Welcome! Thank you for visiting the therapists at NLC How were you referred here?_____

What is your main reason for visit and concern:_____

What is your level of pain right now: 0 (0 no pain) 1 2 3 4 5 (5 moderate) 6 7 8 9 10 (10 call ambulance)

What is your stress level right now: 0 (0 no stress) 1 2 3 4 5 (5 moderate) 6 7 8 9 10 (10 call counselor)

Date: _____ Practitioner:_____ Treatment:_____

Patient Name:_____ DOB:_____

Address:_____

Email:_____ Phone: (____)_____

Allergies, intolerances, sensitivities:_____

Current supplements & medications: _____

Since birth, All Surgeries or Trauma:_____

Are you pregnant_____ History of blood clots and where_____ Diagnosis_____

I hereby authorize my therapist to take and use any photographs or medical information for treatment and educational purpose such as before & after for posture or swelling reduction. X _____

I authorize my therapist to share / release my medical information to my associate listed or insurance company for appropriate purposes. X _____ Associate/Doctor:_____

WAIVER: I understand that my therapist cannot diagnose and that this service is not a one-time cure-all, but rather an assessment, evaluation, and treatment for relief of symptoms yet geared to release the lymphatics and fascia and establish a treatment plan with self maintenance.

I hereby indemnify and hold the indemnified parties harmless from all liability, claims, and claim from any third persona resulting from services and products purchased at National Lymphatic Centers, Inc. or from Sharon Vogel, Nick Talbot, Smita Shah, Renee Matthes, or any other worker at 5002 Main Street, Ste A, Downers Grove. I hereby release on my behalf and on behalf of my heirs any and all liability or responsibility for any injury, camera, or other losses, including attorneys fee, associated with use of establishment. I am aware that this is a release of liability. I understand the information presented and that it is held in the strictest HIPPA guidelines and professional ethics. POLICY: Treatment time begins at the designated agreed upon scheduled time and includes intake form, consultation, procedure, exercise demonstration, and post service consultation. If a guest is late for their service, then the clinician will do as much work as possible with the time remaining. The original agreed upon price will remain respectfully affixed. If the clinician starts late, then the time will be added to the end of their service or the price will be adjusted respectfully. A 48 hour notice of cancellation is appreciated, or full commission is accepted.

X _____ Date:_____Print_____

Signature of Patient or Guardian Revised 03/11/2018 Sharon M. Vogel

National LYMPHATIC CENTERS

National Lymphatic Centers, Inc 5002 Main Street, Suite A, Downers Grove, IL 60515

& Independent Therapists

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.

We are required by law to maintain the privacy of your health information and to give you our Notice of Privacy Practices (this "Notice") that describes our privacy practices, legal duties and your rights concerning your medical information. Your health information includes your individually identifiable medical, insurance, demographic and medical payment information. For example, it includes information about your diagnosis, medications, insurance status, medical claims history, address, and policy or social security number.

Who Will Follow This Notice

This Notice describes the privacy practices of National Lymphatic Centers, Inc., Sharon M. Vogel, Nick Talbot, and any other worker at 5002 Main St, Downers Grove, IL 60515, hereafter known as NLC including other health care providers that the organizations operate, as well as any health care facility or physician practice now or in the future controlled by or under common control by NLC. The organizations are part of the NLC.

MEDICAL STAFF and Allied Health Practitioners. This Notice also describes the privacy practices of the physicians, nurse practitioners and other health care professional on our medical staffs (collectively "Practitioners") and other health care providers that provide health care services in our facility. Legally this is called an "organized health care arrangement" or "OHCA" between the NLC and eligible providers on its Medical Staff. Because the NLC is a clinically-integrated care setting, our patients receive care from NLC staff and from independent practitioners on the Medical Staff. NLC and its staff must be able to share your health information freely for treatment, payment and health care operations as described in this Notice. Because of this, the NLC and all eligible providers on the NLC have entered into the OHCA under which the NLC and the eligible Providers will:

• Use this Notice as a joint notice of privacy practices for all patient visits and follow all information practices described in this notice--

• Obtain a single signed acknowledgment of receipt

• Share health information from visits with eligible providers so that they can help the NLC with its health care operations

Accordingly, this Notice will be followed by (1) employees and (2)the independent physicians and other Practitioners who are not employees, agents, servants, partners or joint ventures of NLC or its Affiliates. All Practitioners are solely responsible for their judgment and conduct entreating or providing professional services to patients and for their compliance with state and federal laws. Nothing in this Notice is meant to imply or create an employment relationship between any independent physician or other Practitioner and us. We use a joint Notice of Privacy Practices and a joint Acknowledgement Form with independent physicians and other practitioners to reduce paperwork and make it easier to share information to improve your care. This Notice does not change or limit any consents for treatment or procedures the patient may sign during the time the patient receives care from any of us. **The OHCA does not cover the information practices of practitioners in their private offices or at other practice locations.**

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following are the types of uses and disclosures we may make of your health information without your permission. Where state or federal law restricts one of the described uses or disclosures, we follow the requirements of such stator federal law. These are general descriptions only. They do not cover every example of disclosure within a category.

Treatment

We will use and disclose your health information for treatment. For example, we will share health information about you with nurses, physicians, students and others who are involved in your care at a Blissful Healthcare Center. Our Affiliates enter and can view your health information in our medical record system. We will also disclose your health information to your

physician and other practitioners, providers and health care facilities that provide care for you at their sites, rather than at our sites, for their use in treating you in the future. We will use and disclose your health information for payment purposes. For example, we will use your health information to prepare your bill and we will send health information with your bill for reimbursement. We may also disclose health information about you to other health care providers, health plans and health care clearinghouses for their payment purposes. If state law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for payment purposes.

Health Care Operations
We may use or disclose your health information for our health care operations. For example, providers or members of our workforce may review your health information to evaluate the treatment and services provided, and the performance of our staff caring for you. In some cases, we will furnish other qualified parties with your health information for their health care operations. If state law requires, we will obtain your permission prior to disclosing your health information toothier providers or health insurance companies for their health care operations.

Appointment Reminders
We may contact you as a reminder that you have an appointment for treatment or services through email, phone, or text.

Treatment Alternatives
We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Family
If any of these individuals are involved in your care or payment for care, we may also disclose such health information as is directly relevant to their involvement. We will only release this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would been your best interest to allow the person to receive the information or act on your behalf.

Required by Law
We will use and disclose your information as required by federal, state or local law, such as to report child or dependent adult abuse. We may disclose health information about you for public health activities. We may notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law (for example, to report a particular type of injury), we will only make this disclosure if you agree or in other limited circumstances when such disclosures authorized by law. These activities may include disclosures:
• to appropriate authorities authorized to receive reports of abuse and neglect
• to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

Health Oversight Activities
We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information
requested.

Law Enforcement
We may release certain health information to law enforcement authorities for law enforcement purposes, such as:
• required by law, including reporting certain wounds and physical injuries
• in response to a court order, subpoena, warrant, summons or similar process
We must comply with federal and state laws in making such disclosures for law enforcement purposes.

Business Associates Some of the activities described above are performed through contracts with outside vendors called business associates. We will disclose your health information to our business associates and allow them to create, use and

disclose your health information to perform their services for us. We require business associates to appropriately safeguard the privacy of your information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION There are many uses and disclosures we will make only with your written authorization. These include:

• **Uses and Disclosures Not Described Above.** We will obtain your authorization for uses and disclosures of your health information that are not described in the Notice above.

• **Marketing.** We will not use or disclose your protected health information for marketing purposes without your authorization. Moreover, if we will receive any financial remuneration from a third party in connection with marketing, we will tell you that in the authorization form.

YOUR RIGHTS You may inspect and copy much of the health information we maintain about you, with some exceptions. If you direct us to transmit your health information to another person, we will do so, provided your signed, written direction clearly designates the recipient and location for delivery. We may charge a fee forth costs of copying, mailing, and other supplies or work associated with your request. We will respond to your requests to exercise any of the above rights on a timely basis in accordance with our policies and as required by law. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care or payment for your care. We are not required to agree to your request, with one exception explained in the next paragraph, but we will let you know whether we have agreed to your request. We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes if (1) you pay out-of-pocket in full for all expenses related to that service either at the time of service or within timeframes specified by our written policies and (2) the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction.

Amendment You may request that we amend certain health information that we keep in your records if you believe that it is incorrect or incomplete. We may require you to give a reason to support your request. We are not required to make all requested amendments, but will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

Accounting You have the right to receive a list of certain disclosures of your health information made by us or our business associates. You must state time period for your request, which may not be longer than six years. The first list in any 12-month period will be provided to you for free; you may be charged fee for each subsequent list you request within the same 12-month period. Your right to an accounting of disclosures does not include disclosures for treatment, payment or health care operations and certain other types of disclosures, for example, as part of a facility directory or disclosure in accordance with your authorization. Requests must be in writing. You may contact the Privacy Officer to obtain a form to request an accounting of disclosures.

Notice in the Case of Breach You have the right to receive notice of an access, acquisition, use or disclosure of your health information that is not permitted by HIPAA, if such access, acquisition, use or disclosure compromises the security or privacy of your PHI (we refer to this as a breach). We will provide such notice to you without unreasonable delay but in no case later than 60 days after we discover the breach.

COMPLAINTS If you have concerns about any of our privacy practices or believe that your privacy rights have been violated, you may file a complaint with the NLC using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint. sharonmvogel@lymphatics.net

I, Print _____, have read, understand, and agree to these notice of privacy practices.

X_____ Signature _____Date

Revised 03/11/2018 Sharon M. Vogel