Maryann Simpson, NP.

Patient Conditions of Treatment and Informed Consent to Treat

This document is a binding agreement (the "Agreement") between Maryann Simpson, NP (NP defined as Nurse Practitioner) and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services which may be provided to you by Maryann Simpson, NP at the present and at all times in the future. You agree as follows (your agreement indicated by placing your initials on the lines following each section and by signing in the space provided):

1. **Consent For Treatment.** You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You hereby consent to and authorize Maryann Simpson, NP to provide You with health care treatment which, depending on Your health conditions, may include one or more of the following procedure: Hormonal Replacement Therapy, HCG Weight-loss Diet program, Subcutaneous vitamin Injections, Dietary and Nutritional Consultation, supplementation and Prescriptions; together the "Treatments" administered by Maryann Simpson, NP. You acknowledge that Maryann Simpson has not made any guarantees or promises as to the outcome or the safety and efficacy of the above listed Treatments.
   (Initials) _________
2. **Experimental Nature of Treatments.** You acknowledge and agree that the Treatments may consist in whole or part of experimental procedures and methods, in which no governmental (including the U.S. Food and Drug Administration), scientific or medical authority has confirmed the safety or efficacy thereof. You acknowledge that the safety and efficacy record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe and effective. Maryann Simpson, NP has informed you that the Treatments may alter, address, or decrease your pain, symptoms, or complaints, but also may have no effect. (Initials) _________
3. **Description of Treatments.** The exact procedure, as well as the recommended sequence of Treatments, will be explained to you when Maryann Simpson actually administers the Treatments. You acknowledge that any of the Treatments may involve insertion of needles into your skin and the injection of standardized formulas which may include various nutritional substances. (Initial) _________
4. **Information You Provide Maryann Simpson, NP.** You have provided with a complete list of all prescription and non-prescription medications and dietary supplements you are currently taking, and a complete list of all known allergies You may have, and all allergic or adverse reactions You have had in the past to any medicines, dietary supplements, or medical treatments of any kind. You agree to update Maryann Simpson, NP., periodically should this list change. (Initials) ____
5. **Assumption of Risk.** You hereby, acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any questions about this Agreement of the Treatment that you have, You are willing to assume any and all risks associate with the Treatments, including without limitation those described in the Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may/or could arise from the Treatments, but that by initialing and signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.
   (Initials) _________

6. **Alternatives.** You have been informed that there are alternatives to the Treatments including prescription medications and taking no action. (Initials) _________
7. **Independent Practitioner.** All treatments and procedures provided are between Maryann Simpson, NP and patient. Maryann Simpson, NP is not an employee at Embody Wellness and is providing care at this facility as an Independent practitioner. (Initials) ________

By signing this Agreement, You indicate that You have read, understood and agree to its terms, You have received a copy of this Agreement, and that You are the patient, Guarantor, the patient's legal representative or legally authorized to sign this Agreement and accept its terms.

Patient Name (Print) ______________________________ Legal Guardian ______________________________

Signature ______________________________________ Signature ___________________________________

Date ____ Date ______________________________________

I Maryann Simpson, NP, hearby certify that I have explained to the patient or authorized person the nature of the proposed treatments, the medically significant alternatives, and in lay terms the purpose, likelihood of success, benefits, and reasonably foreseeable risks, complications, and consequences of treatment. The patient or person authorized has had the opportunity to ask questions and has stated that no further explanation was desired.

Nurse Practitioner Signature (Maryann Simpson, NP) ______________________________ Date __________

PATIENT/PROVIDER AGREEMENT FORM

Maryann Simpson NP.

DESCRIPTION OF SERVICES:

Maryann provides a comprehensive evaluation of your hormones and lifestyle. She will optimize any hormone deficiencies with bio-identical hormone replacement therapy, nutrition and supplementation. Patients are required by law to be seen and tested at least one time per year.

While Maryann is devoted to supporting her patients in optimal health and has a successful history of doing so, she is not solely responsible for your health results. Whole lifestyle approach and personal accountability are crucial pieces to having health, vitality and wellbeing.

PROVIDER CONTACT GUIDELINES:

In order to keep our prices accessible and balance Maryann's schedule, you will be required to schedule an appointment for most questions and concerns.
Please note that our office is not a concierge or boutique type practice. These types of concierge services charge thousands of dollars annually and include 24/7 availability and same day service.

If you have administrative questions call the office at (916) 293-9831. If you have health related questions that are not an emergency (for emergencies you must call 911) please email Maryannsimpsonnp@embodywellness.com and allow 72 hours for a response.

This contract signs you up for our email newsletter. This is our primary source of communication regarding important policy and price changes. It also gives supportive health information and special offerings. You can unsubscribe at any time.

PRESCRIPTION POLICY:

Please call the prescribing pharmacy for all prescription refills. We require 72 hours to respond to all prescription requests which will be sent to us by the pharmacy. If you are due for your annual or would like to see Maryann for a follow-up appointment, you can schedule either by calling the office at (916) 293-9831or online at Embodywellness.com.

TESTING POLICY:

All Hormone and Thyroid testing needs to be ran through Spectracell laboratories. Testing through the same lab company keeps a more accurate record and helps Maryann to track your progress more effectively. If you are put on Testosterone or

thyroid medication you will have to be re-tested in 8-12 weeks to ensure the level is correct. Any change in Testosterone or Thyroid medication requires a visit and you will have to repeat labs again in 8-12 weeks to ensure proper hormone levels as well as a follow-up appointment to review results.

Maryann does not order labs for patients with Medicare, claims will NOT be made to Medicare and therefore Medicare patients must pay the cash price for Labwork.

CANCELLATION POLICY:

We are open Monday-Thursday and we have a 24-hour cancellation policy. You must cancel your appointment one full business day (business day is described as Monday-Thursday) before the scheduled visit. Please contact our office within 24 hours to cancel or reschedule your appointment. We require prepayment for all Initial Consultations, if you do not cancel within one full business day you will not be reimbursed for the cost of that initial visit.

REFUND POLICY:

We do not offer refunds on services provided by Maryann. We offer returns only on un-opened supplements with receipt.

PRICING:

We do not bill medical insurance for our services or products. We are not allowed to provide any blood testing or super bills for Medicare or Medicaid.

Initial Consultation $275
Annual $175
30 Minute Consultation $125
HCG Weight Loss Program (New Patient) $450
HCG Weight Loss Program (Existing Patient) $350

***These prices are subject to change.

I have read the entire Agreement above and been given the opportunity to ask questions.

______________________________ ______________________
Patient Name (Please Print) Todays Date

____
Patient Signature

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Mary Ann Simpson to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. (The Notice of Privacy Practices provided by Mary Ann Simpson NP describes such uses and disclosures more completely
I have the right to review the Notice of Privacy Practices prior to signing this consent. Mary Ann Simpson NP reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mary Ann Simpson NP.
With this consent, Mary Ann Simpson NP may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.
With this consent Mary Ann Simpson NP may mail, email or text to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.
With this consent, Mary Ann Simpson NP may email to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that Mary Ann Simpson NP restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to allow Mary Ann Simpson NP to use and disclose my PHI to carry out treatment, payment, and healthcare operations.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Mary Ann Simpson NP may decline to provide treatment to me.

Signed by: ______________________ Date: ___________________
Patient or Legal Guardian

___________________ ________________________
Print Patient's Name Print Name of Legal Guardian, if applicable

Mary Ann Simpson NP
805-2 Wales Drive
Folsom CA 95630
916-293-9831

INITIAL CONSULTATION EVALUATION

Name_______________________________Date__________ Date of Birth ________
Address ____
E-Mail Address _______________________ Phone #___________________________
Emergency Contact: Name_______________Phone #__________________________
BP __________ HT __________ WT __________
Do you have health insurance?_________
If yes, who is your Carrier?_______________
How did you hear about us?__________________________

Primary Care Physician ____
Dates of most recent PAP __________ Blood Tests __________
Mammogram ________
We will need copies of those results at your initial visit.

SOCIAL HISTORY:

Married / Single / Divorced / Widowed
Occupation ______________________________
How many hours per week ____________________
Children __________
CURRENT MEDICATIONS / SUPPLEMENTS ________________________________
____
____
ALLERGIES TO MEDICATIONS ____
____
____

GYNECOLOGICAL HISTORY:

Age of first period _________
Last menstrual period _________
Please list any current or history of menstrual problems: PMS, breast tenderness, irregular menstrual cycles, heavy or painful periods, headaches ___________________
____
____
Uterine fibroids____
Abnormal PAP results ____
Number of pregnancies __________ Miscarriages __________
Number of children __________ vaginal or cesarean deliveries ___________________

History or current use of birth control ____

MEDICAL HISTORY:
Please circle if indicated or add to the list if not mentioned below.

- Heart disease
- High blood pressure
- High cholesterol
- Gastrointestinal
- Anxiety
- Depression
- Thyroid problem
- Blood clots
- Urinary problems
- Diabetes
- Liver disease
- Insomnia
- Cancer
- Osteoporosis
- Arthritis
- Chronic Fatigue
- Fibromyalgia

Additional medical history information:______________________________________
Smoking, history or current____
Alcohol consumption ____

SURGICAL HISTORY:

Type of surgeries/ dates ____

FAMILY MEDICAL/ SURGICAL HISTORY:

MOTHER

FATHER

BROTHER

SISTER

CHILDREN

EXERCISE PROGRAM ____

24 HOUR DIETARY RECALL:
Briefly list your usual diet habits for breakfast, lunch, dinner and snacks including beverages on a normal day.

Please explain the reason for your visit: