Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

At Wellness Revolution Clinic, we provide safe, effective, affordable, and sustainable health solutions. Working together, we can achieve your optimal health, by combining state-of-the-art medicine with quality, traditional, health care.

Your Visit: Our clinic is located in the Spring Creek Town Center Plaza; from Chattanooga take I 75 North; take exit # 25 and turn left at the stop light; go straight on 25th street; pass through 5 stop lights and turn left at the 6th stop light onto Spring Creek Blvd; turn left into the Spring Creek Town Center Plaza; we are the first office on the far right of the Plaza.

The first visit is typically 60 minutes. This visit includes a health status interview and a physical exam, which may be required to formulate a diagnosis and treatment plan specifically for you, lab draws and explanation for testing. Follow up visits are typically scheduled for 30-60 minutes and follow-up appointments are made by the staff when all of your test results are in.

Adult Client fees:

Women's Comprehensive Wellness Program OR Men's Comprehensive Wellness Program	$ 3200.00 Includes all appropriate serum lab testing, 24 hour urine hormone profile, food allergy testing, testing for pyroluria and organic acids test, 3 clinical visits, 6 week follow-up serum labs, educational and nutritional training, as well as instruction for prescriptions and nutritional supplements. Any other clinical visits within the year are free of charge.
Break down of Adult Individual Labs	Prices for Adult Individual Labs
Initial Lab Corp Serum Labs	$1000.00
Urine Hormone Profile	$425.00
OATs Test	$425.00
HemoPyrrolLactamUria (HPU) Test	$150.00
Food Allergy Testing Adults	$300.00

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Initial consultation	$350.00/each
First Review of Lab Test and consult	$300.00/each
Lab Corp retest labs with reviews and consult	$250.00/ each
Total value	$ 3200.00
Simple Urgent Care Visit	$100.00
Comprehensive Hormone Optimization Package for both Men and Women	$1500.00

Child Client Fees

Children's Comprehensive Wellness Program	$1975.00 Includes all appropriate serum lab testing, food allergy testing, testing for pyroluria and organic acids test, and up to 3 clinical visits, 6 weeks follow-up labs with review, educational and nutritional training, as well as instruction for prescriptions and nutritional supplements. Any other clinical visits within the year are free of charge.
Initial Lab Corp Serum Labs	$500.00
OATs Test	$425.00
HemoPyrrolLactamUria (HPU) Test	$150.00
Food Allergy Testing serum **or** Food Allergy Finger Stick	$300.00
Initial consultation	$200.00/each
First Review of Lab Test and consult	$200.00/each
Lab Corp retest labs with reviews and consult	$200.00

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Total Value	$1975.00
Simple Urgent Care Visit	$100.00

Payment Agreement

Dear New Client,
Welcome to Wellness Revolution Clinic LLC. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care.Please read and initial the following statements:
Payment for all services and vitamins, mineral and supplements are due at the time of the visit. We accept cash, checks, Visa, Master Card, Discover, American Express.

I _____ would like to purchase the following cash program.
Please Check one box:

	Men's Comprehensive Wellness Program	$3200.00
	Women's Comprehensive Wellness Program	$3200.00
	Children's Comprehensive Wellness Program	$1975.00
	Simple Urgent Care Visit	$100.00
	Comprehensive Hormone Optimization Package for both Men and Women	$1500.00

SIGN: Patient Signature (Parent/Guardian Sig. if patient is a minor)

SIGN: _____ DATE: _____
Patient Signature (Parent/guardian signature if minor)

Physician/Witness: _____ DATE: _____

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Patient Bill of Rights

-A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

-A patient has the right to a prompt and reasonable response to questions and requests.

-A patient has the right to know who is providing medical services and who is responsible for his or her care.

-A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

-A patient has the right to know what rules and regulations apply to his or her conduct.

-A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

-A patient has the right to refuse any treatment, except as otherwise provided by law.

-A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

-A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

-A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

-A patient has the right to receive a copy of a reasonably clear and understandable itemized bill, and upon request, to have the charges explained.

-A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

-A patient has the right to treatment of any emergency medical condition that will deteriorate from failure to provide treatment.

-A patient has the right to know if medical treatment is for the purpose of experimental research, and to give his or her consent or refusal to participate in such experimental research.

-A patient has the right to express grievances regarding any violation of his or her rights, as stated in Tennessee law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

-A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and any other matters relating to his or her health.

-A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

-A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action, and what is expected of him or her. -A patient is responsible for following the treatment plan recommended by the health care provider.

-A patient is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

-A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

-A patient is responsible for ensuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

-A patient is responsible for following health care facility rules and regulations affecting patient care and conduct

Authorization to Treat

I _____ hereby acknowledge that I am accepting treatment from a Bess Howard NP-C ABAAHP at Wellness Revolution Clinic
(Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

SIGN: _____ DATE: _____
Patient Signature (Parent/guardian signature if minor)

Physician/Witness: _____ DATE: _____

Confidentiality Statement

Protecting the Privacy of Patients' Health Information

1. INFORMATION REQUIRED TO BE PROTECTED.

The privacy of all medical records and other individually identifiable health information must be protected at all times. Information relating to a patient's health care history, diagnosis, condition, treatment, or evaluation shall be considered individually identifiable health information.

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Confidentiality of this health information must be maintained at all times, and may only be disclosed with the express written consent of the patient. Non-individually identifiable health information, (e.g. health information that cannot be linked to a specific patient) is not included within the definition of protected health information.

2. BOUNDARIES ON HEALTH INFORMATION USE AND RELEASE.

A) An individual's health information can be used for health purposes only.

B) Protect individually identifiable health information. Wellness Revolution Medical Clinic shall not publish or otherwise make generally available any information or data that identifies a patient for purposes other than treatment, payment or other health care operations, without his or her express written consent. This does not restrict the internal use of such information or data that is required in the performance of the scope of work that Wellness Revolution Medical Clinic has been engaged to perform for a client. Wellness Revolution Medical Clinic also maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. Wellness Revolution Medical Clinic is always assessing those safeguards and shall make ongoing improvements to maintain and enhance our level of security for individually identifiable health information.

C) Ensure that health information is not used for non-health purposes. Patient information can be used or disclosed only for purposes of health care treatment, payment, and operations. Health information cannot be used for purposes not related to health care without explicit authorization from the patient. For example, Wellness Revolution Medical Clinic may not access the personal health information obtained by a Wellness Revolution Medical Clinic affiliate for any purpose other than to perform the services, for which we were engaged, unless Wellness Revolution Medical Clinic first obtains the explicit authorization of the patient.

D) Maintain health information in a manner to protect confidentiality. All individually identifiable health information shall be maintained by Wellness Revolution Medical Clinic in a confidential manner that prevents unauthorized or inadvertent disclosure to third parties. For example, Wellness Revolution Medical Clinic may share confidential information with a third party under contract or affiliated with Wellness Revolution Medical Clinic for the same purpose of performing the services for which we were engaged, provided that the information shall remain confidential at all times and shall be shared with only those persons that have authority to receive such information.

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

3. PENALTIES FOR MISUSE OF PERSONAL HEALTH INFORMATION

There are serious penalties for violation of the confidentiality of health information. Please be advised of the following:

A) State Penalties. Various state laws impose criminal and civil penalties on individuals who misuse or disclose individually identifiable health information without explicit consent by the patient.

B) Federal Penalties. HIPAA (Health Insurance Portability and Accountability Act) is a piece of federal legislation that directly addresses the protection of confidential health information. HIPAA provides for civil money penalties up to $25,000 per person, per year for violations of patient confidentiality. HIPAA also provides for federal criminal penalties.

C) Wellness Revolution Medical Clinic Penalties. Any employee who violates the privacy and confidentiality of patient health information, through disclosure or otherwise, may be subject to disciplinary action, including termination of his or her employment with Wellness Revolution Medical Clinic

Acknowledgment of Notice of Privacy Practices

I, _____acknowledge receipt of the currently effective Notice of Privacy Practices from Wellness Revolution Medical Clinic this _____ day of _____, 20_____. I have reviewed the information and am aware of my rights as they are outlined in the document.

I understand that if I feel that my privacy protection rights have been violated, that I may submit a formal, written complaint to the Department of Health and Human Services, Office of Civil Rights, without fear of retaliation by Wellness Revolution Medical Clinic.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient:_____

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

CONSENT TO USE/DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby authorize Wellness Revolution Medical Clinic to use or disclose my protected health information for the purpose of treatment, payment, or healthcare operations as their terms are defined in federal HIPAA privacy rules.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

health information relates to my past, present and future physical or mental health conditions and identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that I have the right to revoke this authorization at any time, but that such revocation must be given to Wellness Revolution Medical Clinic in writing and that any revocation will be honored, except to the extent that Wellness Revolution Medical Clinic has already taken action by reliance on the original consent.

I understand that Wellness Revolution Medical Clinic may refuse to treat me if I, or my authorized representative, fails to sign this Consent Form. (Except to the extent, by law, that Wellness Revolution Medical Clinic is required to treat individuals.) I further understand that if I, or my authorized Representative sign this consent and later revoke this consent, Wellness Revolution Medical Clinic has the right to refuse to provide further treatment to me as of the date of revocation.

(Except to the extent, by law, that Wellness Revolution Medical Clinic is required to treat individuals.)

Signature: _____ Date: _____

Printed Name: _____Relationship to Patient: _____

(Power of Attorney or Judicial Order should be attached for Authorized Representative Signature)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ SSN: _____ Address : _____

DOB: _____City, State, Zip: _____ Phone #: ( ) _____

I, _____, do hereby authorize Wellness Revolution Clinic to release:

{ Discharge Summary { ECG/EEG/Cardiac Cath. { Operative Notes{ Pathology Reports { Laboratory Reports { Radiology Reports

{ Emergency Reports { History & Physical { Progress Notes { All Records { Other _____Dates of Service:

_____

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

INFORMATION TO BE RELEASED

TO:_____

_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign this authorization.

_____ _____

Signature of Individual or Guardian Date

Health History Form

Date: _____Pharmacy Phone Number/

Fax_____

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ DOB: _____ Age: _____

Gender: Male / Female Marital Status: Single / Divorced / Widowed / Separated / Married

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Alternate #: (_____) _____-_____

Occupation: _____ Spouses Occupation: _____

Place of Employment: _____

Emergency Contact Info - Name: _____

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Relationship: _____ Telephone Number: (_____) _____- _____

Who is Financially Responsible for your care? _____ _____

Spouses Name: _____ Number of Children: _____

Insurance Type: Medicare / Medicaid / BCBS / Commercial / None / Other _____

Carrier Name: _____ Policy #: _____

Primary Insured Name: _____ DOB: _____

Social History

Highest level of Education Completed: _____ Race: _____

Do you currently smoke? Yes / No Have you smoked or used tobacco products in the past? Yes / No

If yes, what kind and how long: _____

Do you currently drink alcoholic beverages? Yes / No How many a day? _____ Week: _____ Month: _____

Religious Preference: _____

Hobbies: _____

Are you a student? Yes / No If yes, are you full or part time: _____

Do you have a Living Will or Advanced Directive? Yes / No (If yes, please give a copy to Admitting Clerk.)

_____

Allergies
List if you have hypersensitive or allergies to…
Any drugs? _____
Any foods? _____
Any environmentals or chemicals? _____

Medications (Please list all medications and doses you have taken in the past month. Bring Medication with you to your visit.)

1._____ 4._____ 7._____

2._____ 5._____ 8._____

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

3._____ 6._____ 9._____

Past Medical History **Name: _____ DOB ___/___/___**

List all previous illnesses that required hospitalization including year (Exclude Surgeries).

1._____ 4._____

2._____ 5._____

3._____ 6._____

List all previous surgeries and year.

1._____ 4._____

2._____ 5._____

3._____ 6._____

Accidents and Year (Describe injuries, if any.)

1._____ 3._____

2._____ 4._____

Please list all Physicians seen in last two years.

1._____ 3._____

2._____ 4._____

Total # of Pregnancies: _____ Miscarriages: _____ Weight of largest child at delivery: _____lbs. _____oz.

Age at Onset of Menses: _____ Duration of Menses: _____ Number of days between Menstruation: _____

Last Menstrual Cycle: _____ Last Pap Smear: _____ Last Mammogram: _____

Review of Symptoms (Circle the symptoms that apply to your current problem or any problems you have had in the past.)

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Headaches	Vomiting Blood Loose	Black Bowel Movements	Fever for > 5 days
Seizures/Fits	Numbness in Extremities	Weakness in Extremities	Nervousness
Difficulty with Balance	Dizziness	Fainting/Black-Outs	Hives
Strokes	Ringing in Ears	Difficulty with Hearing	Excessive Sweating
Difficulty with Vision	Double Vision	Changes in Smell	Breast Discharge
Excessive sneezing	Chronic Sinus Infections	Difficulty breathing through Nose	Itching
Nose Bleeds	Voice Changes	Shortness of Breath at Night	Changes in skin appearance
Shortness of Breath while walking	Swelling in Ankles/Feet	Blood in Stool	Stomach Pain
Palpitations	Chest Pain/Tightness	Heart Murmur	Loss of appetite
Heart Attack	High Cholesterol	Swelling of Legs	Changes in Breast Tissue
Cough	Coughing up Blood	Wheezing	Excessive Weight Gain
Diabetes	High Blood Pressure	Night Sweats	Frequent Urination
Urinary Retention	Asthma	Changes in Memory	Mood Disorders
Pain during Urination	Blood in Urine	Changes in Urinary Pattern	Insomnia
Stomach Ulcers	Erectile/Ejaculation	Dysfunction Back Pain	Mood Swings/ Depression

Family History **Name** _____ **DOB** ___/___/___ **Date** _____

Please check all that apply:

Disorder	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Grandmother**	**Grandfather**	**Other**

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Goiter							
Hypothyroidism							
Graves'							
Hashimoto's Thyroiditis							
Cancer							
Tuberculosis							
Allergies/ Hives							
Asthma							
Nervous Breakdown							
Suicide							
Epilepsy							
Migraines Arthritis							
Heart Attack							
Diabetes							
High Blood Pressure							

Bess Howard NP-C ABAAHP
2445 Spring Creek Blvd.
Cleveland, TN 37311
Phone: (423) 310-5443
Fax: (423) 464-5345

Gout							
Kidney Stones							
Bleeding Disorders							
Ulcers							
Celiac/ IBS							
LYME/RMSF/ Bartonella/Babesia							
LUPUS							
MS							
Psoriasis							
Myasthenia Gravis							