SEE Wellness

phone: 830-733-2071, FAX: 888-276-0071

NEW CLIENT INTAKE

Congratulations on your decision to move further on the path to optimal health! We're here to educate and support you as part of our commitment in partnering with you to bring about better health. Please fill out this form as completely and as accurately as possible.

GENERAL INFORMATION

DATE: _____

Name: _____ Preferred Name: _____

Primary Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SS #: _____

Age: _____ Gender: Female Male Race: _____

Ethnicity: _____ Relationship/Marital Status: _____

Home Phone: _____ Preferred Language: _____

Work Phone: _____ Best way to reach you: _____

Cell Phone: _____ Best time to reach you: _____

E-Mail Address: _____

Facebook: _____

Current Occupation, if retired - what from?: _____ Employer: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Address: _____ Apt. No.: _____

City: _____ State/Zip: _____

Primary Care Physician:

Name: _____ Phone #: _____

City: _____

How did you hear about us? _____

Billing Information

Credit Card: _____

Cardholder Name: _____

Card Number: _____ Expiration Date: / Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

PHARMACY INFORMATION

Primary Pharmacy

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Fax*: _____

*** It is extremely important that you list the pharmacy's fax number.**

Compounding/Supplement Pharmacy

Name: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Fax*: _____

*** It is extremely important that you list the pharmacy's fax number.**

MEDICAL CARE HISTORY

PREVENTIVE TESTS *Check box if yes and provide date*	**DATE**
☐ Full Physical Exam	
☐ Bone Density	
☐ Colonoscopy	
☐ Cardiac Stress Test	
☐ EKG	
☐ Hemoccult (stool test for blood)	
☐ Mammogram	
☐ PAP Smear	
☐ PSA	
☐ Shingles Vaccine	
☐ Pneumovax	
☐ Other _____	

SURGICAL HISTORY *Check box if yes and provide date*	**DATE**
☐ Appendectomy	
☐ Hysterectomy	
_____ Ovaries Removed: Right (R) / Left (L) / Both(B)	
☐ Gall Bladder	
☐ Hernia	
☐ Tonsillectomy/Adenoidectomy	
☐ Joint Replacement - Knee/Hip	
☐ Heart Surgery *(type)* _____	
☐ Angioplasty or Stent	
☐ Pacemaker	
☐ Other _____	

HOSPITALIZATIONS

Date	Reason for Hospitalization

SPECIALIST CARE ***Please list all physicians currently managing your care.***

Physician Name	Medical Specialty	Issue(s) Being Managed

MEDICAL SYMPTOM QUESTIONNAIRE

BASED ON THE PAST 30 DAYS rate each of the following symptoms based upon your typical health profile.

NAME _____ DATE _____

Please use the scale shown below to describe the severity of your symptom (please total each section)

0 ***Never*** **or** ***almost never*** **have the symptom**
1 ***Occasionally*** **have it, effect is** ***not severe***
2 ***Occasionally*** **have it, effect is** ***severe***
3 ***Frequently*** **have it, effect is** ***not severe***
4 ***Frequently*** **have it, effect is** ***severe***

HEAD
_____ Headaches
_____ Dizziness/Faintness
_____ Insomnia
_____ **SUBTOTAL (this section)**

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Dark circles under eyes
_____ Vision problems (excluding near or farsighted)
_____ **SUBTOTAL (this section)**

EARS
_____ Itchy ears
_____ Frequent ear infections
_____ Popping of ears
_____ Ringing in ears
_____ **SUBTOTAL (this section)**

NOSE
_____ Stuffy nose/Excessive mucus formation
_____ Sinus problems
_____ Hay fever/Sneezing attacks
_____ Nose bleeding
_____ **SUBTOTAL (this section)**

MOUTH/
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/Discolored tongue, gums, lips
_____ Canker sores
_____ **SUBTOTAL (this section)**

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Excessive hair growth
_____ Excessive sweating/Body odor
_____ Flushing, hot flashes
_____ **SUBTOTAL (this section)**

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ **SUBTOTAL (this section)**

LUNGS
_____ Chest congestion
_____ Asthma, frequent bronchitis
_____ Difficulty breathing
_____ Frequent coughing
_____ **SUBTOTAL (this section)**

Have you been exposed to mold in buildings? Yes or No

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea, loose stools
_____ Constipation, hard/infrequent stools
_____ Bloated feeling
_____ Belching, passing gas, burping
_____ Heartburn/acid taste in mouth
_____ Intestinal/stomach pain
_____ **SUBTOTAL (this section)**

JOINTS / MUSCLE
_____ Pain or aches in joints/Arthritis
_____ Warm, swollen joints
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Muscle weakness
_____ **SUBTOTAL (this section)**

And are you now or were you extra flexible? YES/NO

WEIGHT
_____ Excessive eating/drinking
_____ Strong/Excessive craving certain foods
_____ Overweight/Obese
_____ Difficulty losing weight
_____ Water retention
_____ Difficulty gaining weight
_____ **SUBTOTAL (this section)**

ENERGY / ACTIVITY
_____ Fatigue from mental exhaustion
_____ Fatigue from emotional exhaustion
_____ Hyperactivity (mind or body)
_____ Restlessness (mind or body)
_____ **SUBTOTAL (this section)**

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Speech difficulty
_____ Brain "fog"
_____ Learning disabilities
_____ **SUBTOTAL (this section)**

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression/Sadness
_____ Obsessive, compulsive behaviors
_____ **SUBTOTAL (this section)**

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ **SUBTOTAL (this section)**

TOTAL SUM OF ALL SECTIONS ABOVE: _____

PERSONALIZED HEALTH STRATEGY

*Please describe your **top two (2) health goals** you seek to strategically improve.*

GOAL #1:

GOAL #2:

COMPLAINTS/CONCERNS

When was the last time you felt well?

Did something trigger your change in health?

Is there anything that makes you feel worse?

Is there anything that makes you feel better?

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
example: Difficulty maintaining attention		✓		example: elimination diet	✓		

MEDICAL HISTORY

DISEASES/DIAGNOSES/CONDITIONS

Check appropriate box and provide date of onset
☑ = Past Condition (pc) ☑ = Ongoing Condition (oc)

pc	oc	**GASTROINTESTINAL**	date of onset
☐	☐	Irritable Bowel Syndrome	
☐	☐	Crohn's Disease	
☐	☐	Ulcerative Colitis	
☐	☐	Gastritis or Peptic Ulcer	
☐	☐	GERD (Acid Reflux)	
☐	☐	Celiac Disease	
☐	☐	Other_____	

pc	oc	**CARDIOVASCULAR**	date of onset
☐	☐	Heart Attack	
☐	☐	Poor Circulation	
☐	☐	Stroke	
☐	☐	High Cholesterol	
☐	☐	Arrhythmia (irregular beat)	
☐	☐	Hypertension (high blood pressure)	
☐	☐	Heart Valve Disease	
☐	☐	Other _____	

pc	oc	**METABOLIC/ENDOCRINE**	date of onset
☐	☐	Type 1 Diabetes	
☐	☐	Type 2 Diabetes	
☐	☐	Hypoglycemia (low blood sugar)	
☐	☐	Metabolic Syndrome	
☐	☐	Insulin Resistance or Pre-diabetes	
☐	☐	Obesity/Overweight	
☐	☐	Hypothyroidism (underactive)	
☐	☐	Hyperthyroidism (overactive)	
☐	☐	Polycystic Ovarian Syndrome (PCOS)	
☐	☐	Infertility	
☐	☐	Other _____	

pc	oc	**NEUROLOGIC/PSYCHIATRIC**	date of onset
☐	☐	Depression	
☐	☐	Anxiety	
☐	☐	Bipolar Disorder	
☐	☐	Headaches	
☐	☐	Migraines	
☐	☐	ADD/ADHD	
☐	☐	Autism	
☐	☐	Multiple Sclerosis	
☐	☐	Seizures	
☐	☐	Eating Disorder (Anorexia/Bulimia)	
☐	☐	Other _____	

pc	oc	**GENITAL AND URINARY**	date of onset
☐	☐	Kidney Stones	
☐	☐	Interstitial Cystitis	
☐	☐	Frequent Urinary Tract Infections	
☐	☐	Frequent Yeast Infections	
☐	☐	Erectile or Sexual Dysfunction	
☐	☐	Urinary Incontinence	
☐	☐	Other _____	

pc	oc	**MUSCULOSKELETAL/PAIN**	date of onset
☐	☐	Osteoarthritis	
☐	☐	Fibromyalgia	
☐	☐	Gout	
☐	☐	Chronic Pain Syndrome	
☐	☐	Other _____	

pc	oc	**AUTOIMMUNE/INFLAMMATORY**	date of onset
☐	☐	Chronic Fatigue Syndrome	
☐	☐	Autoimmune Disease	
☐	☐	Rheumatoid Arthritis	
☐	☐	Hashimoto's Thyroiditis	
☐	☐	Psoriasis	
☐	☐	Food Allergies	
☐	☐	Environmental Allergies	
☐	☐	Multiple Chemical Sensitivities	
☐	☐	Other _____	

pc	oc	**PULMONARY/EAR-NOSE-THROAT**	date of onset
☐	☐	Asthma	
☐	☐	Chronic Sinusitis	
☐	☐	Bronchitis	
☐	☐	COPD or Emphysema	
☐	☐	Pneumonia	
☐	☐	Sleep Apnea	
☐	☐	Other _____	

pc	oc	**DERMATOLOGIC**	date of onset
☐	☐	Eczema	
☐	☐	Vitiligo	
☐	☐	Acne	
☐	☐	Other _____	

pc	oc	**CANCER**	date of onset
☐	☐	Lung Cancer	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Ovarian Cancer	
☐	☐	Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Other _____	

FEMALE HISTORY

OBSTETRIC HISTORY *(Check box if yes and provide number of times)*

Pregnancies _____ Cesarean _____ Vaginal Deliveries _____

Miscarriage _____ Abortion _____ Living Children _____

Postpartum Depression Toxemia Gestational Diabetes Baby over 8 lbs

Breastfeeding For How Long? _____

MENSTRUAL HISTORY

Age at first period _____ Menses Frequency: every _____ days Menses Length: _____ days long

Describe your **current** menstrual cycle Regular Irregular Absent

Details: _____

Last Menstrual Period: _____ Date of Last PAP: _____

History of Abnormal PAP? Yes No If yes, date of abnormal PAP: _____

Current contraception? Birth Control Pill Condom Vasectomy IUD Hysterectomy None

Total years of hormonal contraception use? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES (circle all that apply)

Fibrocystic Breasts Endometriosis Fibroids Infertility

Painful Periods Heavy Periods PMS Menstrual Migraines

Are you in menopause (no menses in last 12 months)? No Yes (if yes, what age? _____)

If yes, Natural Surgical removal of ovaries reason for removal _____

Current use of hormone replacement therapy? None

(How Long? _____) Traditional Prescription

(How Long? _____) Bioidentical Hormone Replacement Therapy

Previous use of hormone replacement therapy? None

(How Long? _____) Traditional Prescription

(How Long? _____) Bioidentical Hormone Replacement Therapy

MENOPAUSAL SYMPTOMS (circle all that apply)

Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness

Night Sweats Sleep Problems Postmenopausal Bleeding Loss of Control of Urine

Headaches Palpitations Weight Gain Depression or Anxiety

MALE HISTORY

Have you had a PSA done? No Yes (Date of last PSA? _____)

PSA Level: 0-1 2-4 5-10 >10 Managing Urologist: _____

ANDROPAUSE SYMPTOMS (circle all that apply)

Fatigue Nocturia (urination at night) How many times per night? _____

Irritability Urgency/Hesitancy/Change in urinary stream

Decreased Libido Enlarged Prostate

Erectile Dysfunction

DIGESTIVE/DIETARY HISTORY

TYPICAL DIET: List the most common meal you eat or drink in each category-

Breakfast: _____ Beverage: _____

Lunch: _____ Beverage: _____

Dinner: _____ Beverage: _____

Snack: _____ Beverage: _____

How many cups of water do you drink a day? _____ Cups

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

If yes, ☐ within 30 min after eating ☐ after 1-2 hours of eating

Were there years where you took more than 3 courses of antibiotics per year? ☐ Yes ☐ No

Do you experience frequent yeast infections or toe fungal infections/athlete's foot? ☐ Yes ☐ No

Do you get sick from strong smells, chemicals or medications easier than most people? ☐ Yes ☐ No

Are there some foods to which you are allergic, intolerant or just seem to bother you?

Explain:

Do you notice that after eating you have symptoms of runny nose, achiness, brain fog, or puffiness? Yes / No

Do you suffer from allergies? ☐ Environmental ☐ Food

If environmental, are they. . . ☐ Seasonal ☐ All Year Long

Do you ever find blood in your stool? ☐ Yes ☐ No

How many bowel movements do you have in a typical day? <1 1 2 3 4 _____

If you answered <1, how often do you have a bowel movement? Every _____ days Since When? _____

Describe your typical bowel movement *(check all that apply)*

☐ Hard ☐ Soft ☐ Alternating Diarrhea/constipation ☐ Complete

☐ Pellet-like ☐ Loose ☐ Mucus in stool ☐ Incomplete

☐ Requires straining ☐ Watery ☐ Undigested food in stool

☐ Large ☐ Floating ☐ Strange color/odor

If you experience any digestive issues, when did they begin?

☐ Last 3-6 months ☐ Since childhood

☐ Last 6-12 months ☐ Can't remember

☐ _____ years ago

Have you ever been referred to a Gastroenterologist? ☐ No ☐ Yes Name:_____

Explain:

LIFESTYLE INFORMATION

SMOKING

Currently smoking? Yes No How many years? _____ Packs per day: _____

Attempts to quit: _____ Using what methods: _____

Previous smoking? Yes No How many years? _____ Packs per day: _____

Quit Date: _____

2nd hand smoke exposure? None Low Medium High

Current Past

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5oz wine, 12 oz beer, 1.5 oz liquor)*

None 1-3 4-6 7-10 >10 throughout the week weekends mostly

Do you frequently (more than 2x/week) take:

>1 drink per day for females

>2 drinks per day for males

Previous alcohol intake? None Mild Moderate High

Do you ever feel guilty about your alcohol consumption? Yes No

Do you notice a tolerance to alcohol (you can "hold" more than others)? Yes No

Do you notice you 'feel' your alcohol at very low amounts? Yes No

OTHER SUBSTANCES

Caffeine intake

Cups per day: Coffee: _____ Tea: _____ (Herbal Non-Herbal)

Caffeinated or Diet Beverages per day None 1 2 3 ≥4

List favorite type (e.g. Diet Coke, Pepsi, Red Bull, Monster, etc) _____

Do you often take caffeine to avoid fatigue? Yes No

EXERCISE

Current Exercise Program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency/week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Yoga/Pilates			
Sports/Leisure Activities *(golf, tennis, rollerblading, etc)*			

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

Do you usually sweat when exercising? Yes No

Obstacles or challenges with exercise: (check all that apply) Time Pain Energy

Other _____

LIFESTYLE INFORMATION

STRESS/COPING

1. Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No
2. Do you feel you can manage the stress in a healthy way? ☐ Yes ☐ No
3. Do you feel you make unhealthy choices due to high stress? ☐ Yes ☐ No
4. What is the level of stress in you life? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
5. What has been the level of trauma in your life? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
6. Would you like to improve the way you manage stress? ☐ Yes ☐ No
7. Have you ever sought counseling? ☐ Yes ☐ No

Daily Stressors: Rate on a scale of 1-10 (1=lowest, 10 highest)

Work _____ Family _____ Social _____ Finances _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No

Check all that apply: ☐ Prayer ☐ Breathing ☐ Meditation ☐ Yoga ☐ Tai Chi ☐ Other _____

Are you religious? Yes or No (circle one)

SLEEP/REST

How likely are you to doze off or fall asleep in the following situations using the scale below?

0 = Would never doze *2 = Moderate chance of dozing*

1 = Slight chance of dozing *3 = High chance of dozing*

Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (ex, a theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3

Average number of hours you sleep per night? ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling asleep at night? ☐ Yes ☐ No

If yes, how long does it usually take to fall sleep? _____

Do you have trouble staying asleep at night? ☐ Yes ☐ No

If yes, how long are you awake throughout the night? _____

How many times do you awaken throughout the night? _____

Please list any sleep aids (prescription or natural) or other methods tried:

READINESS ASSESSMENT

In order to improve your health, how willing are you to ***(Rate on a scale of 5 1 very willing to 1 1 not willing)*** please circle below:

Educate yourself on your condition Significantly	**5**	**4**	**3**	**2**	**1**
modify your diet	**5**	**4**	**3**	**2**	**1**
Modify your lifestyle (work demands, sleep, etc)	**5**	**4**	**3**	**2**	**1**
Consider how to make more time for God daily	**5**	**4**	**3**	**2**	**1**
Take several nutritional supplements each day	**5**	**4**	**3**	**2**	**1**
Engage in regular exercise	**5**	**4**	**3**	**2**	**1**
Have periodic lab tests to assess your progress	**5**	**4**	**3**	**2**	**1**

Comments:

GENETIC RISK ANALYSIS

Please place age at diagnosis where appropriate.	Mother	Father	Brother(s)	Brother(s)	Sister(s)	Sister(s)	Child(ren)	Child(ren)	Child(ren)	Child(ren)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still alive)														
Age at death														
Colon Cancer														
Breast Cancer														
Other Cancers - List Type _____														
Heart Disease														
Stroke														
Hypertension														
Obesity/Overweight														
Diabetes														
High Cholesterol														
Arthritis (<60 years old)														
Multiple Sclerosis														
Rheumatoid Arthritis / Lupus / Psoriasis														
Ulcerative Colitis / Crohn's Disease														
Irritable Bowel Syndrome (IBS)														
Celiac Disease														
Asthma / Chronic Bronchitis														
Eczema/Hives														
Food Allergies or Sensitivities														
Environmental Sensitivities														
Multiple Chemical Sensitivities														
Dementia or Parkinson's														
Substance Abuse (alcoholism, drugs)														
Depression														
Anxiety														
ADHD														
Autism														
Thyroid Disorders														
Other _____														

EXPOSURES: (CIRCLE) this section is very important!

MOLD WATER DAMAGED BUILDINGS **PESTICIDES** **HERBICIDES** **ROUNDUP** **OTHER TOXINS**_____

MEDICATION HISTORY

Attach separate page as needed

CURRENT MEDICATIONS

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Use?

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Strength	Dosing Schedule	Start Date (month/year)	Reason for Stopping?

CURRENT NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement	Strength	Dosing Schedule	Start Date (month/year)	Brand of Supplement
Have you used probiotics before?	Y/N	What happened?		

ALLERGIES (ENVIRONMENTAL, FOOD & DRUGS)

Allergen	Associated Symptoms	Treatment needed, if applicable

AUTHORIZATION TO RELEASE & OBTAIN PROTECTED HEALTH INFORMATION

I _____ give permission to Suzanne Ellison MD & SEE Wellness LLC to release OR obtain any information, verbally or written, on my behalf to/from the following persons.

PLEASE PRINT

Release of Records from: _____

Release of Records from: _____

And release records to:

Desired records:

Last year of progress notes and consults from specialists from the last five years.

Lab results in the last 2 years.

Scans, xrays, pathology reports, last 5 years.

Name: _____

Phone: ( ) _____ Relationship to Patient: _____

Name: _____

Phone: ( ) _____ Relationship to Patient: _____

Name: _____

Phone: ( ) _____ Relationship to Patient: _____

This notice will expire upon written notice as provided by patient to SEE Wellness, LLC.

_____ _____

Patient/Guardian Signature Date

_____

Printed Patient's Name

_____ _____

Witness Signature Date

SEE Wellness: **Informed Consent Regarding E-mail or the Internet Use of Protected Personal Information**

SEE Wellness LLC, and Suzanne Ellison MD PA provide patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.

b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of SEE Wellness LLC and Suzanne Ellison MD PA that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. SEE Wellness LLC and Suzanne Ellison MD PA will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Suzanne Ellison, M.D., physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

b. The office may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. We at SEE Wellness, LLC, will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.

d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

f. SEE Wellness LLC, cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication. However, Dr. Ellison and her team are not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform See Wellness, LLC, staff of any type of information you do not want to be sent by e-mail.

h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent, or received, from SEE Wellness, LLC, to protect confidentiality. SEE Wellness, LLC, is not liable for breaches of confidentiality caused by the patient.

SEE Wellness: **Informed Consent Regarding E-mail or the Internet Use of Protected Personal Information (con't)**

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to SEE Wellness, LLC at staff@see-wellness.com

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name Printed: _____

Client Signature: _____

Date:_____