Notice of Privacy Practices Acknowledgment

Dr. Ghislaine Robert, MD has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact our **Front Desk Assistant** at **425-836-1800** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Dr. Ghislaine Robert.

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____

_____

Confidential Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU

Name_____ Birthday_____ Sex ☐ M ☐ F

What is your major complaint?_____

How long have you had this condition_____ Have you had similar conditions in the past_____

Is this condition interfering with your: □ Work □ Sleep □ Daily routine Other_____

Previous treatment for this condition_____

Previous tests or imagery_____

Do you have a family physician?_____Name_____

Allergies:_____

Medication, dosage and frequency:_____

List of surgical operations and years:_____

_____

Have you been in an auto accident or any other personal injuries ☐ Yes ☐ No Describe_____

_____

Caffeine use?_____ Tobacco?_____ Drug?_____ Alcohol?_____

Past medical history

Anemia	_____	years:_____	Heart attack	_____	years:_____
Angina	_____	years:_____	High blood pressure	_____	years:_____
Arthritis	_____	years:_____	Kidney disease	_____	years:_____
Asthma	_____	years:_____	Liver disease	_____	years:_____
Bladder infection	_____	years:_____	Stomach ulcer	_____	years:_____
Bleeding disorder	_____	years:_____	Stroke	_____	years:_____
Cancer	_____	years:_____	Thyroid disorder	_____	years:_____
Depression	_____	years:_____	Tuberculosis	_____	years:_____
Epilepsy	_____	years:_____	Other_____	_____	years:_____
Gout	_____	years:_____			

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

General	Now	Past
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fainting	☐	☐
Weight loss	☐	☐

Skin	Now	Past
Color changes	☐	☐
Hair changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Masses	☐	☐

Head + Eyes	Now	Past
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐

Ears	Now	Past
Hard of hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Dizziness	☐	☐
Room spins	☐	☐

Nose	Now	Past
Decreased smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post nasal drip	☐	☐
Deviated septum	☐	☐
Sinus congestion	☐	☐

Mouth	Now	Past
Bleeding gums	☐	☐
Sores	☐	☐
Dental problems	☐	☐
Bad breath	☐	☐
Loss of taste	☐	☐
Dry mouth	☐	☐
Ulcers	☐	☐

Throat	Now	Past
Soreness	☐	☐
Bad tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble swallowing	☐	☐
Recurrent infections	☐	☐

Neck	Now	Past
Neck enlargement	☐	☐
Stiff neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

Breasts	Now	Past
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple changes	☐	☐
Skin changes	☐	☐

Lungs	Now	Past
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Short of breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐

Heart	Now	Past
Murmur	☐	☐
Palpitations	☐	☐
Arrhythmia	☐	☐
Swollen Extremities	☐	☐
Cold extremities	☐	☐
Chest pain/ Pressure	☐	☐
Varicose veins	☐	☐
Blood clots	☐	☐
Blue extremities	☐	☐

Blood	Now	Past
Low blood iron	☐	☐
Easy bruising	☐	☐
Easy bleeding	☐	☐
Swollen nodes	☐	☐
Painful nodes	☐	☐
Red spots	☐	☐

Gastrointestinal	Now	Past
Nausea	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Abdominal Pain	☐	☐
Irregular bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor appetite	☐	☐
Food intolerance	☐	☐
Bloody stools	☐	☐
Black stools	☐	☐

Genitourinary	Now	Past
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed wetting	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Small stream	☐	☐
Cloudy urine	☐	☐
Spotting between		
Periods	☐	☐
Menstrual cramps	☐	☐
Discharge	☐	☐
Itching	☐	☐
Painful intercourse	☐	☐
Irregular periods	☐	☐
Hot flashes	☐	☐
Contraception type		
No. of pregnancies		
No. of births		
Menstrual flow ☐Heavy ☐Moderate ☐Light		
Last period		
Last pap smear		
Last vaginal exam		
Last mammogram		
Last prostate exam		

MSK/Neuro	Now	Past
Joint pain	☐	☐
Muscle weakness	☐	☐
Numbness	☐	☐
Poor balance	☐	☐

Name_____

Signature_____

Date_____

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Ghislaine Roberts agrees to maintain Privacy of **(PATIENT NAME PRINTED BELOW)** as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. Robert believes this is improper and may not be in the patients' best interest. Accordingly, Dr. Robert agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dr. Robert will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dr. Robert and her practice, expertise and/or treatment - the sole exceptions being communication to a confidential medical-peer review body; to another healthcare provider; to a licensed attorney; to a governmental agency; in the context of a legal proceeding; or unless mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. If patient does prepare commentary for publication about Dr. Robert, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Dr. Robert for any written, pictorial, and/or electronic commentary. This assignment is in further consideration for additional privacy protections provided by Dr. Robert. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary. Dr. Robert has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon Dr. Robert and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dr. Robert's practice.

Dr. Robert feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Dr. Robert and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dr. Robert's last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Dr. Robert is requiring all patients in her practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dr. Robert's patients.

Patient and Dr. Robert acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dr. Robert agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask question and receive satisfactory and adequate explanations.

SO AGREED THIS _____ DAY OF _____, 2011.

X_____(PATIENT) / (GUARDIAN)

X_____PRINT PATIENT NAME)

Notice of Privacy Practices

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.

Dr. Ghislaine Robert, MD respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of **Dr. Ghislaine Robert .** The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If

we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our **[office/medical records department]** to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

[Front Desk Assistant or Office Manager]
[425-836-1800]

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,

- Accounting, legal, risk management, and insurance services; and
- Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.

- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **www.ghislainerobert.com**

7. Effective date

This Notice is effective as of 09/23/2013.

Policies of the clinic

1. You are financially responsible for all charges whether or not paid by your insurance provider.

2. Some of the services provided are not covered by insurance because they do not fall under the definition of medical care (ex: coaching, monitoring of performance, prevention of overtraining syndrome, etc.) Ask for the fees for these services if it is the reason for your visit.

3. Your time is precious and so is mine. I will try to honor your scheduled appointment and I ask you to be on time out of respect for the other patients. I usually take 30 min for a new patient or a new problem. If you are scheduling for a follow up, I might tell you to schedule for a 30 min appointment as well if I need more time. Don't forget to tell the front desk.

4. There is a cancellation policy. If you cancel 24 hours or more in advance, there is no charge. Otherwise we will bill you for $50.

5. If you are scheduled for an appointment, we want you to be aware that children are not allowed to accompany you in the doctor's office for liability reasons (presence of sharp materials, medical supplies, medication, etc.). Children under the age of 12 who are left in the waiting area need to be supervised. We cannot be held responsible for children left unsupervised.

6. If you do tests and the results are normal, we won't call you back (but you can check with my front desk). If your tests are abnormal or if there are other steps to follow for your treatment, you will be asked to reschedule for another appointment.

7. I am happy to answer quick questions via e-mail, but please understand that communications through e-mail are not private anymore. Please do not include personal identifying information such as your birthdate or personal medical information in any e-mails you send to us. Confidential information can't be discussed unless you can encrypt your message. But we can certainly exchange information regarding general matters (ex: the side effects of a medication, a good dosage for glucosamine, etc.)

8. I encourage you to visit my website for information, links and tips. (www.ghislainerobert.com)

I have read the previous information and I agree to pay the charges if it applies.

Printed name: _____
Signature: _____
Date: _____

DR GHISLAINE ROBERT

Date: ____/____/_____

Patient Name:_____
First Middle Initial Last

Address:_____

_____
City State Zip

Phone Numbers: _____
Home Cell Work

Employer: _____ Email: _____

Date of Birth:_____Social Security Number:_____

Gender: M F Marital Status: Student Single Married Divorced Widowed
(Circle One)

Person responsible for bill/Account Guarantor:

_____

Spouse Name:_____Date of Birth:_____

Emergency Contact:_____Phone: _____

May we leave a detailed message on your answering machine if we are unable to reach you? yes_____ no_____

What is your pharmacy of choice: _____

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby authorize you to evaluate and treat me (or my dependent). I have reviewed the information given and confirm it to be true. I understand that I am financially responsible for any bills incurred on this account, regardless of insurance coverage or third party liability. I further understand that in the event this account should go to collections I am responsible for all collection and legal fees and expenses. I hereby authorize assignment of insurance benefits to be paid directly to Dr Ghislaine Robert MD.

I authorize release of information to my insurance company(s). I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Date_____ Guarantor's Signature_____

Regenerative Medicine

DR. GHISLAINE ROBERT OFFERS NATURAL TREATMENTS SUCH AS PRP AND AUTOLOGOUS STEM CELL INJECTIONS USING THE BODY'S OWN NATURAL HEALING ABILITY TO TREAT MUSCULOSKELETAL & COSMETIC CONCERNS INCLUDING;

- HAIR LOSS TREATMENTS
- PRP/VAMPIRE FACIALS
- VAMPIRE LIFT
- GAINSWAVE ED TREATMENTS
- PRP FOR MUSCULOSKELETAL
- STEM CELL MUSCULOSKELETAL
- HEALTHY LIFESTYLE PROGRAMS

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REGENERATIVE MEDICINE

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