

Springfield Wellness Center™

Originator & Producer of  Brain Restoration Plus™

Patient Evaluation

Springfield Wellness Center

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Welcome and Thank You for choosing Springfield Wellness Center

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Patient Information Sheet

Patient's Name: _____ Marital Status: _____

Street Address/ Apt. #: _____

City/State/Zip: _____

Employer: _____

Home Phone Number: _____ Work Phone: _____

Cell Phone Number: _____ Driver's Lic #: _____

Social Security Number: _____ Date of Birth: _____

E-mail Address: _____

Spouse/Guardian: _____ Phone Number: _____

Address/City/State: _____

Social Security Number: _____

Relative/Friend Not Living with you:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____

We require PAYMENT IN FULL prior to treatment. Payment must be received before treatment can begin. We are a fee for service facility. We do not accept payments from insurance companies or file insurance claims. We will provide the necessary documentation in order for you to file or we can refer you to the claims specialist.

Each treatment protocol is individualized. Product orders are made for each individual. **We are not able to provide refunds.**

Are you interested in speaking to an insurance claims Specialist? YES ___ NO ___

I will NOT be filing claims with my insurance company. YES ___ NO ___

I will be filing insurance claims myself. YES ___ NO ___

I have read and understand the Payment Policy and agree to make payment in full prior to treatment.

Signature of patient: _____ Date: ____/____/____

Spouse / Guardian signature: _____ Date: ____/____/____

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NOTICE OF PRIVACY PRACTICES SPRINGFIELD WELLNESS CENTER

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide for you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law for lawful processes. We will use disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

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Public Health Responsibility: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters. In addition, we may contact you to inform you of health screenings, wellness events or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you about seminars or programs that we are providing.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1.00 per page for the first 25 pages and .25 cents per page for 26 and up. If you want the copies mailed to you, postage will be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore, these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. Disclosures prior to April 14, 2003 do not have to be made available.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except emergencies.) This request must be submitted in writing. We can provide you with the following forms to make such requests:

- A. Request to review health care information
- B. Request to amend health care information
- C. List of non-routine disclosures
- D. Complaint form
- E. Authorization for disclosure of protected health information

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QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. (Request a complaint form.) We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Springfield Wellness Center
32900 Pitcher Road, Springfield, LA 70462
Office: 225.294.5955 Fax: 225.294.5944
springfieldwellnesscenter@gmail.com

Print Patient Name: _____

Signature: _____ Date: ____/____/____

HIPAA Notice of Privacy Practices

This form does not constitute legal advice.

ADDENDUM TO HIPPA NOTICE OF PRIVACY PRACTICES

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I hereby consent to release information related to my care and treatment at Springfield Wellness center to the following individuals:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

Print Patient Name: _____

Signature: _____ Date: ____/____/____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____
- Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by patient in writing.

Messages

Please call: my home my work my cell number: _____

If unable to reach me:

- you may leave a detailed message
- please leave a message asking me to return your call
- You may text or e-mail by phone

The best time to reach me is (day) _____ between (time) _____

Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

Medical History

Name: _____ Date of Birth: ____/____/____ Gender: _____

All Current Medication: (Please include dosage / frequency)

Allergies: _____

Are you currently under the care of a Primary Physician? [] Yes [] No

Primary Physician:

Name: _____

Address: _____

Phone number: _____

Check all that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Hepatitis/Liver disease |
| <input type="checkbox"/> Respiratory Disease/COPD | <input type="checkbox"/> Seizures/Fainting Spells | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stomach ulcers/Acid reflux | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> AIDS or HIV infection |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune System Problems |
| <input type="checkbox"/> Alcohol Dependent | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Asthma/Chronic Bronchitis |
| <input type="checkbox"/> Do you think you may be pregnant? | | |

Signature: _____ Date: ____/____/____

Chemical Use History

CHEMICAL TYPE	AGE AT START	AGE OF REGULAR USE	DESCRIBE PATTERN (frequency, duration, amounts, type, method of use)	LAST USE
ALCOHOL Beer, Wine, Liquor				
COCAINE/CRACK				
CANNABINOIDS Marijuana, Pot, Hashish				
AMPHETAMINES Crystal meth, Crank, Speed, Ice, Diet Pills, Benzedrine, Dexedrine, Ritalin, Adderall, Methedrine, Vyvance				
HALLUCINOGENS STP, PCP, LSD, Mescaline, Mushrooms, Ayahuasca, Peyote, Acid, Ketamine, Ecstasy				
CAFFINE Soda, Tea, Coffee				
NICOTINE Tobacco, Dip				
SEDATIVES Downer, Quaaludes, GHB				
SLEEPING PILLS Seconal, Ambien, Dalmane, Restoril, Halcion				
TRANQUILIZERS Mellaril, Thorazine, Haldol				
BENZODIAZEPINES Valium, Librium, Xanax, Ativan, Tranxene, Klonopin, Serax				
OPIATES Heroin, Demerol, Codeine, Methadone, Morphine, Dilaudid, Percodan, Lortab, Opium, Percocet, Oxycontin, Soma, Ultram, Vicodin, Hydrocodone, Kratom				
INHALANTS Gasoline, Glue, Freon				
OTHER				

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Psychiatric Treatment

Signature: _____ Date: ____/____/____

Have you been/or currently being treated by a Psychiatrist? Yes No

If yes, please explain:

Psychiatrist:

Name: _____

Address: _____

Phone number: _____

Please list any past Psychiatric treatment. (Including drug rehabilitation center) Location and dates of treatment.

What is the primary reason for you seeking treatment today? _____

Self-Rating Depression Scale

Name: _____ Date: ____/____/____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-7

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Checklist of Concerns

Signature: _____ Date: ____/____/____

Please mark all items that apply. Feel free to add any others in the space provided. Content IS STRICTLY CONFIDENTIAL PATIENT MEDICAL RECORD. Law expressly prohibits the disclosure and/or transfer of protected patient information.

- | | |
|--|--|
| <input type="checkbox"/> I have no problem or concern bringing me here | <input type="checkbox"/> Irresponsibility |
| <input type="checkbox"/> Abuse: physical, sexual, neglect of self / others, cruelty to animals | <input type="checkbox"/> Judgment problems / risk taking |
| <input type="checkbox"/> Alcohol use / abuse | <input type="checkbox"/> Legal matters / charges / jail / lawsuits |
| <input type="checkbox"/> Anxiety / Nervousness | <input type="checkbox"/> Living arrangement change / conditions |
| <input type="checkbox"/> Attention, concentration, distractibility | <input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs |
| <input type="checkbox"/> Career concerns, goals, occupation choices | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Childbirth difficulties / miscarriage / abortion | <input type="checkbox"/> Menstrual problems / PMS / Menopause |
| <input type="checkbox"/> Childhood Issues (your own) / Abuse / Neglect | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Children: abuse, management, care, custody | <input type="checkbox"/> Obsessions (repetitive thoughts) / Compulsions (repetitive actions) |
| <input type="checkbox"/> Codependence / Dependence: _____ | <input type="checkbox"/> Pain: physical / emotional |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Panic or anxiety attacks |
| <input type="checkbox"/> Delusions (false ideas) / Paranoia | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Pessimism |
| <input type="checkbox"/> Divorce, separation, remarriage, death of spouse | <input type="checkbox"/> Physical limitations and/or problems |
| <input type="checkbox"/> Decision making, indecision, mixed feelings, procrastination | <input type="checkbox"/> Process addictions: gambling, shopping, eating, other _____ |
| <input type="checkbox"/> Drug use / abuse: prescription meds, over-the-counter, street drugs | <input type="checkbox"/> Religious conflicts / Spiritual conflicts |
| <input type="checkbox"/> Eating problems: overeating, undereating, appetite, vomiting | <input type="checkbox"/> Self-centeredness |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Self-esteem / Feelings of Inferiority |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Self-neglect / Poor self-care |
| <input type="checkbox"/> Family of origin conflict / in-laws / launching | <input type="checkbox"/> Sexual issues, addiction, dysfunction, conflict, confusion |
| <input type="checkbox"/> Fatigue, tiredness, low energy, lack of motivation | <input type="checkbox"/> Shyness, over sensitivity to criticism and/or rejection |
| <input type="checkbox"/> Fears / phobias | <input type="checkbox"/> Sleep Issues: too much, too little, insomnia, nightmares |
| <input type="checkbox"/> Financial or money trouble, debt, impulsive spending | <input type="checkbox"/> Smoking / e-cig / tobacco use |
| <input type="checkbox"/> Friendships (trouble / lack of) | <input type="checkbox"/> Social problems / loneliness / isolation |
| <input type="checkbox"/> Grieving / mourning / deaths / losses | <input type="checkbox"/> Stress / relaxation / stress mngmt / stress disorder / stress tension |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Suicidal thoughts / previous suicidal attempts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Temper Issues: self-control, anger, irritability, hostility, violence |
| <input type="checkbox"/> Health / illness / medical concerns | <input type="checkbox"/> Weight loss / diet issues |
| <input type="checkbox"/> Inner conflicts | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Impulsiveness / loss of control / outbursts | <input type="checkbox"/> Other _____ |

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NAD Brain Restoration Plus™

Payment Policies

For services rendered, our practice accepts the following means of payment:

1. Cash, Check or Credit Card
2. Major credit cards: Visa, MasterCard, Discover, American Express

Fees for services are as follows: BR+ Treatment fees:

10 day detox	\$13,500.00
10 day detox with bridge device	\$14,500.00
4 — 6 day stress	\$ 1,350.00 per day
Relapse Treatment	\$ 1,250.00 per day
Maintenance Booster	\$ 850.00 per day

Additional Charges:

Staff Overtime: There will be additional charges for nursing overtime and late arrivals. We start at 8:00 AM, please be on time.

Consultation time: Includes phone, e-mail, and other electronic consultation (i.e. Skype, Text) minimum 1/4 hour

Tyson Olds, M.D. \$175 per hour

Arlene Magee, PhD, LPC-S, NCC \$150 per hour

We are a fee for service facility. **Payment is expected at the time services are rendered.**

I agree to pay any remaining balance and any invoices for additional treatment, consultations, or supplements.

We do not accept payments from insurance companies or file insurance claims. We will provide the necessary documentation in order for you to file or we can refer you to a claim's specialist. The claims specialist charges a fee for this service.

Each treatment protocol is individualized. Product orders are made for each individual. We are not able to provide refunds.

I have read and understand the Payment Policy.

Signature: _____ **Date:** ____/____/____

Individual Responsible for Payment:

Signature: _____ **Date:** ____/____/____