introductory letter and fill out the questionnaire. Please bring all paperwork to your first appointment or fax back to our offices for a telephone consultation.

Please remember, the maintenance of health require some discipline, moderation and maturity. The resolution of disease also requires vigilance and patience. I look forward to meeting with you!

George P. Zabrecky, D.C.

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Patient's Name _____ Sex _____ Age _____

Height _____ Weight _____ Date _____

Please bring this in with you on your first visit; or mail it. **We would appreciate a 48 hour cancellation notice.**

Your appointment is: _____

Patient Selection

At the Life Extension Center, we understand that many of our patients...

- Are unresponsive or are poorly responsive to the conventional standard of care.
- Have acute or chronic conditions which have not been fully explored or diagnosed with conventional approaches.
- Have conditions which can be managed, in part, by conventional medicine, but with continued progression of the disease process and deterioration in quality of life.
- Have conditions for which no conventional standard of care is currently available.

The Life Extension Center has limitations, as do all providers of medical care. In order to provide more effective care for our patients, we strive to accept those individuals we believe can benefit the most through our integrative medicine approach. Therefore, patient selection is a critical aspect of our progress. As a result, all prospective new patients are interviewed by our staff and screened to determine if they are appropriate candidates for treatment at the Life Extension Center.

QUESTIONNAIRE

Please circle (NO) or (YES) if you have had any of the following life changes within the last two (2) years.

- | | | | | | |
|---|----|-----|--|----|-----|
| 1. Death of spouse | NO | YES | 22. Major revision of personal habit..... | NO | YES |
| 2. Divorce..... | NO | YES | 23. Changing to a new school..... | NO | YES |
| 3. Marital separation..... | NO | YES | 24. Change in residence..... | NO | YES |
| 4. Death of close family member..... | NO | YES | 25. Major change in recreation..... | NO | YES |
| 5. Marriage..... | NO | YES | 26. Major change in church activities..... | NO | YES |
| 6. Marital reconciliation..... | NO | YES | 27. Major change in social activities..... | NO | YES |
| 7. Major change in health of family..... | NO | YES | 28. Major change in sleeping habits..... | NO | YES |
| 8. Pregnancy..... | NO | YES | 29. Major change in eating habits..... | NO | YES |
| 9. Addition of new family member..... | NO | YES | 30. Vacation in the last 3 months..... | NO | YES |
| 10. Major change in arguments with wife/husband.. | NO | YES | 31. Christmas in the last 3 months..... | NO | YES |
| 11. Son or daughter leaving home..... | NO | YES | 32. Minor violations of the law..... | NO | YES |
| 12. In-law troubles..... | NO | YES | 33. Being fire from work..... | NO | YES |
| 13. Wife/husband starting or ending work..... | NO | YES | 34. Retirement from work..... | NO | YES |
| 14. Major change in family get-togethers..... | NO | YES | 35. Major business adjustment..... | NO | YES |
| 15. Detention in jail..... | NO | YES | 36. Changing to different line of work..... | NO | YES |
| 16. Major personal injury or illness..... | NO | YES | 37. Major change in work responsibility..... | NO | YES |
| 17. Sexual difficulties..... | NO | YES | 38. Trouble with boss..... | NO | YES |
| 18. Death of a close friend..... | NO | YES | 39. Major change in working conditions..... | NO | YES |
| 19. Outstanding personal achievement..... | NO | YES | 40. Major change in financial state..... | NO | YES |
| 20. Start or end of formal schooling..... | NO | YES | 41. Mortgage or loan over 50,000..... | NO | YES |
| 21. Major change of living conditions..... | NO | YES | 42. Mortgage foreclosure..... | NO | YES |
| | | | 43. Mortgage or loan less than 50,000..... | NO | YES |

Please circle appropriate answer.

1. If female, are you pregnant?..... NO YES
2. Have you any of the following diagnosed health history problems?
 - Heart disease..... NO YES
 - Cancer..... NO YES
 - Diabetes..... NO YES
 - High blood pressure..... NO YES
 - Kidney problems..... NO YES
 - Obesity..... NO YES
 - Stroke..... NO YES
 - Arthritis..... NO YES
 - Periodontal disease (oral, gum and bone problems)..... NO YES
3. Have you had a family history of any of the following conditions?
 - Heart disease..... NO YES
 - Cancer..... NO YES
 - Diabetes..... NO YES
 - High blood pressure..... NO YES
 - Kidney problems..... NO YES
 - Obesity..... NO YES
 - Stroke..... NO YES
4. Are you now taking any of the following medications?
 - Antihypertensive (blood pressure)..... NO YES
 - Antidiabetic..... NO YES
 - Antibiotic..... NO YES
 - Anticancer..... NO YES
 - Antidepressants..... NO YES
 - Drugs for ulcers or stomach upsets..... NO YES
 - Sleeping pills or muscle relaxants..... NO YES
 - Oral contraceptives..... NO YES
5. Do you exercise at least three times per week?..... NO YES
6. Do you use a seatbelt when in a car?..... NO YES
7. Do you have a history of high blood pressure?..... NO YES
8. Are you currently under greater than normal amounts of stress?..... NO YES
9. Do you brush your teeth after meals?..... NO YES
10. Do you floss your teeth each day?..... NO YES
11. What is your average daily alcoholic drink consumption? (1 drink = 1 ounce hard liquor, 1 beer or 1 glass of wine)
 - 1. none 2. 1-2 drinks 3. 3-4 drinks 4. 5 or more drinks
12. How much do you smoke daily?
 - 1. none 2. less than 1/2 pack 3. less than 1 1/2 packs 4. greater than 1 1/2 packs
13. Please give the daily overall hours for the following (should equal 24 hours):
 - Sleep: _____ Rest: _____
 - Physical Activity: Vigorous _____ Moderate _____ Light _____ Sedentary _____
14. What is your daily coffee, tea or cola consumption?
 - 1. one cup _____ 2. two to three cups _____ 3. more than three cups _____

25. Is your tongue cracked, bluish-red in color, or very smooth (no bumps)?
1. no 2. slight 3. moderate 4. significant.....
26. Are your teeth and gums infected, loose, or subject to periodontal disease?
1. no 2. slight 3. moderate 4. significant.....
27. Have you had major surgery including hysterectomy, coronary bypass, mastectomy, or other cancer surgery?
1. no 2. yes.....
28. Do you have difficulty urinating due to pain or poor flow?
1. no 2. slight 3. moderate 4. significant.....
29. Do you have muscle weakness?
1. no 2. slight 3. moderate 4. significant.....
30. Do you have bloodshot eyes or a feeling of sand in your eyes?
1. no 2. slight 3. moderate 4. significant.....
31. Do you have redness at the corners of your nose or mouth, cracked lips, or dermatitis?
1. no 2. slight 3. moderate 4. significant.....
32. Do you often feel drowsy after eating or feel shaky before meals?
1. no 2. slight 3. moderate 4. significant.....
33. Do your ankles swell in hot weather or do you have hay fever?
1. no 2. slight 3. moderate 4. significant.....
34. Is your skin rough or bumpy, particularly on the back of your arms?
1. no 2. slight 3. moderate 4. significant.....
35. To your knowledge, have you ever passed albumin (protein) in your urine?
1. no 2. slight 3. moderate 4. significant.....
36. Do you have night thirst or night sweats or are you constantly thirsty?
1. no 2. slight 3. moderate 4. significant.....
37. Do you have a history of boils, sores that do not heal, or acne?
1. no 2. slight 3. moderate 4. significant.....
38. Do you feel lightheaded when you stand up quickly?
1. no 2. slight 3. moderate 4. significant.....
39. Do you have recurring vaginal or urinary infections?
1. no 2. slight 3. moderate 4. significant.....
40. Do you have a history of kidney stones or blood in the urine?
1. no 2. slight 3. moderate 4. significant.....

41. Any further information important to your health:

CREDIT CARD PREAUTHORIZATION

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Dear Patient,

For your convenience, you may pay your account balance with your credit card. Please complete the information below:

Patient Name: _____ Date: _____

I authorize the health care provider shown above to charge my credit card account for my balance due for:

- Past services
 This visit only
 All visits this year
 Recurring charges for ongoing treatments:
\$ _____ per _____
Amount Week or Month

from _____ to _____
Date Date

- Other _____

 Mastercard  VISA

Other _____

Charge Account Number _____ Exp. Date _____

Cardholder Name _____

I understand that this form is valid for one year unless I cancel the authorization with written notice to the health care provider.

Cardholder Signature _____

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AUTHORIZATION TO RELEASE INFORMATION

Patient's Name _____
Last First Middle Initial

Address _____
Street City State

Home Phone _____ DOB _____ Patient # _____

I, _____, authorize the release of medical information from my medical records to:

- Dr. George P. Zabrecky and Dr. Marcie Wolinsky-Friedland
- Myself: _____
- Other: _____
Please specify name or organization where records are being sent
- My Insurance Company: _____

For the purpose of review/examination, I further authorize you to provide such copies thereof as may be requested. The foregoing is subject to such limitations as indicated below:

- Entire Record
- Specific Information: _____
- Old Records from Previous Physicians: _____

I give special Permissions to release and information regarding: (initial on applicable line(s) below)

_____ Substance Abuse _____ Psychiatatric/Mental Health Information _____ HIV Information
Reason for request

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed _____ Date _____
If not patient, state relation

Witness _____ Date _____

Spouse/Family Information Disclosure

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I, _____ /_____/_____
(Print Name) (Date of Birth)

Request the following restrictions to the use or disclosure of my protected information.

Life Extension Center may discuss my medical condition/information with the following people:

Please circle YES or NO and print in the appropriate person's name.

Spouse: YES NO Name: _____

Parents: YES NO Name: _____

YES NO Name: _____

Children: YES NO Name: _____

YES NO Name: _____

YES NO Name: _____

YES NO Name: _____

Significant

Other: YES NO Name: _____

YES NO Name: _____

YES NO Name: _____

Patient Signature: _____ Date: _____

Notice of Privacy Practices

The Life Extension Center, LLC

Effective Date: August 1, 2008

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information	p. 2
B. When This Medical Practice May Not Use or Disclose Your Health Information	p. 4
C. Your Health Information Rights	p. 5
1. Right to Request Special Privacy Protections	
2. Right to Request Confidential Communications	
3. Right to Inspect and Copy	
4. Right to Amend or Supplement	
5. Right to an Accounting of Disclosures	
6. Right to a Paper Copy of this Notice	
D. Changes to this Notice of Privacy Practices	p. 5
E. Complaints	p. 5

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians, or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.
4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to

agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Georgia law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

20. Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Georgia law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: **Department of Health and Human Services, Office of Civil Rights**

You will not be penalized for filing a complaint.

Complaints submitted to the DHHS Office for Civil Rights should be directed to:

Office for Civil Rights/U.S. Department of Health & Human Services
61 Forsyth Street, SW. - Suite 3B70/Atlanta, GA 30323
(404) 562-7886; (404) 331-2867 (TDD)
(404) 562-7881 FAX

The Physicians and Staff of the Life Extension Center Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") covers physicians and all other health care providers, health insurance companies and their claims processing staffs.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices on their first visit to us. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: _____
(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:

The Life Extension Center, LLC

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: _____

Address: _____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:

Reasons for refusal:

The Life Extension Center, LLC

Special Note on Authorizations Related to Marketing

HIPAA established special requirements for marketing activities. The patient's authorization must be obtained for all marketing activities except:

1. face-to-face communication by the physician or other employee of the physician practice; or
2. promotional gifts of nominal value provided to the patient by the physician practice.

In addition, the authorization must indicate whether the physician practice receives direct or indirect remuneration from a third party in connection with the marketing activities.

Thus, to the extent the authorization concerns marketing activities, the following should be added to the form:

Marketing

This authorization authorizes marketing activities for which this medical practice will will not receive direct or indirect compensation.

"Marketing" is defined by HIPAA to include all communications that encourage the purchase or use of a product or service except communications for:

1. treatment;
2. case management or care coordination of the individual, or direct or to recommended alternative treatments, therapies, health care providers or settings of care; or
3. certain other health plan communications concerning benefits.

The Life Extension Center, LLC
Authorization Tracking Information

Name of Patient: _____

Address: _____

For Office Use Only:

Date received:	Processed by:
Review Date:	Response Date:
Patient Follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Patient Follow-up:
Practice Follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Practice Follow-up:

Reviewer's Comments:

Action Taken:

**CONSENT FOR DISCLOSURE TO FAMILY MEMBER
AND/OR PERSONAL REPRESENTATIVE**

PATIENT NAME/ID # _____

ADDRESS _____	ADDRESS _____
ADDRESS _____	ADDRESS _____
CITY, STATE ZIP _____	CITY/STATE/ZIP _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for The Life Extension Center, LLC and Doctor _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient : _____

Conditions for Disclosure (Check the item(s) that apply):

- The practice may disclose my personal health information to the individual(s) above **only** in my presence.
- The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.
- Other Conditions of Disclosure: _____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____
Date of Signature: _____

Witnessed by: _____ Title/Position: _____
Print Name of Witness: _____ Date: _____

The Life Extension Center, LLC
REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our practice is using this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice of Privacy Practices provided to our patients includes information about how we collect and use the protected health information of our patients. Our Notice also contains a section on Patient Rights that describes our patient's rights under the current privacy law. These laws confirm that patients have the right to access, inspect, and copy the protected health care information used to make decisions about them.

The Practice is required by law to keep the original patient record. This form is to request access to your records, however, please keep in mind that any questions you may have about medical records created by another practice or health care provider must be directed to that provider. In providing access to these records:

1. We will only include information used to make decisions about the patient;
2. We may limit access to information generated only by this The Life Extension Center;
3. Under some circumstances, such as increased risk of harm or injury, the practice may withhold the requested information;
4. We may also provide a summary of the requested information, if you are agreeable. This may be preferred when there is a large volume of chart pages or to provide a layman's description of complex medical data.

Our Privacy Officer will evaluate your request and notify you of our decision within fifteen (15) days of this request. If the request is approved, we will provide the information within thirty (30) days. In some circumstances, an extension of an additional thirty (30) days may be necessary, for example, if patient is not an active patient or if the chart is many years old.

If you wish to have a personal copy, reasonable costs will be charged for the request to cover our administrative costs, as well as the cost of postage or other delivery, when applicable. We will provide you with an estimated cost for this Request upon approval of the Request and give you the option of withdrawing or amending this request.

Patient Name: _____ Date of Birth: _____
(Please Print)

Health Care Information requested. Please provide dates, diagnosis, treatment, or any other indications of the specific information you desire: _____

Is a summary of the information acceptable? Yes _____ No _____

Do you wish to:

- Arrange an appointment to inspect the requested information?
- Receive a copy of the information?

If you would like a personal copy, what are your instructions regarding delivery?

- I will pick the up the copies
- Please mail the copies to me at the following address: _____

This Request was signed by: _____
Printed Name – Patient or Representative

Signature: _____ Date: _____

Relationship to Patient (if other than patient): _____

The Life Extension Center, LLC
Request for Amendment of or Addition to Protected Health Information

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. We will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures. Alternatively, you may request that we append to your medical record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

I, _____ (*print name*) believe that the following health information pertaining to me is incorrect or incomplete (please copy below or attach the challenged entry and identify its location in the medical record):

I believe that the information described above is incomplete or incorrect for the following reasons:

Please choose one of the following:

ADDENDUM REQUEST:

I, _____ (*print name*) hereby request that the attached statement of no more than 250 words be made a part of any medical record (*attach statement*). I understand that you will attach this to my record and include it with each future disclosure of the contested portion of my medical record.

AMENDMENT REQUEST:

I, _____ (*print name*) hereby request that you amend the health information identified above as follows:

Additionally, I request that the following people be notified of the correction:

Name	Address
_____	_____
_____	_____
_____	_____

We must tell you within sixty (60) days if we will make the change you requested, or that we need more time (up to 30 more days) to decide. We do not have to make your requested changes if (1) they do not involve your medical records, billing records or other records that we use to make decisions about you; or (2) they involve records you have no right to access; or (3) we did not create the information (unless the person or entity that created the information is unable to act on your request; or (4) the information is already accurate and complete.

If we agree to change your information, we will send the change as you have requested, above. We will also send the change to any other persons that we know received the information before it was amended, unless you instruct us not to.

Optional: Do not send the change to anyone other than those I have specified. _____
Initial

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____