Age Reversal Technology Center
Healthcare of the Future Today!
3226 Clark Rd.
Sarasota, Florida 34231
941-806-5511

NEW PATIENT INTAKE PACKET

Thank you for your interest in our center. In order for us to properly serve you in the area of medicinal marijuana authorization certification, there are several things that the state requires us to obtain to properly document this process. Please accept our apologies for the number of items and the amount of paperwork required.

First, we will need a copy of a valid Florida driver's license or state ID card. If you do not possess a valid Florida driver license or Florida identification card, you may submit a copy of a utility bill in the your name including a Florida address, or a Florida voter registration card. For minor patients, the parent or designated legal representative must submit proof of residency of the parent or designated legal representative.

To streamline your initial appointment, we ask that you print, read, and complete each form within this packet prior to your scheduled visit.

The forms and paperwork included are:

- Informed Consent (5 pgs)
- Demographic & Condition Form (1 pg)
- Medical Records Release (1 pg)
- VA Records Release (1 pg)
  **if necessary and applicable.*
- Cancellation No/Show Policy (2 pgs)

- History of Cannabis Acknowledgement (1 pg)
  *Visit our New Patient Guide online to read
- (HQ) Health Questionnaire (3 pgs)
- (PHQ-9) Psychological Health Questionnaire (1 pg)
- HIPAA Privacy Policy (5 pgs)

We would like to see your most current medical records from the last 12 months although not required. It is especially helpful to have the record of any previous diagnosis that qualifies you for medical marijuana. You can ask your current physician to email or mail us a copy of your records. Our email for medical records is **MMJ@ARTC.health.** You can print and complete our medical records form included within this packet and give it to your current doctor. Note that your doctor's office may charge you to send us records. We can also complete a records release and email it to your doctor from our office the day of your visit.

You will also need to complete our online patient intake that will include personal health history. You can complete this at our website by going to https://www.artc.health/244/60/Get-Your-Medical-Marijuana-Card-MMJ/ARTC-Medical-Marijuana-MMJ/programs.html and clicking the Online Patient Intake link.

If you are unable to complete or print this packet at home, you'll need to fill out all of this information prior to being seen by the doctor. Please call us at 941-806-5511 or email us at info@ARTC.health if you have questions or issues.

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Medical Marijuana Acknowledgement of Disclosure and Informed Consent

Please read each item below and initial in the space provided to indicate that you understand and agree with the information regarding the risks and side effects of using Medical Marijuana[1]. Do not sign this agreement and do not use Medical Marijuana if you have questions about or do not understand the information you have received. Please tell us if you do not understand any of the information provided.

Patient's Name_____DOB___/___/___

Address_____

City_____, FL Zip Code_____

Physician Obtaining Consent: Dr. Arthur Hodge, MD

Physician Signature: _____ Date ___/___/___

Warnings:

I am being evaluated for a physician's order for Medical Marijuana. The physician will make this order based, in part, on the medical information I have provided. I hereby acknowledge that I have not misrepresented my medical condition to obtain this recommendation and it is my intent to use Medical Marijuana only as needed for the treatment of my medical condition, not for recreational or non- medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of Medical Marijuana. I have been informed of and understand the following as evidenced by my initials in the boxes to the right of each statement:

I understand that possession or use of Medical Marijuana is unlawful under Federal law and outside of the state of Florida. I also understand that possession or use of Medical Marijuana is unlawful within the state of Florida if not recommended for medical purposes by a licensed medical doctor with the legal ability to do so.	
Certain forms of Medical Marijuana may have intoxicating effects and has not been analyzed or approved by the United States Food and Drug Administration and was produced without FDA oversight for health, safety, or efficacy. Medical Marijuana may contain unknown quantities of active ingredients, impurities, or contaminants.	

[1] "Medical Marijuana" has the meaning given "Medical cannabis" as defined in Section 381.986(1)(b), Florida Statutes (2016) "Medical cannabis" means all parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, sale, derivative, mixture or preparation of the plant or its seeds or resin that is dispensed only from a dispensing organization for medical use by an eligible patient as defined in Section 499.0295, Florida Statutes (2016).

The efficacy and potency of Medical Marijuana may vary widely depending on the strain and ingestion method.	
If Medical Marijuana is vaporized: Such use may be hazardous to your health. Medical Marijuana contains carcinogens and can lead to an increased risk for cancer, tachycardia, hypertension, heart attack, birth defects, brain damage, and lung disease.	
If Medical Marijuana is eaten or swallowed: This product has been infused with cannabis or active compounds of cannabis. When eaten, or swallowed, the intoxicating effects of this drug may be delayed by two or three hours or more.	
There is limited information on the side effects of using Medical Marijuana, and there may be associated health risks.	
Symptoms of Medical Marijuana overdose include but are not limited to nausea, vomiting and disturbances to heart rhythm.	
For some patients, chronic Medical Marijuana usage can lead to laryngitis, bronchitis, and general apathy.	
I understand side effects of Medical Marijuana can include but are not limited to: Memory loss, Irregular heartbeat, Slower reaction time/inability to concentrate, Poor physical condition, Cough/bronchitis/shortness of breath, Dizziness, Impaired vision, Drowsiness/fatigue/abnormal sleep, Depression, Laryngitis, Low blood pressure, Impairment of motor skills, Anxiety/Nervousness, Dry mouth, Suppression of immune system, Hunger/Loss of appetite, Dependency, Confusion, Feelings of euphoria, Headache/nausea/vomiting, Numbness, Agitation, Paranoia/psychotic symptoms, Sedation	
The scientific basis for the medical use of Medical Marijuana is not complete. There is little known regarding how Medical Marijuana may, or may not, react with other pharmaceutical or herbal medications.	
Some patients can become dependent on Medical Marijuana. This means they experience withdrawal symptoms when they stop using Medical Marijuana. Signs of withdrawal symptoms can include feelings of depression, sadness or irritability, restlessness or mild agitation, insomnia, sleep disturbance, unusual tiredness, trouble concentrating, and loss of appetite.	
Some users develop a tolerance to Medical Marijuana. This means higher and higher doses are required to achieve the same symptom relief.	

The possibility exists that Medical Marijuana may exacerbate schizophrenia in persons predisposed to that disorder.	
Women should not consume Medical Marijuana while planning to become pregnant, during pregnancy, or while breast feeding, except on the advice of the certifying health practitioner, and in the case of breast feeding mothers, on the advice or the infant's pediatrician.	
Using Medical Marijuana while under the influence of alcohol is not recommended.	
The use of Medical Marijuana may affect coordination, cognition, and judgment. While under the influence of Medical Marijuana, do not to drive, operate machinery, or engage in potentially hazardous activities.	
Please note that Medical Marijuana will degrade over time. Always keep out of reach of children and pets.	

Medical Marijuana Patient Agreement

I am over 18 years of age and understand the requirements of the State of Florida's Medical Marijuana program.	
I have been advised of the current state of knowledge in the medical community of the effectiveness of Medical Marijuana for the treatment of my condition.	
I have been advised of the potential risks and side effects of using Medical Marijuana.	
I have been advised of the medically acceptable alternatives (as set fourth in Addendum A). ***FOR PATIENTS WHO HAVE ESTABLISHED THEIR 90 DAYS ONLY!***	
I have read and understand the foregoing disclosures and have initialed next to each to acknowledge this understanding.	
I have been further advised that some forms of Medical Marijuana may contain chemicals known as tars that may be harmful to my health.	
I understand that side effects may occur while I am taking Medical Marijuana.	
In the event that I experience an adverse reaction, I am advised to contact my medical professional. In the event my medical professional is not available, I agree to call 911 for help and I am advised to lie down, relax, and rest until help arrives.	

I have never had symptoms of schizophrenia or have been diagnosed as having schizophrenia by a physician or mental health professional.	
I have no direct blood relatives (father, mother, siblings) that have had symptoms or has been diagnosed as having schizophrenia or has been psychotic.	
I agree to tell my medical professional if I have ever had symptoms of schizophrenia, been psychotic or attempted suicide. I also agree to tell my medical professional if I have ever been prescribed or taken medicine for any of these problems.	
I understand that my medical professional does not suggest nor condone that I cease treatment of medications that stabilize my mental or physical condition.	
I am not pregnant, intending on becoming pregnant, or breastfeeding.	
When under the influence and/or in possession of Medical Marijuana in public, your state issued Medical Marijuana ID Card or temporary state issued verification should be on your person at all times.	
I understand if I give dishonest or untruthful information, I will be discharged.	
I understand I must give 48-hours' notice for cancellation of appointments. I further understand that I will be charged for missed appointments with no recourse. A valid form of payment must be provided upon scheduling all appointments.	
I understand there are certain requirements to remain in compliance with Florida law regarding Medical Marijuana. Some of these requirements include (but are not limited to): • Patient establishment within our practice for 90 days • Regularly scheduled follow-ups at intervals determined by state law	
I understand that the Department of Health may revoke a Compassionate Use Registry identification card for any of the following: (a) The patient or legal representative makes material misrepresentations in his or her application. (b) The patient uses his or her card to obtain cannabis for another individual (c) The legal representative purchases, obtains, possesses, or uses cannabis not sold by an approved dispensing organization, or (d) The patient is no longer a qualified patient.	

I further understand that if I am not in compliance with state law and regulations set forth and enforced by the Office of Compassionate Use, my order may be revoked.	
I understand and acknowledge that my patient information must be provided to the Office of Compassionate Use and that my treatment plan (and follow-up treatment plans) must be provided to the University of Florida's College of Pharmacy by state law.	
If I start taking Medical Marijuana, I agree to tell my medical professional if I experience (any one or more of the following): Start to feel sad or have crying spells Have changes in my normal sleep patterns Lose my appetite Become more irritable than usual Become unusually tired Withdraw from family and friends Lose interest in my usual activities	

Release of Liability

I hereby acknowledge Age Reversal Technology Center of Sarasota, Florida, and its employees are not addressing specific aspects of my medical care nor are any of them my primary care provider. Furthermore, I, for myself, my heirs, assigns, or anyone acting on my behalf, hold Age Reversal Technology Center, and its principals, agents, and employees free of and harmless from any responsibility for any harm resulting to me and/or other individuals because of my Medical Marijuana use.	
I certify that I fully understand the potential risks and side effects related to the use of Medical Marijuana as described above.	
In using Medical Marijuana, I fully accept responsibility and assume the risks and side effects associated with its use.	
I agree that ge Reversal Technology Center, LLC, and employees shall not be held responsible for any harm resulting to me and/or any other individual(s) because of my use of Medical Marijuana.	
I certify that I have read this document and declare under penalties of perjury that the information contained herein is true, correct, and complete.	

Patient's (or legal guardian's) Signature:_____Date: _____

Printed Name: _____

Age Reversal Technology Center
3226 Clark Rd.
Sarasota, Florida 34231
941-806-5511

Name: _____
First M Last

DOB: _____

Address _____

City, ST. Zip: _____

Phone: _____ Cell: _____

Email: _____

Qualifying Conditions*

Your Qualifying Conditions for the "The Florida Medical Marijuana Program"

- ☐ Cancer
- ☐ Glaucoma
- ☐ AIDS
- ☐ HIV
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Crohn's Disease
- ☐ Parkinson's
- ☐ PTSD
- ☐ ALS
- ☐ or other debilitating conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

☐ Other *_____

How Did You Hear About Us? _____

*Other conditions that qualify for use of Medical Marijuana include: Anxiety, Chronic pain, Headaches, chronic muscle spasms, irritable bowel syndrome, chronic nausea, Anorexia, Arthritis, Cachexia (wasting), cyclical vomiting syndrome, diabetes, hepatitis C, Lyme's disease, muscle spasms, muscular dystrophy, severe chronic pain, sickle cell anemia, spasticity, and any terminal condition, other conditions of similar kind or class.

Age Reversal Technology Center
941-806-5511

I,_____ **(PRINT PATIENT NAME)**

_____/_____/_____, XXX-XX- _____
BIRTHDATE **SOCIAL SECURITY #**

Authorize _____
(Doctor Name) (Doctors Phone or Email address)
to release and discuss any and all medical records and medical information that you have for me in your possession regarding my medical condition and my medical treatment, including but not limited to, my medical history, my medical treatment, your findings regarding my medical condition, records of consultations that I have had, records of medication prescribed for me, x-rays taken of me, my radiology reports, and hospital, and medical records to:

Age Reversal Technology Center

3226 Clark Rd., Sarasota, Florida 34231; (941) 806-5511

for the sole purpose of medical records review and certification of my medical condition.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is intended to be an unlimited, full, and complete Authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Medical Records Access Act, as amended, and under the rules and regulations thereof, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. A covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b) (4) applies. It is understood that the person to whom this Authorization is given has my permission to use and disseminate this information in his or her sole discretion.

1. **Expiration.** This authorization expires 18 months after patient signed this release.

2. **Right to Revoke.** I have the right to revoke this authorization by signing and dating a written statement revoking this authorization, and it shall become effective on delivery to you. If this authorization is revoked, any person or entity acting in good faith in reliance upon it and lacking actual knowledge of its revocation shall be held harmless.

3. **Redisclosure.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this rule.

4. **Administrative Provisions.** I revoke any prior authorizations I have made to disclose health information that are inconsistent with this authorization. This document shall be governed by Florida law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub L No 104-191, and the Medical Records Access Act, MCL 333.26261 et seq. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Florida law and HIPAA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts. I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I am at least 18 years old and of sound mind.

5. Any Billing for Medical Records is solely the patient's responsibility.

PATIENT OR LEGAL REPRESENTATIVE'S SIGNATURE **DATE**

Optional VA records request for Veterans wishing us to incorporate any info from the VA.

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

Veterans Health Administration
Location:

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Age Reversal Technology Center, LLC; 3226 Clark Rd., Sarasota, Florida 34231

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

Pertinent health information from electronic health records from the last 12 months including information created within 24 months after their signature date of this authorization.

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Certification

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s):

Two years from the date of signature

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE (mm/dd/yyyy)

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA) (Sign in ink)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED

RELEASED BY

Age Reversal Technology Center
3226 Clark Rd.
Sarasota, Florida 34231
941-806-5511

Cancellation/No Show Payment 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 when another patient fails to cancel and we were unable to schedule you for a visit, due to a full schedule.

Cancellations

It is our policy that all appointments must be cancelled at least 48 hours in advance of the appointment. If an appointment is not cancelled 48 hours in advance, you will be charged the full appointment cost. Your credit or debit card on file will automatically be charged on the day of the cancellation if you are cancelling less than 48 business hours prior to your appointment. All patients will have the opportunity to show proof of an "urgent" reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for late cancellations.

No Show

Patients who "No Show" their visit will be charged for that visit, AND will need to prepay future appointments. Your credit or debit card on file will automatically be charged on the day you "No Show" your appointment. All patients will have the opportunity to show proof of an "urgent'' reason as to why they were unable to make their scheduled appointment. Upon doing so, the patient will be reimbursed the charges incurred for not showing for their scheduled appointment.

Follow Up Visits

Follow up visits are crucial to maintaining the state mandate of creating and maintaining a bonafide relationship with your provider. Patients who miss the scheduled follow up visits will be charged $75 for the missed appointment

Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. We request you come 30 minutes early to your appointment to account for traffic and to complete the required paperwork. If you are 15 minutes past your scheduled time, your provider may not be able to complete a full visit or we will do our best to accommodate you and fit you into the schedule later in the day. If you can not complete your visit you will be charged for the full visit and you will be required to book a new visit.

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Account Balances

We will require that patients pay their account balances to zero (0) prior to receiving further services by our practice. We also require payment be rendered prior to services.

Acknowledgement of Receipt of Cancellation/No Show Policy

I, _____ do hereby acknowledge receipt of a copy of the Cancellation and No Show Payment Policy of Age Reversal Technology Center, LLC.

Signature: _____ Date:_____

Authorization To Charge My Credit/Debit Card

I, _____ authorize Age Reversal Technology Center, LLC to keep my credit/debit card information on file and charge my credit/debit card in the event that I do not cancel my appointment with a 48 business hour notice OR no show for my scheduled appointment(s).

Signature: _____ Date:_____

Patients not authorizing Florida Vacation Telehealth, PA to keep their credit/debit card information on file will be required to prepay all follow-up and recertification visits.

The full text of the History Of Cannabis as a Medicine is available on our website at: https://www.artc.health/245/60/HISTORY-OF-CANNABIS-AS-A-MEDICINE/ARTC-Medical-Marijuana-MMJ/programs.htm

ACKNOWLEDGMENT OF RECEIPT OF HISTORY OF CANNABIS AS A MEDICINE

The History of Cannabis as a Medicine contains important information about Cannabis, and I understand that I should consult Age Reversal Technology Center, LLC regarding any questions not answered in the handbook. I understand that I may ask Dr. Arthur Hodge, M.D., or any associate of Age Reversla Technology Center, LLC. for any questions I might have concerning the handbook.

I understand that I am expected to read the entire handbook. **I understand that this form will be retained in my patient chart.**

_____ _____

Signature of Patient Date

_____

Patient's Name (print)

Reference:

History of Cannabis as a Medicine
By Lester Grinspoon, M.D.,
August 16, 2005

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.			
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.				
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

		NO	YES
6. Questions about eating.			
a.	Do you often feel that you can't control what or how much you eat?	☐	☐
b.	Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.			
c.	Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

	NO	YES
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?		
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

	NO	YES
10. Have any of the following happened to you more than once in the last 6 months?		
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date

The effective date of this Notice is December 14, 2016.

Contact Information

Age Reversal Technology Center, LLC
Email: info@ARTC.health
Phone: 941-806-5511