

SAN FRANCISCO PREVENTIVE MEDICAL GROUP

PATIENT INFORMATION FORM

DATE: _____

PATIENT'S NAME: _____ MR. _____ MRS. _____ MS. _____ AGE: _____
(LAST) (FIRST)

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

DATE OF BIRTH: _____ HOME PHONE #: () _____

EMPLOYER: _____ WORK PHONE #: () _____

EMPLOYER'S ADDRESS: _____

OCCUPATION: _____ SOCIAL SECURITY #: _____ - _____ - _____

SPOUSE'S EMPLOYER: _____ WORK PHONE #: () _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

PATIENT'S NEAREST RELATIVE: _____ PHONE #: () _____

PHYSICIAN: _____ DATE OF LAST PHYSICAL: _____

DENTIST: _____ DATE OF LAST VISIT: _____

YOUR REFERRAL: _____ PHONE #: () _____

NAME OF MEDICAL INSURANCE: _____

IF PATIENT IS A MINOR, WHO IS FINANCIALLY RESPONSIBLE? _____

WHOM TO CONTACT IN CASE OF EMERGENCY? _____

ACKNOWLEDGEMENT:

I acknowledge full responsibility for the payment of services and agree to pay for them, in full, at the time of service unless other arrangements have been made with the office in writing. A valid credit card number will be required at the time of scheduling in order to secure an appointment. I understand that a \$100.00 fee will be charged if my initial appointment is not cancelled 48 hours in advance, as well as a \$25.00 service fee for any returned checks.

PARENT OR GUARDIAN'S SIGNATURE

PATIENT'S SIGNATURE

DUE TO OUR BUSY SCHEDULE, WE WOULD APPRECIATE YOUR CALLING-IN TO CANCEL OR RE-SCHEDULE YOUR APPOINTMENT TO GIVE THE TIME SET ASIDE FOR YOU TO PATIENTS WHO ARE WAITING TO SEE THE DOCTOR. THANK YOU.

Section 2

68

- 71. 0 1 2 3 Pain between shoulder blades
- 72. 0 1 2 3 Stomach upset by greasy foods
- 73. 0 1 2 3 Greasy or shiny stools
- 74. 0 1 2 3 Nausea
- 75. 0 1 2 3 Sea, car, airplane or motion sickness
- 76. 0 1 History of morning sickness (0 = no, 1 = yes)
- 77. 0 1 2 3 Light or clay colored stools
- 78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
- 79. 0 1 2 3 Headache over eyes
- 80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
- 81. 0 1 Gallbladder removed (0=no, 1=yes)
- 82. 0 1 2 3 Bitter taste in mouth, especially after meals
- 83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
- 84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
- 85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
- 86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
- 87. 0 1 Recovering alcoholic (0=no, 1=yes)
- 88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
- 89. 0 1 History of hepatitis (0=no, 1=yes)
- 90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
- 91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
- 92. 0 1 2 3 Sensitive to tobacco smoke
- 93. 0 1 2 3 Exposure to diesel fumes
- 94. 0 1 2 3 Pain under right side of rib cage
- 95. 0 1 2 3 Hemorrhoids or varicose veins
- 96. 0 1 2 3 Nutrasweet (aspartame) consumption
- 97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
- 98. 0 1 2 3 Chronic fatigue or Fibromyalgia

Section 3

47

- 99. 0 1 2 3 Food allergies
- 100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
- 101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
- 102. 0 1 2 3 Pulse speeds after eating
- 103. 0 1 2 3 Airborne allergies
- 104. 0 1 2 3 Experience hives
- 105. 0 1 2 3 Sinus congestion, "stuffy head"
- 106. 0 1 2 3 Crave bread or noodles
- 107. 0 1 2 3 Alternating constipation and diarrhea
- 108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currenty mild condition, 3=severe)
- 109. 0 1 2 3 Wheat or grain sensitivity
- 110. 0 1 2 3 Dairy sensitivity
- 111. 0 1 Are there foods you could not give up (0=no, 1=yes)
- 112. 0 1 2 3 Asthma, sinus infections, stuffy nose
- 113. 0 1 2 3 Bizarre vivid dreams, nightmares
- 114. 0 1 2 3 Use over-the-counter pain medications
- 115. 0 1 2 3 Feel spacey or unreal

Section 4

58

- 116. 0 1 2 3 Anus itches
- 117. 0 1 2 3 Coated tongue
- 118. 0 1 2 3 Feel worse in moldy or musty place
- 119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
- 120. 0 1 2 3 Fungus or yeast infections
- 121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
- 122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
- 123. 0 1 2 3 Stools hard or difficult to pass
- 124. 0 1 History of parasites (0=no, 1=yes)
- 125. 0 1 2 3 Less than one bowel movement per day
- 126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
- 127. 0 1 2 3 Stools are not well formed (loose)
- 128. 0 1 2 3 Irritable bowel or mucus colitis
- 129. 0 1 2 3 Blood in stool
- 130. 0 1 2 3 Mucus in stool
- 131. 0 1 2 3 Excessive foul smelling lower bowel gas
- 132. 0 1 2 3 Bad breath or strong body odors
- 133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
- 134. 0 1 2 3 Cramping in lower abdominal region
- 135. 0 1 2 3 Dark circles under eyes

Section 5

75

- 136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
- 137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
- 138. 0 1 History of stress fracture (0=no, 1=yes)
- 139. 0 1 2 3 Bone loss (reduced density on bone scan)
- 140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
- 141. 0 1 2 3 Calf, foot or toe cramps at rest
- 142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
- 143. 0 1 2 3 Frequent fevers
- 144. 0 1 2 3 Frequent skin rashes and/or hives
- 145. 0 1 Herniated disc (0=no, 1=yes)
- 146. 0 1 2 3 Excessively flexible joints, "double jointed"
- 147. 0 1 2 3 Joints pop or click
- 148. 0 1 2 3 Pain or swelling in joints
- 149. 0 1 2 3 Bursitis or tendonitis
- 150. 0 1 History of bone spurs (0=no, 1=yes)
- 151. 0 1 2 3 Morning stiffness
- 152. 0 1 2 3 Nausea with vomiting
- 153. 0 1 2 3 Crave chocolate
- 154. 0 1 2 3 Feet have a strong odor
- 155. 0 1 2 3 History of anemia
- 156. 0 1 2 3 Whites of eyes (sclera) blue tinted
- 157. 0 1 2 3 Hoarseness
- 158. 0 1 2 3 Difficulty swallowing
- 159. 0 1 2 3 Lump in throat
- 160. 0 1 2 3 Dry mouth, eyes and/or nose
- 161. 0 1 2 3 Gag easily
- 162. 0 1 2 3 White spots on fingernails
- 163. 0 1 2 3 Cuts heal slowly and/or scar easily
- 164. 0 1 2 3 Decreased sense of taste or smell

KEY: 0=No, symptom does not occur 1=Yes, minor or mild symptom, rarely occurs (monthly)	2=Moderate symptom, occurs occasionally (weekly) 3=Severe symptom, occurs frequently (daily)
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Section 6

22

- 165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
- 166. 0 1 2 3 Crave fatty or greasy foods
- 167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
- 168. 0 1 2 3 Tension headaches at base of skull
- 169. 0 1 2 3 Headaches when out in the hot sun
- 170. 0 1 2 3 Sunburn easily or suffer sun poisoning
- 171. 0 1 2 3 Muscles easily fatigued
- 172. 0 1 2 3 Dry flaky skin or dandruff

Section 7

39

- 173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
- 174. 0 1 2 3 Crave sweets
- 175. 0 1 2 3 Binge or uncontrolled eating
- 176. 0 1 2 3 Excessive appetite
- 177. 0 1 2 3 Crave coffee or sugar in the afternoon
- 178. 0 1 2 3 Sleepy in afternoon
- 179. 0 1 2 3 Fatigue that is relieved by eating
- 180. 0 1 2 3 Headache if meals are skipped or delayed
- 181. 0 1 2 3 Irritable before meals
- 182. 0 1 2 3 Shaky if meals delayed
- 183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
- 184. 0 1 2 3 Frequent thirst
- 185. 0 1 2 3 Frequent urination

Section 8

81

- 186. 0 1 2 3 Muscles become easily fatigued
- 187. 0 1 2 3 Feel exhausted or sore after moderate exercise
- 188. 0 1 2 3 Vulnerable to insect bites
- 189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
- 190. 0 1 2 3 Enlarged heart or congestive heart failure
- 191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
- 192. 0 1 2 3 Ringing in the ears (Tinnitus)
- 193. 0 1 2 3 Numbness, tingling or itching in hands and feet
- 194. 0 1 2 3 Depressed
- 195. 0 1 2 3 Fear of impending doom
- 196. 0 1 2 3 Worrier, apprehensive, anxious
- 197. 0 1 2 3 Nervous or agitated
- 198. 0 1 2 3 Feelings of insecurity
- 199. 0 1 2 3 Heart races
- 200. 0 1 2 3 Can hear heart beat on pillow at night
- 201. 0 1 2 3 Whole body or limb jerk as falling asleep
- 202. 0 1 2 3 Night sweats
- 203. 0 1 2 3 Restless leg syndrome
- 204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
- 205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
- 206. 0 1 2 3 Polyps or warts
- 207. 0 1 2 3 MSG sensitivity
- 208. 0 1 2 3 Wake up without remembering dreams
- 209. 0 1 2 3 Small bumps on back of arms
- 210. 0 1 2 3 Strong light at night irritates eyes
- 211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
- 212. 0 1 2 3 Bleeding gums especially when brushing teeth

Section 9

78

- 213. 0 1 2 3 Tend to be a "night person"
- 214. 0 1 2 3 Difficulty falling asleep
- 215. 0 1 2 3 Slow starter in the morning
- 216. 0 1 2 3 Tend to be keyed up, trouble calming down
- 217. 0 1 2 3 Blood pressure above 120/80
- 218. 0 1 2 3 Headache after exercising
- 219. 0 1 2 3 Feeling wired or jittery after drinking coffee
- 220. 0 1 2 3 Clench or grind teeth
- 221. 0 1 2 3 Calm on the outside, troubled on the inside
- 222. 0 1 2 3 Chronic low back pain, worse with fatigue
- 223. 0 1 2 3 Become dizzy when standing up suddenly
- 224. 0 1 2 3 Difficulty maintaining manipulative correction
- 225. 0 1 2 3 Pain after manipulative correction
- 226. 0 1 2 3 Arthritic tendencies
- 227. 0 1 2 3 Crave salty foods
- 228. 0 1 2 3 Salt foods before tasting
- 229. 0 1 2 3 Perspire easily
- 230. 0 1 2 3 Chronic fatigue, or get drowsy often
- 231. 0 1 2 3 Afternoon yawning
- 232. 0 1 2 3 Afternoon headache
- 233. 0 1 2 3 Asthma, wheezing or difficulty breathing
- 234. 0 1 2 3 Pain on the medial or inner side of the knee
- 235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
- 236. 0 1 2 3 Tendency to need sunglasses
- 237. 0 1 2 3 Allergies and/or hives
- 238. 0 1 2 3 Weakness, dizziness

Section 10

29

- 239. 0 1 Height over 6' 6" (0=no, 1=yes)
- 240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
- 241. 0 1 2 3 Increased libido
- 242. 0 1 2 3 Splitting type headache
- 243. 0 1 2 3 Memory failing
- 244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
- 245. 0 1 Height under 4' 10" (0=no, 1=yes)
- 246. 0 1 2 3 Decreased libido
- 247. 0 1 2 3 Excessive thirst
- 248. 0 1 2 3 Weight gain around hips or waist
- 249. 0 1 2 3 Menstrual disorders
- 250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
- 251. 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur 1=Yes, minor or mild symptom, rarely occurs (monthly)	2=Moderate symptom, occurs occasionally (weekly) 3=Severe symptom, occurs frequently (daily)
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Section 11

48

- 252. 0 1 2 3 Sensitive/allergic to iodine
- 253. 0 1 2 3 Difficulty gaining weight, even with large appetite
- 254. 0 1 2 3 Nervous, emotional, can't work under pressure
- 255. 0 1 2 3 Inward trembling
- 256. 0 1 2 3 Flush easily
- 257. 0 1 2 3 Fast pulse at rest
- 258. 0 1 2 3 Intolerance to high temperatures
- 259. 0 1 2 3 Difficulty losing weight
- 260. 0 1 2 3 Mentally sluggish, reduced initiative
- 261. 0 1 2 3 Easily fatigued, sleepy during the day
- 262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
- 263. 0 1 2 3 Constipation, chronic
- 264. 0 1 2 3 Excessive hair loss and/or coarse hair
- 265. 0 1 2 3 Morning headaches, wear off during the day
- 266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
- 267. 0 1 2 3 Seasonal sadness

Section 12 – Men Only

27

- 268. 0 1 2 3 Prostate problems
- 269. 0 1 2 3 Difficulty with urination, dribbling
- 270. 0 1 2 3 Difficult to start and stop urine stream
- 271. 0 1 2 3 Pain or burning with urination
- 272. 0 1 2 3 Waking to urinate at night
- 273. 0 1 2 3 Interruption of stream during urination
- 274. 0 1 2 3 Pain on inside of legs or heels
- 275. 0 1 2 3 Feeling of incomplete bowel evacuation
- 276. 0 1 2 3 Decreased sexual function

Section 13 – Women Only

60

- 277. 0 1 2 3 Depression during periods
- 278. 0 1 2 3 Mood swings associated with periods (PMS)
- 279. 0 1 2 3 Crave chocolate around periods
- 280. 0 1 2 3 Breast tenderness associated with cycle
- 281. 0 1 2 3 Excessive menstrual flow
- 282. 0 1 2 3 Scanty blood flow during periods
- 283. 0 1 2 3 Occasional skipped periods
- 284. 0 1 2 3 Variations in menstrual cycles
- 285. 0 1 2 3 Endometriosis
- 286. 0 1 2 3 Uterine fibroids
- 287. 0 1 2 3 Breast fibroids, benign masses
- 288. 0 1 2 3 Painful intercourse (dysparenia)
- 289. 0 1 2 3 Vaginal discharge
- 290. 0 1 2 3 Vaginal dryness
- 291. 0 1 2 3 Vaginal itchiness
- 292. 0 1 2 3 Gain weight around hips, thighs and buttocks
- 293. 0 1 2 3 Excess facial or body hair
- 294. 0 1 2 3 Hot flashes
- 295. 0 1 2 3 Night sweats (in menopausal females)
- 296. 0 1 2 3 Thinning skin

Section 14

30

- 297. 0 1 2 3 Aware of heavy and/or irregular breathing
- 298. 0 1 2 3 Discomfort at high altitudes
- 299. 0 1 2 3 "Air hunger" or sigh frequently
- 300. 0 1 2 3 Compelled to open windows in a closed room
- 301. 0 1 2 3 Shortness of breath with moderate exertion
- 302. 0 1 2 3 Ankles swell, especially at end of day
- 303. 0 1 2 3 Cough at night
- 304. 0 1 2 3 Blush or face turns red for no reason
- 305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
- 306. 0 1 2 3 Muscle cramps with exertion

Section 15

13

- 307. 0 1 2 3 Pain in mid-back region
- 308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
- 309. 0 1 History of kidney stones (0=no, 1=yes)
- 310. 0 1 2 3 Cloudy, bloody or darkened urine
- 311. 0 1 2 3 Urine has a strong odor

Section 16

30

- 312. 0 1 2 3 Runny or drippy nose
- 313. 0 1 2 3 Catch colds at the beginning of winter
- 314. 0 1 2 3 Mucus producing cough
- 315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
- 316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
- 317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
- 318. 0 1 2 3 Acne (adult)
- 319. 0 1 2 3 Itchy skin (Dermatitis)
- 320. 0 1 2 3 Cysts, boils, rashes
- 321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

SAN FRANCISCO PREVENTIVE MEDICAL GROUP

380 WEST PORTAL AVE. STE. C
SAN FRANCISCO, CALIFORNIA 94127
TELEPHONE (415) 566-1000

INFORMED CONSENT FORM

I am seeking medical health care services at SFPMG. I understand that this medical practice uses some diagnostic and treatment methods that are variously known as complementary, alternative, holistic, or nutritionally oriented. Some of these methods have not been accepted by consensus mainstream medicine.

Some of the characteristics qualities of complementary medicine that are used in this practice include the following:

1. A person's lifestyle including his or her diet, exercise patterns, sleep habits, stresses and interpersonal relationships are believed to be directly related to the development and maintenance of illness. Complementary medicine evaluates these factors and seeks to help the patient give up negative life style patterns and establish more positive ones regardless of age or type of medical problem.
2. Although prescription and over-the-counter medications are used when the physician believes it is necessary, an attempt is also made to use products that are natural to the body. These include nutritional supplements such as vitamins, minerals, glandulars, enzymes, amino acids, essential fatty acids, homeopathic medicines and herbs.
3. In addition to recommending that a patient take nutritional supplements by mouth, we frequently recommend that a patient receive a series of injections either intravenously or by intramuscular injection, (intravenous vitamin therapy is an example). Some of the reasons for recommending this procedure include the assurance that the particular substance gets into the body (which may not happen when the supplement is taken orally and the patient has absorption problems) and achieving high concentration of the substances in the bloodstream, which may be difficult if the substance is taken only by mouth.

4. Because we look for imbalances in the body and for trends that may result in illness if not addressed, we sometimes order tests that may be considered by consensus mainstream medicine to be either unnecessary or of no value. These tests may include tests for nutritional status, such as blood levels for functional vitamin or mineral tests, hormonal levels, test for allergies, saliva tests, and urine tests for excreted substances.
5. We very much believe in a person being involved in his own health care and encourage questions, exploration and participation in decisions surrounding diagnostic and treatment procedures. We encourage consultations with consensus mainstream medicine practitioners and use of any other means that a person feels he needs to help him decide about health issues.
6. We believe in the mind-body-spirit connection in bringing about wellness and preventing and dealing with illness. Consequently, part of our program may involve recommendations for counseling, meditation, psychotherapy or hypnotherapy.
7. Exercise is extremely important in maintaining health and promoting wellness as well as helping one to recover from an illness. Graded exercise, both aerobic and stretching, is encouraged for most patients.
8. We sometimes use medications that are approved by the FDA to treat one condition to treat another condition for which the FDA has not approved the medication. It should be noted that this is common practice throughout all medical fields, not only in complementary medicine. Perhaps the best example we have is our use of EDTA chelation therapy to treat all forms of atherosclerotic cardiovascular disease and other degenerative diseases.

The above represents some of the ways that our practice may differ from other physician's offices that you have visited. You should also be aware of the following points:

1. WE MAKE NO REPRESENTATIONS, CLAIM OR GUARANTEES THAT YOU WILL BE HELPED WITH YOUR MEDICAL PROBLEMS OR CONDITIONS BY UNDERGOING TREATMENT HERE. However, we will do our best to help you to accomplish your health care and wellness goals.
2. In our office, we make available nutritional supplements and other recommended products. Generally, we believe the prices are competitive with outside sources. (Please let us know if you find this not to be the case.) Mail order service is also available from our office. YOU ARE IN NO WAY

OBLIGATED TO PURCHASE THESE PRODUCTS FROM THIS OFFICE. YOU ARE FREE TO PURCHASE THESE PRODUCTS FROM ANY SOURCE THAT YOU MAY CHOOSE AS LONG AS THEY ARE EXACTLY THE SAME.

3. Most health insurance plans today have clauses, which limit coverage to “usual and customary services”. Because many of the treatments used in complementary medicine are not recognized by consensus mainstream medicine, we cannot guarantee the amount of availability of coverage of our services and treatments under your health insurance policy. You are responsible for the payment of all non-covered services. You are entitled to know the cost of all services and procedures in advance. Please ask if they are not told to you.

I have read, understand and agree to the foregoing. I agree that if I ever have any claim with respect to the services and treatment given to me at SFPMG, its employees and/or staff, that they shall be judged by the standards and principles of complementary, alternative, environmental, holistic, and nutritionally-oriented medicine and not by the standards and principles of consensus mainstream medicine. I understand that I have the right to review this Consent with a lawyer I choose before accepting any medical services at SFPMG. I have executed this Consent freely and willingly and understand its provisions. I recognize that SFPMG will rely upon my execution of this document in rendering all services provided. I acknowledge receipt of a copy of this Consent.

Date: _____

Signature: _____

Printed Name: _____

SAN FRANCISCO PREVENTIVE MEDICAL GROUP

380 WEST PORTAL AVE. STE. C
SAN FRANCISCO, CALIFORNIA 94127
TELEPHONE (415) 566-1000

Information on Protecting Privacy of Patient Records - Maintenance of Confidentiality

At the office of San Francisco Preventive Medical Group, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, by issuing this notice to all patients and following the terms and conditions described. This notice describes how your health information may be used/disclosed, and how you can access this information.

Please review the following carefully:

- For ALL medical record release requests, we will not disclose your health information without your prior written authorization and approval from one of the medical practitioners.
- We are permitted to release your medical records to all who participate in your treatment (ie. referred specialist, hospitals).
- We are permitted to release your medical records by request from non-medical facilities/sources such as insurance companies, law offices, etc., and have the right to charge a nominal fee for the medical records given.
- You have the right to request personal copies of some/all of your medical records, and have the right to transfer your medical file to another physician/practice. This information may only be mailed to the appropriate address, or picked up in person by you or a designated representative.
- We may use your information to contact you: For example, we may send newsletters or other information. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers our call.
- As we will contact you from time to time, we will use whatever address or telephone number you prefer. Please keep us updated with your current contact information (as well as current insurance information) with each follow up visit to the office.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- You have the right to know if any disclosures we make with your medical records beyond the above normal uses.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- Your medical information will remain on file in the San Francisco Preventive Medical Group for as long as you are an active patient. We have the right to remove patient records that are inactive for five years or more. The records removed will be placed into storage and subsequently destroyed if they continue to remain inactive for one year after their initial removal from the office.
- You have a right to receive a copy of this notice. If we change any details in this document, we will issue a new agreement, and distribute it to you for a reassessment and patient signature.
- This privacy notice goes into effect as of April 14, 2003.

Acknowledgement

I have read and am in agreement with the above mentioned notification of privacy practices for the office of San Francisco Preventive Medical Group. I also have the right to request a copy for my personal records.

Signed: _____ Date: _____

Print Name: _____

E-mail: _____

SAN FRANCISCO PREVENTIVE MEDICAL GROUP

380 WEST PORTAL AVE. STE. C
SAN FRANCISCO, CALIFORNIA 94127
TELEPHONE (415) 566-1000

ADVANCED BENEFICIARY NOTICE

I, _____ (patients name) _____ (social security #)

hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided by at the San Francisco Preventive Medical Group on or after this date by Dr. Paul Lynn and his associates may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that in case my insurance coverage including Medicare will not pay for such non-covered services, I will be personally responsible for payment.

MEDICARE WILL NEVER PAY FOR VITAMINS, MINERALS AND NUTRITIONAL SUPPLEMENTS IN ANY FORM INCLUDING CHELATION

Signature _____ Date _____

Witness _____