Brian Mehling, M.D., Founder

info@BHIRejuve.com
855-553-8500

800 Montauk Highway
West Islip, New York
11795

New Patient Intake Form

for Men

Please remember to bring this package to your appointment.

Legal First Name: _____

Legal Last Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Email: _____

PERSONAL INFORMATION

Date:_____ **Patient's Social Security Number**_____

Patient Name:_____ **DOB:**_____ **Age:** _____

Check those that apply: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ **City/St:** _____ **Zip** _____

PHONE: (H) _____ **(W)** _____ **(Cell)** _____

Email:_____

Employer Name: _____ **Occupation:** _____

Employer Address:_____ **City:** _____ **State**_____ **Zip** _____

Pharmacy Name, Address, Phone: _____

_____

In the event of an emergency, who should we contact?

Name:_____ **Relationship:** _____

Phone number:_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:

Name of Insured: _____

Relationship to patient: _____

Insured's birthdate: _____

SS#: _____

Employer:_____

Occupation:_____

Insurance Company: _____

Group#: _____ **ID#:** _____

Insurance Billing Address: _____

City/St:_____ **Zip:**_____

Insurance Co. Phone Number: _____

SECONDARY INSURANCE CARRIER:

Name of Insured: _____

Relationship to patient: _____

Insured's birthdate: _____

SS#: _____

Employer:_____

Occupation:_____

Insurance Company: _____

Group#: _____

Insurance Billing Address: _____

City/St:_____ **Zip:**_____

Insurance Co. Phone Number: _____

Health History

Name: _____ **Date of Birth: _____** **Date: _____**

Occupation: _____ Age: _____ Gender: ___ Height: _____ Number of Children: _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separate ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? ☐

Reason for office visit:

List current health problems for which you are being treated:

List all Allergies: _____

What types of therapies have you tried for your problem(s) or to improve your over-all health?

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic

☐ Acupuncture ☐ Conventional drugs Other : _____

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches Dizziness	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating		☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Current medications (prescription or over-the-counter):

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome:

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome

Indicate your stress level on a scale of 1 (low) to 10 (high, extreme): ☐

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life-threatening activities (e.g., fireman, etc.)?

What are your current health goals:

Name: _____ **Date of Birth:** _____ **Date:** _____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

_____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Health Habits

- ☐ Tobacco:
  - Cigarettes: #/day _____
  - Cigars: #/day _____
- ☐ Alcohol:
  - Wine: #glasses/d or wk _____
  - Liquor: #ounces/d or wk _____
  - Beer: #glasses/d or wk _____
- ☐ Caffeine:
  - Coffee: #6 oz cups/d _____
  - Tea: #6 oz cups/d _____
  - Soda w/caffeine: #cans/d _____
  - Other sources _____
- ☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 min duration per workout
- ☐ Less than 30 minutes
- ☐ Walk - #days/wk _____
- ☐ Run, jog, other aerobic activity - #days/wk _____
- ☐ Weight lift - #days/wk _____
- ☐ Stretch - #days/wk _____

Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and
- ☐ Vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs
☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ☐ Skip meals – which ones _____
- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplementst

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, sleeping aids, anti-histamines, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

BODY COMPOSITION

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

LIFE ENRICHMENT

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

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Name: _____ **Date of Birth:** _____ **Date:** _____

Stress Hormone Life Experience Correlation Scale

Please mark those areas in which you are experiencing stress.

Life Change		Score
Death of spouse or partner.....	(10)	__
Marriage dissolution.....	(7)	__
Death in immediate family.....	(6.5)	__
Major illness.....	(5.5)	__
Marriage.....	(5)	__
Termination from employment.....	(4.5)	__
Retirement.....	(4.5)	__
Major change in health of family member..	(4.5)	__
Pregnancy, childbirth.....	(4)	__
Sexual difficulties.....	(4)	__
Major change in financial status.....	(4)	__
Taking out a mortgage.....	(3)	__
Son or daughter leaving home.....	(3)	__
Beginning or ceasing formal schooling.....	(2.5)	__
Major change in living conditions.....	(2.5)	__
Change in residence.....	(2)	__
Major change in amount of recreation.....	(2)	__
Major change in social activities.....	(2)	__
Major change in sleeping habits.....	(1.5)	__
Major change in eating habits.....	(1.5)	__
	Total	__

If your score is less than or equal to 10, it is unlikely that stress is a factor at this time. A score between 20 and 30 indicates that stress is probably compromising your quality of life. The warning flag is waving.

Name: _____ **Date of Birth:** _____ **Date:** _____

Male Hormone Balance Inventory

		None	Moderate	Frequent
Mental				
	Inability to Concentrate			
	Afternoon Sleepiness			
	Decreased Mental Sharpness			
	Decreased Initiative			
	Decreased Competitiveness			
	Increased Depression			
Musculoskeletal				
	Sore Body Syndrome			
	Decreased Flexibility / Stiffness			
	Decreased Muscle Strength			
	Decreased Athletic Performance			
	Tendency to pull muscles			
	Decreased Physical Stamina			
Physical / Sexual				
	Development of Chest Pain			
	Shortness of Breath with Activity			
	Decreased morning erection			
	Decreased libido / Desire for Sex			
	Difficulty maintaining full erection			
	Difficulty in Starting erection / no erection			
General Well Being				
	Change to Bowel Motions	How many per day?		
	Change of weight	Increase ☐	Decrease ☐	
	Change to Stress Level	Current Stress Level (1 – 10)		

Name: _____ **Date of Birth:** _____ **Date:** _____

Do You Have Low Testosterone?

ADAM (Androgen Deficiency in Aging Men)

	Yes	No
1. Do you have a decrease in libido (sex drive)?		
2. Do you have a lack of energy?		
3. Do you have a decrease in strength and/or endurance?		
4. Have you lost height?		
5. Have you noticed a decreased enjoyment of life?		
6. Are you sad and/or grumpy?		
7. Are your erections less strong?		
8. During sexual intercourse, has it been more difficult to maintain your erection to completion of intercourse?		
9. Are you falling asleep after dinner?		
10. Has there been a recent deterioration in your work performance?		

If you answered yes to question 1 or 7, or at least three of the other questions, you may have low testosterone levels. Fortunately there is something your doctor can do to help. **Be sure to discuss the results of this quiz with your doctor.**

Morley JE. *J Gend Specif Med.* 2001;4(2):49-53. St. Louis University School of Medicine.

Name: _____ **Date of Birth:** _____ **Date:** _____

International Prostate Symptom Score (I-PPS)

In the past month:	Not at all (0)	Less than 1 in 5 Times (1)	Less than Half the time (2)	About Half the Time (3)	More than Half the Time (4)	Almost Always (5)	Your Score
1. Incomplete Emptying How often have you had the sensation of not emptying your bladder?							
2. Frequency How often have you had to urinate less than every two hours?							
3. Intermittency How often have you found you stopped and started again several times when you urinated?							
4. Urgency How often have you found it difficult to postpone urination?							
5. Weak Stream How often have you had a weak urinary stream?							
6. Straining How often have you had to strain to start urination?							
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**	
7. Nocturia How many times do you typically get up at night to urinate?							
Total I-PSS Score							

Score: 1 – 7: *Mild* 8 – 19: *Moderate* 20 – 35: *Severe*

Quality of Life Due to Urinary Symptoms	Delighted (0)	Pleased (1)	Mostly Satisfied (2)	Mixed (3)	Mostly Dissatisfied (4)	Unhappy (5)	Terrible (6)
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?							

Metabolic Assessment Form

Name: _____ **Date of Birth:** _____ **Date:** _____

Age: _____ Gender: M Height: _____ Weight: _____

Please list your 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please check ✓ all that apply

Category I – Colon / 10

- ☐ Feeling that bowels do not empty completely
- ☐ Lower abdominal pain relief by passing stool or gas
- ☐ Alternating constipation and diarrhea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hard, dry or small stool
- ☐ Coated tongue of "fuzzy" debris on tongue
- ☐ Pass large amount of foul smelling gas
- ☐ More than 3 bowel movements daily
- ☐ Use laxatives frequently

Category II – Hypochlorydia / 7

- ☐ Excessive belching, burping or bloating
- ☐ Gas immediately following meal
- ☐ Offensive breath
- ☐ Difficult bowel movements
- ☐ Sense of fullness during and after meals
- ☐ Difficulty digesting fruits and vegetables
- ☐ Undigested foods found in stools

Category III – Hyperacidity / 7

- ☐ Stomach pain, burning or aching 1-4 hrs after eating
- ☐ Frequently use antacids
- ☐ Feeling hungry an hour or two after eating
- ☐ Heartburn when lying down or bending forward
- ☐ Temporary relief from antacids, food, milk or carbonated beverages
- ☐ Digestive problems subside with rest and relaxation
- ☐ Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine

Category IV – Small Intestine & Pancreas / 9

- ☐ Roughage and fiber cause constipation
- ☐ Indigestion and fullness lasts 2-4 hrs after eating
- ☐ Pain, tenderness, soreness on left side under rib cage
- ☐ Excessive passage of gas
- ☐ Nausea and/or vomiting
- ☐ Difficulty losing weight
- ☐ Stool undigested, foul smelling, mucous-like, greasy or poorly formed
- ☐ Frequent urination
- ☐ Increased thirst and appetite

Category V – Biliary Insufficiency / 10

- ☐ Greasy or high fat foods cause distress
- ☐ Lower bowel gas and/or bloating after eating
- ☐ Bitter metallic taste in mouth, esp in the morning
- ☐ Unexplained itchy skin
- ☐ Yellowish cast to eyes
- ☐ Stool color alternates from clay color to normal brown
- ☐ Reddened skin, especially palms
- ☐ Dry or flaky skin and/or hair
- ☐ History of gallbladder attacks or stones
- ☐ Gallbladder removed

Category VI – Hypoglycemia / 9

- ☐ Crave sweets during the day
- ☐ Irritable if meals are missed
- ☐ Depend on coffee to keep yourself going or to get started
- ☐ Get lightheaded if meals are missed
- ☐ Eating relieves fatigue
- ☐ Feel shaky, jittery, tremors
- ☐ Agitated, easily upset, nervous
- ☐ Poor memory, forgetful
- ☐ Blurred vision

Category VII – Insulin Resistance / 8

- ☐ Fatigue after meals
- ☐ Crave sweets during the day
- ☐ Eating sweets does not relieve cravings for sugar
- ☐ Must have sweets after meals
- ☐ Waist girth is equal to or larger than hip girth
- ☐ Frequent urination
- ☐ Increased thirst & appetite
- ☐ Difficulty losing weight

Category VIII – Hypoadrenal / 8

- ☐ Cannot stay asleep
- ☐ Crave salt
- ☐ Slow starter in the morning
- ☐ Afternoon fatigue
- ☐ Dizziness when standing up quickly
- ☐ Afternoon headaches
- ☐ Headaches with exertion or stress
- ☐ Weak nails

Metabolic Assessment Form continued

Name: _____ **Date of Birth:** _____ **Date:** _____

Please check ✓ all that apply

Category IX – Hyperadrenal / 6

- ☐ Cannot fall asleep
- ☐ Perspire easily
- ☐ Under high amounts of stress
- ☐ Weight gain when under stress
- ☐ Wake up tired even after 6 or more hours of sleep
- ☐ Excessive perspiration or perspiration with little or no activity

Category X – Hypothyroid / 12

- ☐ Tired, sluggish
- ☐ Feel cold – hands, feet, all over
- ☐ Require excessive amounts of sleep to function
- ☐ Increase in weight gain even with low calorie diets
- ☐ Gain weight easily
- ☐ Difficult, infrequent bowel movements
- ☐ Depression, lack of motivation
- ☐ Morning headaches that wear off as the day progresses
- ☐ Outer third of eyebrow thins
- ☐ Thinning of hair on scalp, face or genitals or excessive falling hair
- ☐ Dryness of skin and/or scalp
- ☐ Mental sluggishness

Category XI – Hyperthyroid / 7

- ☐ Heart palpitations
- ☐ Inward trembling
- ☐ Increased pulse even at rest
- ☐ Nervous and emotional
- ☐ Insomnia
- ☐ Night sweats
- ☐ Difficulty gaining weight

Category XII – Hypopituitary / 2

- ☐ Diminished sex drive
- ☐ Increased ability to eat sugars without symptoms

Category XIII – Hyperpituitary / 3

- ☐ Increased sex drive
- ☐ Tolerance to sugars reduced
- ☐ Splitting type headaches

List any surgeries or medical conditions past or present:

_____

_____

_____

_____

Category XIV (Male Only) / 5

- ☐ Urination difficulty or dribbling
- ☐ Urination frequent
- ☐ Pain inside of legs or heels
- ☐ Feeling of incomplete bowel evacuation
- ☐ Leg nervous at night

Category XV (Male Only) / 12

- ☐ Decrease in libido
- ☐ Decrease in spontaneous morning erections
- ☐ Decrease in fullness of erections
- ☐ Difficulty in maintaining morning erections
- ☐ Mental fatigue
- ☐ Inability to concentrate/Episodes of depression
- ☐ Muscle soreness
- ☐ Decrease in physical stamina
- ☐ Unexplained weight gain
- ☐ Increase in fat distribution around chest and hips
- ☐ Sweating attacks
- ☐ More emotional than in the past

PART III

How many times a week do you eat fish? _____

How many alcohol beverages do you consume per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you work out? _____

Rate your stress level on a scale of 1 – 10 during the average week _____

List the three worst foods you eat during the average week _____, _____, _____

List the three healthiest foods you eat during the average week _____, _____, _____

Do you smoke? _____

How many caffeinated beverages do you consume per day? _____

List any medications you currently take and for what conditions:

_____

List any natural supplements you currently take and for what conditions:

_____

GENERAL CONSENT FOR TREATMENT
I, the undersigned, do hereby agree and give my consent for (my/below patient's) treatment with Mehling Orthopedics, LLC ("Provider"). I hereby request Provider to provide such care and administer such diagnostic, radiological, and/or therapeutic procedures and treatment as is deemed necessary or advisable in (my/below patient's) care. This includes all routine diagnostic tests and procedures. I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatments or examinations done. I further understand that this consent allows for the exchange of medical information relevant to my care with other health care providers.

OUT-OF-NETWORK DISCLOSURE/PATIENT ACKNOWLEDGMENT OF RESPONSIBILITY
You understand that the Provider is an out-of-network provider and that, consequently, you are responsible for the difference between charges and payments made by your health plan and any co-insurance and deductible required by your health plan. The Provider cannot waive any such patient responsibility. Any recovery of funds made by us in connection with any litigation or arbitration we file against your health plan will be paid to the Provider and not to you. You specifically agree that such recovery is owed to the Provider and not to you. We will take our fees from this recovery if obtained.

FINANCIAL RESPONSIBILITY AND GUARANTEE AGREEMENT
I have requested professional services from Provider on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance. With respect to bill collections, I understand that if I do not pay what I owe, I understand that I will be in default and Provider may retain an attorney to collect the balance due to it. If Provider retains an attorney, I agree to pay Provider's reasonable attorney frees upon placement of the claim with the law firm.
I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the court of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

CANCELLATION POLICY
It is important that you keep your scheduled appointments. If you are unable to do this, please call the office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged a $50.00 Cancellation Fee, and your insurance company cannot and will not reimburse for this.

I have read and understood the above policies.

Patient Name(Print)_____ Parent/Guardian Name(Print)_____

Signature (Patient/Parent/Guardian)_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the BHI Rejuve Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative's Signature

Relationship: _____

For BHI Rejuve use only:
Complete this section if this form is not signed and dated by the patient or patient's personal representative. I have made a good faith effort to obtain a written acknowledgement of receipt of BHI Rejuve Notice of Privacy Practices but was unable to for the following reason (please circle):

Patient refused to sign
Patient unable to sign
Other _____

_____ _____

Employee Name ***Date***

This form should be placed in the patient's medical record.

Revised December 2015

BHI Rejuve
800 Montauk Highway
West Islip, NY 11795

bhirejuve.com
Fidel Desmar, 855-553-8500
info@bhirejuve.com
Doreen Santora, 201-342-7662

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

➤ ***See page 2*** *for more information on these rights and how to exercise them*

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

➤ ***See page 3*** *for more information on these choices and how to exercise them*

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

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

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.*

continued on next page

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.

We do not create or manage a hospital directory at this practice.
We do not create or maintain psychotherapy notes at this practice.
We will never share any substance abuse treatment records without your written permission.

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.

This notice is effective as of July 3, 2018.

This Notice of Privacy Practices applies to the following organizations.

BHI Rejuve
800 Montauk Highway
West Islip, NY 11795
855-553-8500

Fidel Desmar, fdesmar@mehlingorthopedics.com, 855-553-8500
Doreen Santora, dsantora@bluehorizoninternational.com, 201-342-7662

Revocable Assignment Of Benefits & Authorization

I, _____ (**"Patient**"), assign to my medical provider MEHLING ORTHOPEDICS (the "**Provider**"), any and all of my rights and benefits under my insurance contract and/or my employee welfare benefit plan(s) as well as all of my rights and benefits under the **Employee Retirement Income Security Act of 1974** ("**ERISA**") and any other applicable state or federal law(s), regulation(s), statute(s), or rule(s), which are in any way related to the medical services provided to me by **Provider** at any time.

I assign to **Provider** any and all of my rights and benefits under my plan or policy as well as state and/or federal law(s), regulation(s), statute(s), or rule(s), to seek plan or policy documents, file appeals, seek statutory and other penalties, seek equitable relief, commence legal action, and directly receive payment of benefits insofar as they in any way relate to the treatment and/or services provided to me by **Provider** at any time. I assign to **Provider** any recovery, settlement, penalty, and/or other relief obtained.

I authorize **Provider** to file insurance claims on my behalf for services rendered to me at any time by **Provider**. I direct that all reimbursable payments for treatment and/or services rendered to me by **Provider** go directly to the **Provider** or any individual or entity they deem appropriate,

I authorize **Provider** to file arbitration and/or litigation in my name and on my behalf against my PIP carrier, Healthcare Carrier, Employee Welfare Benefit Plan, Workers' Compensation Plan, or any similar entity, which is in any way related to the treatment and/or services provided to me by **Provider** at any time.

I authorize **Provider** to retain an attorney of **Provider's** choice on my behalf for collection of **Provider's** bills and/or to file insurance claims on my behalf for services rendered to me. I authorize and consent to **Provider** acting on my behalf in this regard and in regard to my general health insurance coverage, and I specifically authorize **Provider** to pursue any administrative appeals conducted pursuant to any contract, plan, law or statute, including, but not limited to, **ERISA**.

Provider may affirmatively disclaim any part of this assignment and authorization at any time and for any and/or no reason(s) through writing. There is no reciprocal right on the part of the **Patient** once this document is executed. **Patient** does not retain any power, right, or ability, to revoke or withdraw any authorization or assignment. Should **Provider** disclaim any part of this assignment or authorization it shall result in the right(s) and/or benefit(s) explicitly disclaimed returning to **Patient**.

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Name of Person Signing (print) Relationship to Patient

EMAIL AND TEXT POLICY

I, _____, (patient/guardian) hereby voluntarily provide my email and cellphone number to BHI Rejuve and affiliated facilities.

I agree to permit BHI Rejuve and their Authorized Representative to communicate with me by email and text message with respect to the medical claims submitted to my health plan and with respect to any balances due to BHI Rejuve after health plan and other payments received by BHI Rejuve and for balances not covered by my health plan, co-insurance, deductibles or any other balance deemed client responsibility.

To be clear, I am consenting to communication by email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify BHI Rejuve in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to BHI Revjuve. There are no hardware or software requirements needed to receive email communication from the Practice of their authorized representatives other than an active email account obtained from a vendor that provides such email accounts.

BHI Rejuve and their Authorized Representatives will not sell, share, or rent your email address or any other personal information collected on this consent.

Email address:_____

Cell phone #:_____

Patient/Guardian Signature:_____