Please return this packet at least 2 days before your appointment! Thank you!

Patient History

Name: ____Date: ______________________

Address: ____________________________City/State/Zip:__________________________

Home Phone: _________________________Cell: _____________ Other: ______________

Email Address ____

Birth date:_________ Sex : M - F Age_______ # of Children: ________

Marital Status: ________ Emergency Contact: ____________________________________

Phone: Cell __________________________ Home_______________________________

Medicare: Yes - No Medicare #:____

Name as it appears on Medicare card:____
PLEASE provide a copy of card!

CURRENT HEALTH CONDITION

What brings you to our office?

____

____

____

____

Other Doctor's seen within the past 2 years:

____

____

____

_____Date Condition Started: _________________

Are you pregnant Yes - No - Maybe

PAST HEALTH HISTORY

Major Surgery/Operations – Circle:
Appendectomy / Tonsillectomy / Gall Bladder / Hernia / Broken Bones (List below other)

Other Hospitalizations:

Major Accidents/Falls:

Treatment for any health conditions this last year:

Previous Chiropractic Care - Doctor's Name and Date of Last Visit:

Please mark the areas of pain you are experiencing today on the diagram below. Use the symbols shown to the left of the diagram. Label the worst area of pain #1 on the diagram, #2 on the next most intense area of pain, etc.

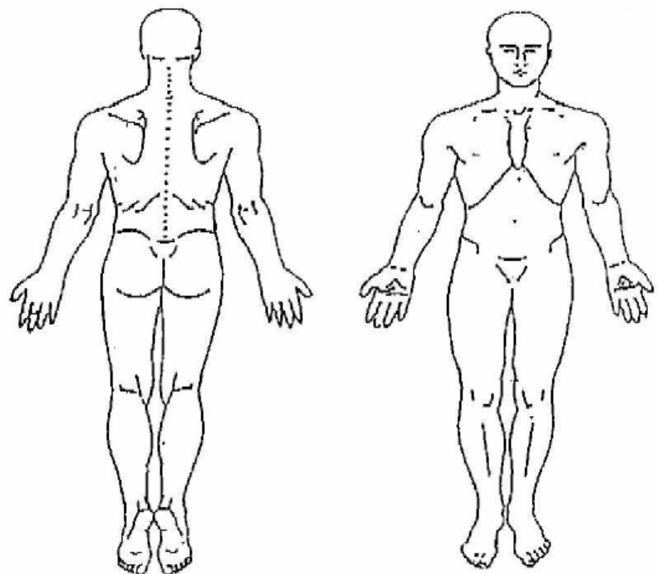
Mark the intensity by placing a mark somewhere between the "no pain" and the "intense pain" end of the dotted line for areas 1, 2, and

AREA 1: no pain ←------------→ intense pain

AREA 2: no pain ←------------→ intense pain

AREA 3: no pain ←------------→ intense pain

SHARP	XX XX
BURNING	++ ++
DULL PAIN	✓✓ ✓✓
NUMB	OO OO
PINS AND NEEDLES	••• •••



We offer patient directed care. This means we are about understanding your goals, so you can get just what you want from your care. Which type of care do you desire?

_____ Initial Intensive – Symptomatic Pain Relief

_____ Comprehensive – Working to correct the cause of your problem

_____ Therapeutic Lifestyle change (TLC) – Helping you create a lifestyle that fits your genetic uniqueness to boost your healing ability, health and wellness.

_____ Check here if you want Dr. Gerhart to select the type of care appropriate for your condition.

I understand that although Medicare is billed, I may not be reimbursed.

I understand and agree that all services I receive are to be paid on the date of service.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me and that I am solely responsible for payment of services rendered to me.

Patient's Signature: ______________________________________ Date______

Guardian or Spouse's
Signature Authorizing Care:________________________________ Date:______

FAMILY HEALTH HISTORY

PATIENT: **DATE:**

Please review the below listed diseases and conditions and indicate those that are current health problems of a family member by the designation C under the column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	*FATHER* *AGE ____*	*MOTHER* *AGE____*	*SPOUSE* *AGE ____*	*BROTHER(S)* *AGE____*	*SISTER(S)* *AGE ____*	CHILDREN *AGE____ AGE____* *AGE____ AGE ____*
Allergies						
Anemia						
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Cancer						
Chronic Fatigue						
Constipation						
Diabetes						
Dics Problem						
Emotional Problems						
Emphysema						
Epilepsy						
Fibromyalgia						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness/Anxiety						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Stroke						
Thyroid						
Other						

Patient Name___________________________

MEDICATION SUMMARY: Over the Counter and Prescription Medications

Date	Medication used and purpose of each

Patient Name ____

SUPPLEMENT SUMMARY: Vitamins, minerals, etc.

DATE	Supplements Currently Using with Dosage and Purpose of

PATIENT DIAGNOSTIC QUESTIONNAIRE

Name ___________________________ Age_______ Weight ________

Please mark with an (X) the conditions about which you are concerned			
	Overweight		Headaches
	Underweight		Female Problems
	Sexual problems		Extreme Fatigue
	Menopause Problems		Cancer
	Heart Condition		Circulatory Problems
	Blood Pressure Problems		Lung and/or Breathing
	Digestive Trouble		Stomach and/or Gallbladder
	Gallbladder Problems		Intestine or Bowel Troubles
	Diabetes Mellitus		Neck and/or Spine Problems
	Skin Disorder		Eye Condition
	Ear or Hearing Disorder		Nose/Throat/Mouth Problems
	Sinus Infections		Dizziness/Balance Disorder
	Nervous/Emotional Trouble		Kidney/Bladder/Urinary
	Allergies to Food		Allergies in General
	Nutritional Evaluation		Thorough Diagnostic Checkup
	Arthritis/Rheumatism		Alcohol or Tobacco Addiction

	GENERAL
	Are you overweight?
	Are you underweight?
	Are your fingernails ridged or have white spots?
	Do you sleep less than seven hours per night?
	Do you rarely exercise?
	Do you smoke over 9 cigarettes each day or inhale pipe/cigars?
	Do you drink alcoholic beverages each day?
	Are you sensitive to chemicals, paint exhaust fumes, cologne?
	Are you able to recall your dreams the next day?
	Were you bottle fed as an infant?
	Were you delivered by C-section?
	Was your delivery induced?
	Did your mother have a “nerve block” during your birth process?

	EYES
	Are you unusually sensitive to bright light?
	Do you have macular degeneration?
	Do your eyes frequently itch?
	Do you suffer from cross eyes?
	Do you have or have you had Cataracts
	Do you experience pain in your eyes?
	Are your eyes bloodshot?
	Do your eyes water?
	Do your eyes feel gritty?
	Is your vision blurred?

	MOUTH AND THROAT
	Do you have jaw joint problems (TMJ)
	Do you clench or grind your teeth?
	Is your tongue badly coated?
	Do you have bad breath?
	Do you suffer from sores or cracks at corners of your mouth?
	Do you frequently experience canker sores?
	Are your gums sore?
	Do your gums bleed when you brush your teeth?
	Do you have sore throats frequently?
	Are your glands often swollen?
	Do you suffer from toothaches?
	In the mornings, do you have a bitter taste in your mouth?
	Do you frequently have a sore tongue?
	How many silver fillings (mercury amalgams) do you have?
	Have you ever had braces/orthodontic care?

	EARS
	Are you hard of hearing?
	Are you experiencing any discharge from your ears?
	Do you have ringing or noises in your ears
	Do you suffer from recurrent ear infections?
	Do you have a punctured eardrum?

	CARDIOVASCULAR
	Do you have high blood pressure?
	Do you have low blood pressure?
	Do you have pains in the heart or chest?
	Are you troubled with blood clots?
	Do you have cold hands?
	Are your feet frequently cold?
	Do you have varicose veins?
	Are your ankles frequently swollen?
	Do you have an unusually slow pulse rate?
	Do you experience spells of rapid heartbeat?
	Are you aware of your heart skipping beats?
	Do you experience shortness of breath while sitting still?
	Do you suffer from leg cramps after retiring to bed?
	Do you suffer from leg cramps during the day?
	Do you experience pain in your leg/hips when walking?

	RESPIRATORY
	Do you have frequent colds?
	Do you suffer from nasal polyps?
	Do you often have sinus infections?
	Do you experience night sweats?
	Do you have hay fever?
	Do you wheeze?
	Do you have asthma?
	Do you catch severe colds?
	Do you experience difficulty in breathing?
	Do you have a chronic cough?
	Do you spit up phlegm?
	Do you spit up blood?
	Do you have spells of sneezing?
	Is your nose frequently stuffy?
	Does your nose run constantly?
	Do you have frequent nose bleeds?
	Do you have a chronic chest condition?
	Do you have postnasal drip?

	GASTROINTESTINAL
	Is your appetite poor?
	Do you have excessive hunger?
	Do you experience fainting spells when hungry?
	Does eating relieve fatigue?
	Do you feel shaky when hungry?
	Are you frequently drowsy after eating a meal?
	Do you eat when nervous?
	Do you frequently have diarrhea?
	Do you have difficulty in swallowing?
	Do you vomit frequently?
	Are you frequently nauseated?
	Are you bloated after eating?
	Do you have abdominal gas?
	Does eating greasy food cause you to have indigestion?
	Do you belch or burp after eating?
	Do you have: Indigestion immediately upon eating? ___Indigestion within 1 hour after meals? ___Indigestion 2 hours or more after meals?
	Do you have loose bowel movements?
	Have you ever had intestinal worms?
	Do you have pale or yellow colored stools?
	Do you suffer from constipation?
	Do you have one or less bowel movements daily?
	Are your stools bloody?
	Do you have black tarry stools?
	Do you use laxatives?
	Do you suffer from severe abdominal pain?
	Do you have hemorrhoids (piles)?
	Do you have stomach ulcers?
	Do you have gallbladder disease?
	Do you have liver disease?

	NEUROMUSCULAR
	Do you have neck pain?
	Do you have pain between the shoulders?
	Do you suffer from low back pain?
	Do you have swollen joints?
	Do you have spinal curvature?
	Do you suffer from muscle spasms?
	Are your muscles frequently sore?
	Do you have muscle weakness?
	Are your joints stiff in the morning?
	Do you have shoulder/arm pain?
	Do you suffer from leg pain at rest?
	Do you have rheumatism?
	Does any part of your body experience numbness/tingling?
	Do you have frequent headaches?
	Are you often dizzy?
	Do you frequently feel faint?
	Do you have epilepsy?
	Do you bite your nails badly?
	Do you stutter or stammer?
	Are you a sleep walker?
	Do you have osteoarthritis?
	Do you suffer from motion sickness?

	FEET
	Do you suffer from painful feet?
	Do you have frequent foot cramps?
	Do you have plantar warts?
	Do you have heel spurs?
	Are you troubled with corns?
	Do you have hammer toes?
	Do you have plantar fasciitis/arch pain?

	SKIN
	Is your skin tender?
	Does your skin itch?
	Do you have skin eruptions?
	Is your skin rough, especially on the back of the arms?
	Do you have psoriasis?
	Do you bruise easily?
	Do you have acne?
	Are you troubled with boils?
	Do you have eczema?
	Are you aware of moles which are changing in size or color?
	Do you frequently experience goose bumps?
	Do you have hives (allergy reaction of the skin)?
	Do you get sores that are slow to heal?

	URINARY
	Do you have frequent urination?
	Do you awaken at night to urinate?
	Are you a bed wetter?
	Do you dribble when sneezing or when laughing?
	Have you ever lost control of your bladder?
	Do you have painful urination?
	Do you have blood in your urine?
	Are you troubled by urgent urination?
	Do you have difficulty in starting the stream?
	Do you have frequent bladder infections?
	Do you have frequent kidney infections?
	Do you have kidney stones?

	ENDOCRINE
	Do you have excessive thirst?
	Do you frequently feel cold?
	Do you frequently feel hot?
	Are you unusually tired most of the time?
	Are you unusually jumpy or nervous?
	Is your hair coarse?
	Is your skin coarse?
	Are you diabetic?
	Do you get lightheaded when standing quickly?

	FOR WOMEN ONLY
	Do you have painful periods?
	Do you have an excessive flow?
	Do you have irregular cycles?
	Do you suffer from menstrual cramps?
	Do you have hot flashes?
	Do you have vaginal discharge?
	Do you have a bloody spotting discharge?
	Have you had a hysterectomy?
	Do you retain fluid during your periods?
	Have you ever miscarried?
	Do you have acne worse at menstruation?
	Do you have tender breasts?
	Do you have frequent yeast infections?
	Do you have lumps in your breasts?
	Do you have heavy hair growth on your face or body?
	Do you take birth control pills?
	Do you have premenstrual depression?
	Is intercourse painful for you?
	Do you have diminished sex desire?
	Do you have sexual problems?

	FOR MEN ONLY
	Do you have painful genitals?
	Do you have prostate troubles?
	Do you have lumps in your testicles?
	Do you have a discharge from the urethra?
	Do you have sores on external genitalia?
	Do you have difficulty getting or keeping an erection?
	Do you have difficulty completing intercourse?
	Have you had difficulty fathering children?

	METABOLIC SYNDROME/CHD RISK
	Do you often skip breakfast?
	Have you tried "dieting" by calorie restriction to lose weight multiple times?
	Do you exercise less than 30 min. 5 times per week?
	Do you exercise intensely more than 7 hours a week?
	Do you get enough sleep to feel rested in the AM?
	Do you use caffeine or other stimulants more than 2 times/week?
	Do you consume high sugar beverages and foods more than 2 times per week?

	BEHAVIORAL
	Do you have difficulty falling asleep?
	Do you have difficulty staying asleep?
	Do you have recurrent bad dreams?
	Do you have difficulty concentrating?
	Is your memory poor?
	Do strange people or places make you afraid?
	Are you scared to be alone?
	Do you always need someone to advise you?
	Are you afraid to eat anywhere except at home?
	Are you unhappy when others are happy?
	Are you usually unhappy and depressed?
	Do you often cry?
	Are you frequently miserable or blue?
	Do you sometimes wish you were dead and away from it all?
	Are your feelings easily hurt?
	Does criticism always upset you?
	Do people usually misunderstand you?
	Do you have to be on guard even with your friends?
	Do people often annoy you?
	Are you easily angered?
	Do you frequently become scared for no reason?
	Do you feel you are under considerable emotional stress?
	Have you experienced a job change, home relocation, or change in marital status in the last 18 months?

	LIFESTYLE
	Do you live in a new home or residence (less than 5 years old)?
	Has your residence been remodeled within the last 18 months (carpet, paint, drywall)?
	Have you been exposed to pesticides/pest control toxic chemicals?
	Do you have mold problems in your residence or workplace?
	Do you exercise for at least 30 minutes 5 times per week?
	Do you have 20 minutes of sunlight daily?
	Do you get 8 hours or more of sleep each night on average?
	Do you awake rested and renewed in the AM?
	Are you satisfied with your energy level?
	How long since you really felt good?
	Do you often rush when eating?
	Is your diet mostly: health food, fast food, typical American diet?
	Do you use a memory foam type mattress or pillow?
	What type of water filtration system do you use for drinking water?
	What type of water filtration for bath and shower?
	Do you use nonstick cookware?

TOXIC EXPOSURE HISTORY

Do you have a family history of sensitivity to chemicals, smoke or specific foods? YES NO
Do you have a personal history of sensitivity to chemicals, perfumes, fragrances, smoke or foods YES NO
Do you have a family or personal history of autoimmune disease (i.e., SLE, MS, RA, thyroiditis)? YES NO
Do you have a significant number of dental fillings? YES NO
Have you had synthetic materials put into your body (i.e., prosthetics, implants) YES NO
Are you taking multiple medications – over the counter or prescriptions? YES NO
Do you suffer from allergies or food sensitivities? YES NO
Do you have an autoimmune disease? YES NO
Do you suffer from low energy or excessive fatigue? YES NO
If you were immunized, did you have any reactions or problems associated with those? YES NO
Do you suffer from muscle pain of unknown origin? YES NO
Do you have poor concentration or excessive forgetfulness? YES NO
Do you tend to catch "every illness that comes along"? YES NO
Do you have Type 2 diabetes or Metabolic Syndrome? YES NO
Are you overweight even though you "watch your diet"? YES NO

ENVIRONMENT AND OCCUPATION
Do you smoke? YES NO
Do you work in the chemical, paint or dye industry? YES NO
Do you have routine exposure to air pollution? YES NO
Do you use soft plastic containers for food or water? YES NO
Are you exposed to household cleaning products on a routine basis? Yes NO
Do you use a pest control service? YES NO
Do you apply weed killer or bug sprays? YES NO
Do you apply termite chemicals? YES NO

DIET AND NUITRITION INTAKE
Do you routinely consume fast or packaged processed food? YES NO
Do you consume fish on a regular basis? YES NO
Do you regularly eat non-organic fruits and vegetables? YES NO
Do you consume a high animal product diet (i.e., meat, milk, cheese and eggs)? YES NO

TOTAL <u>YES</u> ANSWERS________________

THE FOLLOWING QUESTIONS HAVE TO DO WITH BRAIN STEM FUNCTION:

HIGH IML

Are you sensitive to light or have blurring vision? YES / NO

Have you experienced an increase in sweating? YES / NO

Do you have trouble sleeping, continuously waking up during the night or trouble getting to sleep?
YES / NO

Have you experienced an increase in pulse or heart rate, or experienced heart palpitations? YES / NO

Do you have a history of urinary tract infections? YES / NO

Have you experienced visual changes before migraine headaches? YES / NO

Do you have, or have you had bedsores or lesions? YES / NO

LOW IML

Do you fatigue easily? YES / NO

Do you have cold hands or feet? YES / NO

Do you experience frequent urination or are you unable to control urinary or bowel movements?
YES / NO

Do you have episodes of fainting or hypoxia? YES / NO

For the next several questions please answer briefly and give the dates each began to the best of your knowledge and if you can think of what contributed to it.

1. Any history of fainting/loss of consciousness?

2. Noticeable changes in your handwriting?

3. Changes in sexual function?

4. Are you more irritable or angry?

5. Episodes of depression or anxiety?

6. Problems with equilibrium, loss of balance, tripping, dropping things, etc?

7. Difficulty scanning pages while reading a book?

8. Difficulty adding or subtracting?

9. Difficulty moving your eyes? Or double vision?

10. Difficulty expressing what you would like to say?

11. Any changes in speech?

12. Any changes in sensation?

13. Any changes in memory?

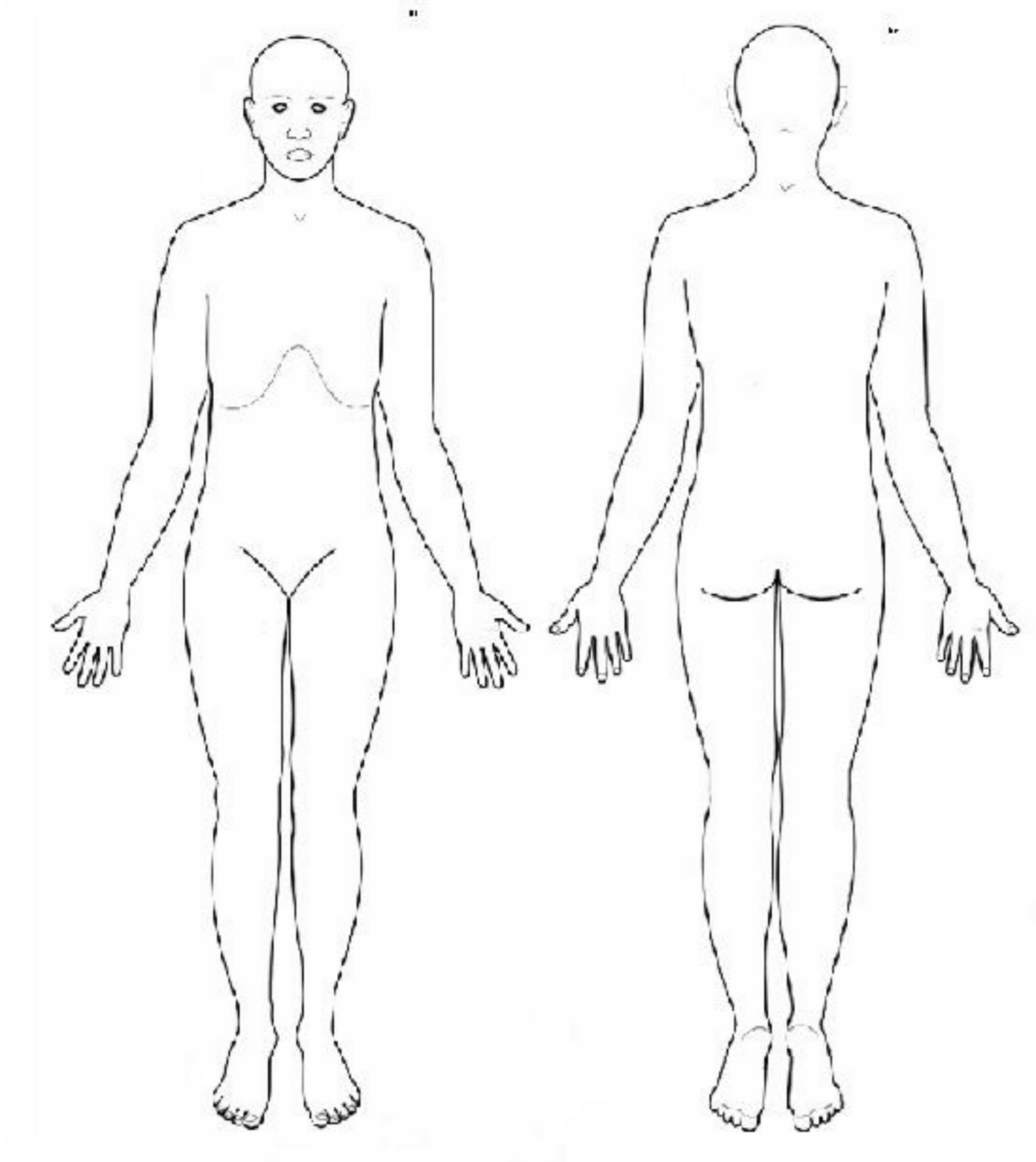
14. Any changes in hearing?

15. Excess dryness or wetness of the eyes or nose?

Scars and Burns

Scars have a profound effect on key acupuncture meridians (energy pathways) that are critical for organ function and health. When the flow of a meridian is interrupted by a scar, nerve supply and circulation above or below the scar and to all areas regulated by that meridian, will become weaker.

Please indicate any scars from surgeries or burns on the diagrams below.



What You Need to Know About Our Care Process

It is important to be part of your active care process for best results. This involves learning and adjusting your lifestyle to support your Chiropractic Natural Healing process.

Rather than treating your disease or condition, we utilize an Integrated Chiropractic approach to treat the Subluxation Complex which involves:

- Rebalancing your joint and muscle function to improve pain and function and decrease neurological stress.
- Rebalancing your nervous system and bioelectric/acupuncture system to power your healing process.
- Rebalancing body chemistry and function to supply what your body needs and decrease your total toxic stress load.
- Assisting you in creating a balanced, low stress LifeStyle that supports your high level energy, vitality, and wellness.

As a Chiropractic Physician, we take the extra time and energy to go beyond the diagnosis by asking "Why do you have your symptoms/conditions?"

We then recommend exams and testing to seek the causes of your symptoms so we can create a customized treatment process that fits your unique needs and to monitor the effectiveness of your care. We encourage each patient to be an active participant in deciding the level of exam/testing and treatment that fits your desires.

The treatment process we offer involves Spinal Manipulative Therapy (SMT), Physiotherapy, Acupuncture, Diet and LifeStyle recommendations, nutritional supplements including amino acids, vitamins, minerals herbs, homeopathics and other natural products.

This treatment process works synergistically to support and enhance your Integrated Chiropractic Natural Healing and Wellness process.

The treatment process we offer is goal oriented. We work to assist your enormous Natural Healing potential to maximize your energy, vitality, and high level Wellness. We establish measurable goals and then carefully monitor your progress so we can continually improve your treatment until you reach your desired goals.

We are committed to your best care results. If a referral for Dental, Medical or any other type of care makes sense, we will help you connect with other care providers who also offer exceptional care.

Our goal is to help you exceed your health goals and enjoy celebrating your progress together!

I have read this, my questions have been answered, and I wish to proceed.

Patient Name ____

Date: ____________________

Our Approach to Insurance

You pay a lot of money for your insurance. Your premiums are often outrageous and you expect your care should be paid by your insurance. You are told by your insurance company that all of your “medically necessary” care will be covered.

The reality is that health insurance is much like auto insurance – it only really covers when you have had a wreck. It does not cover oil changes, new tires, tune-ups, replacing worn parts, or renovating your car to run and look like a new car again.

Insurance is really only designed for accidents/catastrophes. The rise of the “Managed Care” tried to put a different face on things. Unfortunately, we are realizing this is much less about “You Getting What You Want” and much more about controlling your care choices and increasing their profits.

Insurance is also historically quite slow in accepting and paying for the newest advances in health care. Insurance tends to only pay for “average” or “accepted” care. This means that the advanced, LifeStyle Healing care you desire is not covered as you would expect.

We are also learning that “average” care does not work well for those with complex or chronic (ongoing) struggles with fatigue, degenerative diseases, pain, autoimmune diseases, and being unwell.

For your care in our Clinic, you are empowered to choose the level and cost of your care. Make your choices as if your insurance won’t be a factor so you don’t get “surprises” should the insurance deny or pay less than you had hoped. We supply the diagnosis and procedure code info to you on each visit so you can send it to your insurance provider and purse payment.

The most expensive care is the care that does not work – Especially in the long run.

APPOINTMENT CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

In the unfortunate event that you need to cancel your appointment, we request a phone call 24 hours in advance. Your phone call enables us to utilize our time more efficiently for our patients.

A fee of $50 will be charged for any additional missed appointments without a 24 hour notice…a message left on our 24 hour voice mail qualifies as notice.

Thank you for your understanding.

______________________________________ _______________

Patient Signature / Guardian Signature Date

Notice of Privacy Practices

This notice describes how private health
information about
you may be used and disclosed, and how you may access this information

Renovare Wellness By Design

Our Healthcare Practice takes patient privacy matters seriously. We work hard to always be respectful regarding the protection and privacy of your health records in our office. We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your rights concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it. You may request a copy of our Notice and at time, and may request additional copies, as needed, by contacted our office.

How We Disclosed Health Information

Specialist Referrals:

We use and disclose health information about you for treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to our immediate staff, and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as other doctors, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information to any outside Associates.

General Business Operations:

Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, conducting training programs, licensing, accreditation, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

Payment and Collection:

Your health information may be sent to third party payers to assist with your insurance collection. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment.

Family, Friends, Personal Representatives and Others:

We may disclose your health information to a family member, friend or other persons to the extent necessary to help with your healthcare or with payment of your healthcare. You may, however, request that we not disclose to anyone other than yourself, of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a supplement or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information that it is directly relevant to the person's involvement in your healthcare. We may disclose health information to others who may be involved in your health care and are trying to ascertain your general condition.

Marketing, Health-Related Services:
We will not use your health information for marketing communications without your written authorization. Under Federal Privacy Rules, we will send you update information about our practice, send you information regarding programs and products we offer to further enhance your care and treatment. We will never provide your name to an outside organization for marketing.

When the Law Requires Us to Disclose:
We may disclose your health information to government agencies or others, as required by law. Examples of this include, but are not limited to, law enforcement, required state agency reporting, and to military authorities for purposes such as national security.

Abuse and Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or are the victim of possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

PATIENT RIGHTS

Access to Records:
You have a right to look at copies of your health information. You may request photo copies and copies of x -rays. We will use the format you request, unless we are unable to practically do so. You must make your request access or health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photo copies, we will charge you a set amount for each page copied. Check with the office for the current fee schedule. If you request an alternate format, we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

Restrictions:
You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however, if we do agree, we will abide by our agreement, except in certain emergency situations.

Communications to You:
You may request we communicate with you about your health information by alternative means or alternative locations, when you make the request in writing. You must specify the alternative means or locations and provide satisfactory explanation how payments will be made under the alternative means or location.

Amendment of Your Records:

You have the right to request that we amend your health information when requested in writing. We may deny your request, however, we will note in your records your request to amend and reason. We cannot delete anything from the formal record, but we can add addendums to the record that may be able to meet your amendment request.

Protocol for Preservation of Patient Records

Pursuant to ARS 32-2310 and the requirements of the State of Arizona for the preservation of patient records, these documents is intended to inform all patients of Renovare Wellness By Design of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. Renovare Wellness By Design agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

Renovare Wellness By Design will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, Renovare Wellness By Design reserves the right to destroy your records. Should Renovare Wellness By Design exercise that right, Renovare Wellness By Design will first attempt to contact you and inform you of your right to obtain a copy of these records. Renovare Wellness By Design will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should Renovare Wellness by Design retire, cease to practice, or sell his practice to another health care professional, Renovare Clinic will notify all eligible patients, by regular mail, concerning the location of their records and how they request copies of those records. The required notice will be sent to each eligible patient’s last known address.

I do hereby acknowledge I have read and understand the doctor’s protocol for the preservation of patient records. I agree to inform Renovare Wellness By Design of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor’s office may comply with all statutory notification requirements to me by regular mail to my indicated address.

I have received a copy of this office’s Notice of Records Practices:

Print your name here: ____

Sign your name here: ____

Fill in today’s date here:_______________________

Directions to Renovare Wellness By Design

Our address is: Renovare Wellness By Design, 18969 N. 83rd Ave. Suite 1, Peoria, AZ 85382

Our phone is 623-776-0206 and our fax number is 623-776-0282.

Directions to the Clinic:

From the Freeway:
Exit Loop 101 and go west 1 block to 83rd Ave. and turn North. Take a right at the first stoplight North of Union Hills and turn into the parking area of Uncle Sam's.
Follow this north to the building with Paradise Picture Frame – we are Suite 1 of this building.

From Union Hills: Take Union Hills to 83rd Ave. and turn North (use Left lane). Take a right at the first stoplight North of Union Hills to turn into the parking area of Uncle Sam's. Follow this north to the building with Paradise Picture Frame – we are Suite 1 of this building.

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