Your Health Solutions

Functional & Lifestyle Medicine

Consent Form

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The Keys To My Success

To be successful with my program, I will commit to the following:

- ☐ I will comply and follow through with Your Health Solutions recommendations.
- ☐ I will modify my diet based on Your Health Solutions recommendations and my laboratory findings.
- ☐ I will take my prescribed nutritional supplements.
- ☐ I understand that I may be required to keep a record of my food intake.
- ☐ I understand that my lifestyle may be a contributing to my condition and I will make modifications within reason (e.g. work demands, sleep habits, relationships).
- ☐ I will do my best to reduce stress.
- ☐ I may be required to change my home and personal care products.
- ☐ I will engage in the exercise regimen prescribed by Your Health Solutions.
- ☐ I understand that I will need to have periodic lab tests to assess my progress.
- ☐ I will utilize all resources made available by Your Health Solutions to maximize my success.
- ☐ I will notify Your Health Solutions immediately if I have any concerns regarding my program.
- ☐ I realize that my condition may take longer than 6 months to correct.
- ☐ I realize that there may be times that I need to see a specialist in addition to Your Health Solutions.

Patient Name: _____Date: _____

Patient Signature: _____

Witness: _____

Important Patient Information

Appointments

- There is a 48-hour cancellation policy (please see cancellation policy in Practice Policies for Patients).
- It is your responsibility to keep the scheduled appointment or reschedule.

Lab Tests

- After your initial and follow-up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Some lab tests are performed "fasting", which means nothing except water 12 hours before your test.
- Some lab tests take up to 4 weeks to be finalized. The results will be given to you at your follow up. appointment or emailed to you when they are finalized. If your follow-up appointment was not booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.
- For most lab testing, you will pay the lab directly for all payments due.

Billing/Insurance

- Payment for the office visit, or phone consultation or lab tests is expected at time of service. We accept cash, check or credit cards. All credit card payments will be processed the same day of the visit or phone call.
- We do not accept insurance and we cannot assist you with claim resolution. We will provide you with a billing summary which you can submit to your insurance carrier.

Primary Care Physician

- Please note that Dr. Bryan W. Reid is not your primary care physician. We recommend that you have a primary care physician at home.

All Medicare Patients Must Sign This Form
(US Patients ONLY)

Notice Of Possible Medicare Denial

Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

Medicare Notice

Dr. Bryan W. Reid is not a Medicare providers; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent to Medicare by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

Patient Acknowledgement

My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Authorization For Release of Medical Records (US Patients ONLY)

Requesting records of Dr. _____
Address: _____
Telephone Number: _____ Fax Number: _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to: _____
all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent there to. In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ◯ Yes ◯ No

Communicable disease related information, including AIDS
or ARC diagnosis and/or HIT or HTLA-III test results or treatment: ◯ Yes ◯ No

Genetic Testing: ◯ Yes ◯ No

PLEASE NOTE: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release: _____
employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: _____ D.O.B. _____
Signature: _____ Date: _____

Records Requested by:
Doctor's Name: _____
Signature: _____

Please send Records to:

Your Health Solutions | 2805 North Center, Maryville, IL 62062

Phone: 618.855.8105

Informed consent regarding email or the internet use of protected personal information.

Your Health Solutions provides patients the opportunity to communicate with their physicians, health care providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

    a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
    b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their email.

2. It is the policy of Your Health Solutions that all e-mail messages sent or received which concern the diag-nosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Your Health Solutions will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Your Health Solutions physicians, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
    b. Your Health Solutions may forward e-mail messages within the practice as necessary for diagnosis and treatment. Your Health Solutions will not, however, forward the email outside the practice without the consent of the patient as required by law.
    c. Your Health Solutions will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
    d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
    e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.

f. Your Health Solutions cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Your Health Solutions is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform Your Health Solutions of any types of information you do not want to be sent by e-mail.

h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from Your Health Solutions to protect confidentiality. Your Health Solutions is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Your Health Solutions.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail.

I agree to assume all risks associated with the use of e-mail.

Privacy Policy

Under the Personal Health Information Protection Act, 2004 (PHIPA), you have the right to consent, or to withhold your consent, to the collection, use and disclosure of your personal health information, except in specific circumstances where the law authorizes Your Health Solutions to collect, use or disclose your information without consent.

Your Health Solutions collects your personal health information directly from you, from a person acting on your behalf, and from others such as healthcare providers. Your Health Solutions will not collect more personal health information than is reasonably necessary to meet its purposes.

Your Health Solutions uses personal health information to:

- To assess your health needs and provide safe and efficient care
- Plan a strategy to address your concerns
- To enable us to contact and maintain communication with you to distribute health care information and to book and confirm appointments
- To communicate with other treating health care providers, including other dentists, physicians, pharmacists and lab technician (with your consent and if required)

Our office will ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols
- We do not share your information with any government or insurance agency

Functional Medicine - Informed Consent

Care Program

Functional Medicine involves the recommendation of lifestyle, dietary and supplement changes and additions based on my history and functional medicine test findings. Functional medicine uses the most recent research to assess the body as a whole emphasizing the relationship between your body and your internal and external environment.

The relationship between the client and functional medicine provider includes mentorship and guidance towards achieving a healthy balance within the body. I understand that no diagnoses are made and no treatment for a pre-existing diagnosis will be rendered. Functional medicine addresses the underlying pathophysiology that may be contributing to these prior diagnoses.

Testing

Functional lab testing involves the evaluation of nutritional, biochemical and physiological imbalances. It is important to remember that these lab tests are not intended to diagnose a disease. The testing will help make the appropriate recommendations. This testing is not intended to replace the testing provided by your medical physician.

Recommendations

All recommendations are meant to be in the patient's best interest and I acknowledge that the doctor may not be able to anticipate all risks and complications. I will keep my doctor fully informed about any changes in medication, supplements, diet, and any other pertinent information.

Consent

I acknowledge that I have discussed, or have had the opportunity to discuss, with my functional medicine provider the nature and purpose of the consultations and the contents of this Consent Form. I agree to accept the care program on my own free will and I have read the consent form in its entirety. I provide consent for functional medicine care for the duration of this program and any future consultations required.

Patient Name: _____ Date: _____

Patient Signature: _____

Witness: _____

SUBMIT