

Ageless Integrative Medicine & Laser Skin Care
Holistic Nursing Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Even if some questions seem unrelated to your current condition, please answer this questionnaire as thoroughly as possible. Please print clearly, and mark any areas of confusion with a question mark. Thank you.

All information is strictly confidential.

Name _____ Date ____/____/____

Date of Birth ____/____/____ Place of Birth _____ Age _____

Address _____ Sex M / F / FTM / MTF / O

City _____ State _____ Zip _____

Home Phone Number (_____) _____ - _____ Cell Phone Number (_____) _____ - _____

Email Address _____ Relationship status _____

Would you like email reminders?

Would you like text message reminders?

Preferred method of communication? Email Mail Home Phone Mobile Phone

Emergency Contact Person _____

Emergency Contact Phone Number(s) (_____) _____ - _____ or (_____) _____ - _____

Primary Care Provider _____

Approx. Date of Last Visit _____ Physician's Office Phone Number (_____) _____ - _____

I would like you to send chart notes to my primary care provider _____ (sign here)

How did you hear about Ageless Integrative Medicine? _____

Have you ever had integrated medicine treatment before? _____

What is the main reason for your appointment today? _____

How long have you been experiencing this problem? _____

What makes this condition worse? _____

What makes this condition better? _____

What other treatments have you tried for this condition? _____

What would you like to achieve from coming here?

1.

2.

3.

Please list any other health concerns in order of importance:

1.

2.

3.

Medical History

Height: _____ft. _____in. **Weight:** _____ **Cholesterol:** _____

Blood Pressure: Most recent reading _____/_____ When was this taken? _____

Please answer the following questions:

Yes / No I have a pacemaker

Yes / No I am currently being treated with blood thinners or anti-clotting medications

Yes / No I am prone to excessive bleeding and/or poor wound healing

Yes / No I have a medical condition that may cause my liver, spleen, heart or lungs to be enlarged

Childhood Illness (please check all you have had):

Scarlet Fever

Mumps

German Measles

Rheumatic Fever

Measles

Chicken Pox

Immunizations (please check all you have had):

Polio

Measles/Mumps/Rubella

HPV (Cervical Cancer)

Tetanus

Diphtheria

Varicella (Chicken Pox)

Pertussis

Hepatitis B

Influenza (Flu)

Have you been diagnosed with any of these conditions? Check all that apply.

AIDS/HIV

Endocrine Disorder

Lyme's Disease

Alcoholism

Epilepsy

Multiple Sclerosis

Arterial disease

Fibromyalgia

Polio

Asthma

Gout

Rheumatic Fever

Birth trauma

Heart Disease

Scarlet Fever

Cancer

Hepatitis A / B / C

Seasonal Allergies

Diabetes

Herpes

Seizures

Drug Addiction

High blood pressure

Tuberculosis

Emphysema

Joint Replacement(s)

Thyroid Disorder

Have you suffered any major traumas, physical or emotional? ____ If yes, please describe:

Hospitalizations and Surgeries

Reason

Date

Reason

Date

Please list any known allergies (environmental, latex, food, medications, stings, etc.)

Allergen

Reaction

Allergen

Reaction

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List your current Medications, Vitamins & Supplements: (use the back of page if needed)

Medication/ Supplement	Dosage	For what purpose/condition?

Family Health History: Check all that apply to your Mother, Father, Siblings and Children:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Drug Abuse/ Alcoholism | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cholesterol, Elevated | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | |

Energy & Sleep

How is your energy? _____ Do you fatigue easily? _____
 When is your energy highest? _____ Lowest? _____
 How long do you normally sleep? _____ hours per night. Do you wake feeling rested? _____
 Do you have difficulties with any of the following (check all that apply):
 Falling asleep Dream disturbed sleep Restless leg
 Staying asleep Snoring Mind racing at night
 Do you wake at a certain time of night? _____ If yes, when? _____

Emotions & Stress

Depression Over-thinking Poor concentration Anxiety Nervousness
 Fear Panic attacks Poor memory Irritable Short temper
 How do you hold stress? _____
 How do you relax? _____
 What is your occupation? _____
 How do you feel about your work? _____
 What kind of exercise do you do? _____ How often? _____

Eating Habits: Please describe your current eating habits:

- | | | |
|--|---|--|
| <input type="checkbox"/> Low-carbohydrate diet | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Eat a lot of fried food |
| <input type="checkbox"/> Low-fat diet | <input type="checkbox"/> Eat a lot of dairy | <input type="checkbox"/> Eat a lot of red meat |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Eat a lot of carbohydrates | <input type="checkbox"/> Eat a lot of sweets |
- Do you place any restrictions on your diet? _____ If yes, please explain _____

How do you perceive your current weight? Underweight/ Normal/ Slightly overweight/ Overweight

Tobacco/ Alcohol Use

- | | |
|---|---|
| <input type="checkbox"/> Smoke tobacco, # of packs per day: _____ | <input type="checkbox"/> Quit smoking _____ months/years ago |
| <input type="checkbox"/> Drink alcohol, # of drinks per week: _____ | <input type="checkbox"/> Quit drinking _____ months/years ago |

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Please write "C" next to symptoms you currently experience, and "P" next to symptoms you have experienced in the past year.

General

- Prefer cold drinks
- Prefer hot drinks
- Recent weight loss or gain
- Cold hands & feet
- Chills
- Fever or sensation of heat
- Frequent colds

Head & Neck

- Headaches/ Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Frequent Ear Infections
- Earache

Eyes

- Glasses/ contacts
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth / tongue ulcers
- Nosebleed
- Dry nose/ mouth/ throat
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems

Skin & Hair

- Hives / rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Skin texture changes
- Easy bruising
- Mole/ lump changes
- Itching
- Dry hair
- Hair loss
- Change in hair color
- Hair texture changes

Respiratory

- Shortness of breath
- Tight chest
- Asthma / wheezing
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain / tightness
- Palpitations
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas

- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Reduced range of motion

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination

Urinary

- Painful urination
- Frequent urination
- Urgent urination
- Incomplete urination
- Decreased urine flow
- Blood in urine
- Unable to hold urine
- Wake to urinate
- Kidney stones
- Lower abdominal pain

Male Reproductive

- Increased / decreased libido
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain of genitalia
- Genital itching
- Testicular pain / swelling
- Lumps in testicle(s)

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OB/GYN History

Date of last period: ___/___/___ Avg. duration of flow: _____ Avg. length of cycle: _____

Age at first menses: _____ Number of pregnancies: _____ Number of abortions: _____

Age at menopause: _____ Number of live births: _____ Number of miscarriages: _____

Do you use birth control? Y / N If yes, please describe: _____

Do you have any reason to suspect that you might be pregnant? Y / N

Are you currently trying to become pregnant? Y / N

Have you ever had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> IUD or Hormone IUD | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Cervical cancer |
| <input type="checkbox"/> Ectopic pregnancy | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Uterine cancer |

Please write "C" next to symptoms you currently experience, and "P" next to symptoms you have experienced in the past year.

- | | | |
|------------------------------|------------------------------|------------------------------|
| ___ Decreased libido | ___ Breast lumps | ___ Bleeding between cycles |
| ___ Increased libido | ___ Breast tenderness | ___ Blood clots |
| ___ PMS | ___ Excess vaginal discharge | ___ Heavy bleeding (weeks) |
| ___ Pain before menstruation | ___ Vaginal odor | ___ Pain during intercourse |
| ___ Pain during menstruation | ___ Vaginal sores | ___ Bleeding after menopause |
| ___ Pain after menstruation | ___ Vaginal dryness | ___ Hot flashes |
| ___ Bone density changes | ___ Vaginal itching | |
| ___ Fibrocystic breasts | ___ Vaginal pain | |

Do you experience any of the following pre-menstrual symptoms?

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Suicidal feelings |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Water retention | <input type="checkbox"/> Other emotions? _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dull pain, where? _____ |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Depression | <input type="checkbox"/> Sharp pain, where? _____ |

Medical Screening:

Most recent pap smear: ___/___/___ What was the result? Normal / Abnormal

Most recent mammogram: ___/___/___ What was the result? Normal / Abnormal

Hormone Replacement Therapy

Are you currently using Hormone Replacement Therapy? Y / N

Type/ Dose: _____ How long have you been on HRT? _____

Any side effects? _____

Office Policies & Procedures

1. General Consent for Treatment

I hereby voluntarily consent to receive medical evaluation and treatment by the licensed providers at Ageless Integrative Medicine and Laser Skin Care. I understand that this clinic provides both conventional medical services and integrative therapies, which may include, but are not limited to:

- ***Physical examination and lab work***
- ***Prescription medications, some of which may be used “off-label,” for indications that have not been studied or approved by the FDA.***
- ***Lifestyle, nutrition, and supplement counseling***
- ***Herbal medicine from various traditions***
- ***Myofascial release, reflexology, craniosacral therapy, Dry needling and trigger point therapy***
- ***IV nutritional therapy and injections***
- ***Bioidentical hormone therapy***
- ***Aesthetic services such as laser treatment, Botox, and dermal fillers***

I acknowledge that I may refuse or withdraw consent to any specific treatment at any time.

2. Informed Consent for Integrative and Complementary Therapies

I understand that some of the therapies provided at Ageless Integrative Medicine fall outside the scope of conventional Western medicine. These may include herbal remedies, nutritional therapies, and body-based treatments with historical or traditional use but limited scientific validation. Herbs, supplements and other holistic medicine tools are often not FDA approved. They are not intended to diagnose, treat, prevent or cure disease. They support the structure and function of the body. I understand that:

- ***Herbal and supplement therapies may carry the risk of allergic reaction, interaction with prescription drugs, or other unexpected effects.***
- ***IV therapy may include risks such as vein irritation, bruising, or infection.***
- ***Dry needling or trigger point therapy may cause soreness, bruising, or temporary discomfort. Rarely serious side-effects such as lung injury may occur.***
- ***Complementary therapies are not guaranteed to result in improvement and should not replace emergency or specialized medical care.***

I agree to disclose all medications, diagnoses, and therapies I am receiving to help prevent contraindications.

3. Consent for Aesthetic and Laser Procedures

(If applicable to patient visit)

I understand that aesthetic services offered may include laser therapy, photorejuvenation, spider vein treatment, Pellevé radiofrequency therapy, Botox, dermal fillers, and microneedling.

These procedures may carry risks such as redness, swelling, bruising, infection, burns, pigmentation changes, allergic reaction, and dissatisfaction with cosmetic results. Results are not guaranteed.

I acknowledge that:

- Pre- and post-treatment instructions will be provided and must be followed.***
 - Follow-up visits may be necessary.***
 - I must disclose any health conditions or medications.***
 - Sun exposure may not be compatible with treatment. I agree that I have not had enough sun exposure to turn skin pink or darken skin in the last two weeks nor will I have sun exposure for two weeks after my treatment. I will use sunscreen (SPF 30 or more) for two weeks after my treatment. Failure to follow these guidelines may result in blistering or hyperpigmentation.***
-

4. Communication and Confidentiality Policy

Ageless Integrative Medicine complies with the Health Insurance Portability and Accountability Act (HIPAA) and takes all reasonable steps to protect your private health information.

I acknowledge the following:

- Secure Communication: The patient portal and phone communication are HIPAA compliant.***
- Non-Secure Communication: Email and text messaging are not secure methods under HIPAA standards. Email should not be used for urgent communications. A more secure, HIPAA compliant option is to use the patient portal. Seth is the only one who checks messages from the patient portal. Messages are typically checked on it twice a day, even on the weekends. Urgent messages should be left by phone by calling (423) 952-5300. If you have an emergency after hours, call 911 or go to the Urgent Care or Emergency Room.***

4a. Consent to Communicate via Email or Text

YES, I authorize Ageless Integrative Medicine to communicate with me by email or text message, understanding that:

- **These are not HIPAA-compliant communication methods.**
- **There is a risk that my protected health information (PHI) could be intercepted or disclosed.**
- **Email and text messages may include appointment reminders, educational materials, or non-sensitive follow-up information, and may include detailed diagnostic or treatment data if I request or approve it.**

NO, I do not authorize the use of email or text messaging for communication.

I understand that I can revoke this consent at any time in writing.

5. Financial Policy and Payment Responsibility

I understand and agree to the following:

- **Payment is due at the time of service. While we do not offer financing, we do take Care Credit or Alle Payment Plans which may independently finance medical expenses.**
 - **Ageless Integrative Medicine does not bill insurance and is considered an out-of-network provider.**
 - **A superbill may be provided for submission to my insurance company, but reimbursement is not guaranteed.**
 - **Services rendered, including lab fees or supplement costs, are my financial responsibility.**
-

6. Consent for Laboratory and Diagnostic Testing

I authorize Ageless Integrative Medicine to order and interpret diagnostic tests, including bloodwork, hormone panels, nutritional assessments, and imaging studies. I understand that:

- **Some tests may be performed by third-party laboratories.**
 - **I am responsible for any charges billed directly to me by outside labs.**
 - **It is my responsibility to follow up on testing results and schedule review appointments.**
-

7. Telehealth Consent

Applicable to patients residing in Tennessee and Virginia

Definition of Telehealth

Telehealth (also known as telemedicine) involves the use of electronic communications to enable health care providers at different locations to evaluate, diagnose, treat, and educate patients using interactive audio, video, and/or data communications. This may include but is not limited to:

- ***Video conferencing***
- ***Phone consultations***
- ***Secure messaging***
- ***Transmission of images, health records, or lab data***

Services delivered via telehealth may include:

- ***Medical consultations and follow-up care***
- ***Lifestyle and nutrition counseling***
- ***Prescription management***
- ***Integrative medicine guidance***
- ***Mental health support***
- ***Functional medicine and hormone consultations***

If my condition requires it, my provider may request that I get a physical examination in this office or by another provider in my area.

This consent complies with telehealth regulations in:

- ***Tennessee, pursuant to Tenn. Code Ann. § 63-1-155 and related regulations.***
- ***Virginia, under Va. Code § 38.2-3418.16 and § 54.1-3303 and related provisions.***

Both states permit licensed providers to deliver care via telehealth provided that the standard of care is equivalent to an in-person visit and informed consent is obtained.

Patient Rights and Responsibilities

- **Voluntary Participation:** *I understand that I may choose not to participate in telehealth services or may withdraw consent at any time without affecting my access to future care or services.*
 - **Right to Refuse:** *I may refuse any specific telehealth treatment, exam, or service and request an in-person alternative where available.*
 - **Provider Licensure:** *I confirm that I am physically located in a state (Tennessee or Virginia) where the provider is licensed to practice during the time of the telehealth encounter.*
 - **Documentation:** *I have the right to access a copy of my medical records from telehealth encounters, subject to applicable law.*
-

Risks and Limitations of Telehealth

I understand that:

- **Telehealth services rely on technology, which may fail, be disrupted, or result in incomplete transmission of information.**
 - **There may be limitations in assessment or diagnosis due to the lack of a physical examination.**
 - **My provider may determine that a telehealth visit is not appropriate for my condition and may recommend in-person care or referral.**
 - **Emergencies or urgent conditions are not appropriate for telehealth. I agree to call 911 or go to the nearest emergency department in the event of a medical emergency.**
-

Confidentiality and Security

- **All telehealth communication complies with HIPAA privacy and security requirements.**
 - **While reasonable security measures will be taken, there is a risk that unauthorized persons could gain access to the electronic information shared.**
 - **I agree to take appropriate precautions on my end, including using a secure internet connection and private environment for appointments.**
-

Billing, Fees, and Insurance

- **I understand that I am responsible for any fees associated with the telehealth visit.**

- *Telehealth services may or may not be covered by my insurance plan. It is my responsibility to verify coverage.*
 - *I understand that I may be responsible for full payment at the time of service unless otherwise arranged.*
-

Consent to Telehealth

By signing this form, I confirm that:

- *I have read and understand the information provided above regarding telehealth.*
- *I understand the potential risks and benefits of receiving care via telehealth.*
- *I consent to participate in telehealth services offered by Ageless Integrative Medicine and Laser Skin Care.*
- *I acknowledge that I must be physically present in Tennessee or Virginia at the appointment time.*

8. Notice of Privacy Practices (HIPAA Acknowledgement)

I acknowledge that I have received or been offered a copy of Ageless Integrative Medicine's Notice of Privacy Practices, which describes how my health information may be used or disclosed and how I can access it.

Patient Initials: _____

9. Photography Consent

(for documentation or aesthetic care)

- I consent to the use of photographs for medical documentation.*
 - I consent to the use of de-identified images for educational or marketing purposes.*
 - I decline all photography.*
-

10. Patient Responsibilities

I understand that I am responsible for:

- *Providing accurate and complete health information.*

- ***Disclosing any changes in health, medications, or treatments from other providers.***
 - ***Following care plans as advised and seeking clarification when needed.***
 - ***Alerting my provider if I experience worsening symptoms, side effects, or concerns.***
 - ***It is my responsibility to request records from all previous providers for the last two years and any other providers before that who have important records. These can be faxed to (423) 402-8557.***
-

11. Cancellation Policy

We understand that life is complex and issues may arise without warning. For this reason, we give everyone a free pass the first time they are late, no-show, or cancel with less than 24 hours notice. After the first time, we will remind you of the policy and ensure you have signed the policy. After the second time, all appointments must have a non-refundable deposit paid as described below:

No-show, Late Arrival or Late Cancellation

Late Cancellation – If you cancel or reschedule your appointment with less than 24 business hours notice, you agree to forfeit your \$50 prepaid appointment fee. This fee will not be refunded or applied to a future visit.

No-Show – If you fail to arrive for your scheduled appointment and do not notify us in advance, this will be considered a “no show.” You agree to forfeit your \$50 prepaid appointment fee. This fee will not be refunded or applied to a future visit.

Late Arrival – If you arrive 15 minutes or more after your scheduled appointment time, your appointment will be cancelled and considered a no-show. You agree to forfeit your \$50 prepaid appointment fee. This fee will not be refunded or applied to a future visit.

12. Consent to Treatment and Acknowledgment of Policies

The information that I have given to Ageless Integrative Medicine & Laser Skin Care is complete and true to the best of my knowledge. I authorize the providers and staff to administer such procedures as they deem necessary and that I find agreeable. I understand that Ageless Integrative Medicine & Laser Skin Care implies no guarantees of cure, that I have the right to choose my treatment plan, and that I may refuse any or all treatment suggestions at any time. I acknowledge that I have been given no guarantees or warranties, expressed or implied, regarding the outcome of procedures or care. I acknowledge that I have not been asked to discontinue care given to me by my primary care provider or specialists. I understand that our care including Holistic Nursing care employs techniques commonly used among integrative medicine practitioners but are not considered mainstream among conventional physicians. I have read the policies and procedures and agree to abide by them. In the event that any dispute shall arise, I agree that, if asked, I will submit information about that dispute in writing for clarity. I further agree to participate in mediation under the laws of the state of Tennessee. Both parties shall share equally in any associated costs of mediation. Mediation involves each

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party to a dispute sitting down with an impartial person, the mediator, to attempt to reach a voluntary settlement. I have read and understood the policies set forth above and do agree to them.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

If Minor: Parent/Guardian Name: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____

Date: _____

Before your first appointment

Contact your health care professionals to get copies of your recent medical records, including laboratory assessments. Of course, Seth McLaughlin may order additional lab work, if needed. Drop your records off at least one week before your appointment to give Seth time to review them. It's helpful to have a journal of your activities, foods, sleep record, nutritional supplements, medications, and how you felt for three days (two weekdays, 1 weekend day). Fax (423) 402-8557

On the day of your appointment

You can expect to have some of the same evaluations you are used to and some new ones as well. We strive to start your appointment within 15 minutes of your appointment time. To keep us on time, we ask that you arrive before your appointment time. Please have all paperwork filled out by the time your appointment is set to start. Please bring a prioritized list of issues you'd like to address. Seth typically types out notes regarding your concerns and provides you a detailed copy of your encounter by mail or email within a week after your appointment.

Insurance

We are happy to provide you with documentation you may need to file for insurance reimbursement of your visit. Your visit would typically fall into your out of network coverage. Although we are happy to help you with insurance requests, we do not participate in any insurance plans or file insurance at this time. For letters of medical necessity or complex forms, a form generation fee will be charged.

Fees

A new patient evaluation is typically 1 – 1 & ½ hours in length and costs \$200, regardless of length of the appointment. Subsequent appointments are billed in 15-30 minutes at \$70 for the first 30 minutes with additional increments at \$50/ 15 min increment. Your first follow up appointment will typically be 15-30 minutes. Medications administered during your appointment represent additional cost. Fees may be paid by cash, check, Visa, MasterCard, American Express, Discover Card, or Care Credit. Returned checks will be charged the maximum fee allowed by law.

Lab Testing and Prescriptions

Lab testing is typically billed by the performing lab and may be filed to your insurance through them. Prescriptions are typically billed through your pharmacy and may be billed to your insurance through them. Virginia Medicaid and TennCare will not allow prescriptions or labs to be billed by non-participating providers. We cannot see patients with these insurance

Primary Care Provider

You have a choice whether you maintain your current primary care provider and treat Seth McLaughlin as a holistic medicine specialist or whether you transfer your care to Seth McLaughlin for holistic medicine and primary care. Please communicate your wish with Seth McLaughlin so he knows whether his responsibilities encompass your complete care.

Telephone Consultations

Telephone consultations are billed at the same price as in-person consultations. Payment will be due at the time of your appointment or before your appointment.

Follow-up Appointments

We generally see patients every month until stable and then every 3-6 months thereafter. If we order any prescription medication, you must be seen every six months, at minimum. To remain a patient, you must be seen at least annually.

Prescription refills

Refills are done at appointment times. Seth prescribes enough medication to get you through to your next appointment. It is essential that you schedule an appointment by the time you pick up your last refill so we have time to get you in. Pharmacy fax refill requests will not be honored. We want to see you and make sure the medication is working well without side effects. If you run out of medication and have not scheduled a follow up appointment, you must call and schedule before we will send any medication in. That way, we know exactly how much to send in to ensure uninterrupted medication. Seth will send in the required amount. This lapse in scheduling may mean that you pay a full copay at the pharmacy for less than a month's supply.

Nutritional Supplements

Nutritional supplements may be recommended during your appointment. With experience recommending herbs and supplements since 1995, Seth may specify a brand of supplements to use. You may purchase supplements from local health food stores & pharmacies, from online retailers, or from our web store below: <https://us.fullscript.com/welcome/smclaughlin1740696665>

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Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used And Disclosed By Ageless Integrative Medicine & Laser Skin Care And How You Can Get Access To It. Please Read This Notice Carefully.

1. Our Privacy Obligations: We are required by law to maintain the privacy of medical and health information about you (Protected Health Information or PHI) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure)
2. Permissible Uses and Disclosures Without Your Written Authorization:

PHI is held in strict confidence, only our physicians, receptionists, medical assistants, laboratory technicians and billers have access to PHI. In certain situations, described in section III below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our "health care operations" (e.g., internal administration, quality improvement and customer service) as detailed below:

Treatment. We use and disclose PHI to provide treatment and other services to you- for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

Payment: We may use and disclose PHI to obtain payment for services that we provide to you (ex. Disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (Your Payor or to verify that Your Payor will pay for health care.)

Health Care Operations. We may use and disclose PHI for our health care operations, which include internal administrations and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers, we may disclose PHI to our HIPAA officer to resolve any complaints you may have and ensure that you have a pleasant visit with us.

WE may also disclose PHI to your other health care providers when such is needed for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for fraud and abuse detection or compliance.

B. Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to family members, other relatives, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures please notify the HIPAA Officer. If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling, disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of judicial or administrative proceedings in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the US military or the US Department of State under certain circumstances required by law.

M. Workers Compensation. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating in workers compensation or other similar programs.

N. As Required by Law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

III. Use and Disclosures Requiring Your Written Authorization.

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our authorization form ("Your Authorization") For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved.

B. Special Authorization. Confidential HIV- related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, HIV related illness or AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances, to public health or other government officials (as required by law) to persons specified in a special court order, to insurers as necessary for payment for your care or treatment, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with specified process set forth in Tennessee State Law) This opposed to Your Special Authorization: disclosures to a third party payor for any reason other than obtaining payment for health care services rendered to you.

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C. Marketing Communications. We must also obtain your written authorization prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to face encounter, without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining your marketing authorization. In addition, we may communicate with you about products or services relation to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

D. Parents or Legal Guardians of minors please note: portions of the medical record relating to sexual activity, sexual conduct tests for sexually transmitted diseases, contraception, family planning or abortion will not be accessible to you and will therefore not be a part of any records or results that are given to you unless we receive written specific authorization from the patient, although a minor.

IV. Your Individual Rights

A. For Further Information: Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our HIPAA Officer. You may also file written complaints with the Director, Office for Civil Rights of the US Department of Health and Human Services. Upon request, the HIPAA Officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction, if you wish to request additional restrictions, please obtain a request form from our HIPAA Officer and submit the completed form to the HIPAA Officer. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative location.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form and submit the completed form to the HIPAA Officer. We will charge you \$0.75 cents for each page for any second requests of medical records, but there will be a \$10.00 charge for duplicate receipts/bills paid. You should take note that ,if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, parental care, care received by a married minor, and contraception and/or family planning services).

E. Right to Revoke Your Authorization. You may revoke your authorization, your special authorization, or your marketing authorization except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the HIPAA Officer identified below. (A form of written revocation is available upon request)

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form and submit the completed form to the HIPAA Officer. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive an Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you (\$1.50 per page) for the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

V. Effective Date and Duration of This Notice

A. This Notice is effective on the date signed

B. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the office. You may also obtain any revised notice by contacting the HIPAA Officer.

VI. HIPAA Officer You May Contact

Seth McLaughlin, MSN APN FNP-BC

926 W Oakland Ave #208

Johnson City, TN 37604

(423) 952-5300

Release of Information

Patient Name _____ DOB _____

I authorize Ageless Integrative Medicine & Laser Skin Care and/or the providers listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at any time of my choosing. I understand that Ageless Integrative Medicine & Laser Skin Care is not authorized by me to use or disclose my protected health information for any purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use or disclose the information, and the recipient(s) of that information. I further understand that other providers may charge me for copies of my records.

Description of information to be used or disclosed:

The patient's full medical record for the past two years

Specific information as detailed below

X-ray, CT, MRI _____

Lab reports _____

History & Physical _____

Notes _____

To / From _____

Phone/Fax _____

To / From _____

Phone/Fax _____

To / From _____

Phone/Fax _____

This authorization shall expire one year from the signature date. After this date, Ageless Integrative Medicine & Laser Skin Care can no longer disclose the patient's protected health information without first obtaining a new authorization form.

The patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization. I fully understand and accept the terms of this authorization.

Signature _____

Date _____

Ageless Integrative Medicine & Laser Skin Care
926 W Oakland Ave
Johnson City, TN 37604
(423) 952-5300 (phone) (423) 402-8557

Medicare Private Contract (Opt-out Agreement)

This agreement is between Seth McLaughlin, FNP-BC, APHN-BC, a Medicare opt-out provider, and the undersigned Medicare beneficiary (patient). By signing this agreement, the patient agrees to receive medical care on a private-pay basis and acknowledges that neither the provider nor the patient will submit claims to Medicare for reimbursement.

This contract is made in accordance with Section 1802(b) of the Social Security Act and 42 CFR 405.400 et seq., which governs provider opt-outs from Medicare.

TERMS OF AGREEMENT

1. **VOLUNTARY AGREEMENT-** The patient freely and voluntarily agrees to receive medical services from Seth McLaughlin, FNP-BC, APHN-BC, understanding that he has opted out of Medicare participation.- The patient is not required to enter into this agreement for services covered by Medicare that they can obtain from a Medicare-participating provider.
2. **NO MEDICARE REIMBURSEMENT**
 - a. The patient agrees not to submit a claim (or ask the provider to submit a claim) to Medicare for payment for services received under this agreement.
 - b. The patient understands that they will be personally responsible for payment in full for services rendered and that no reimbursement will be provided.
3. **NO MEDICARE SECONDARY COVERAGE**
 - a. The patient acknowledges that Medigap and other Medicare secondary insurance will not pay for services provided under this agreement.
 - b. The patient may submit claims to non-Medicare private insurance if applicable, but the provider makes no guarantee of reimbursement.
4. **NO INFLUENCE ON MEDICARE-COVERED SERVICES**
 - a. This agreement applies only to services provided by Seth McLaughlin, FNP-BC, APHN-BC at Ageless Integrative Medicine and Laser Skin Care.
 - b. Medicare-covered services from other providers not opted out of Medicare remain unaffected.
5. **DURATION & CANCELLATION**
 - a. This agreement is effective for a period of two years from the date signed, unless terminated earlier by mutual written consent.
 - b. The patient may terminate this agreement at any time, but Medicare coverage will not be retroactively applied to past services.
6. **PROVIDER'S OBLIGATIONS**
 - a. The provider will not submit claims to Medicare on the patient's behalf.
 - b. The provider will provide a copy of this agreement to the patient upon request.
 - c. The provider is not excluded from Medicare participation but has legally opted out of Medicare.
7. **ACKNOWLEDGMENT & AGREEMENT** By signing below, I acknowledge that:
 - a. I understand that Seth McLaughlin, FNP-BC, APHN-BC and Ageless Integrative Medicine and Laser Skin Care have opted out of Medicare.

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- b. I voluntarily agree to pay for all services rendered, understanding that Medicare and Medigap will not reimburse me.
- c. I will not attempt to bill Medicare or request reimbursement for services received under this agreement.
- d. I have the right to seek care from a Medicare-enrolled provider for covered services if I choose.
- e. I have been provided an opportunity to ask questions and receive satisfactory answers before signing this agreement.

PATIENT SIGNATURE

Patient Name: _____

Signature: _____ Date: _____

PROVIDER SIGNATURE

Provider Name: Seth McLaughlin, FNP-BC, APHN-BC



Nurse Practitioner & Herbalist