Springfield Wellness Center™

Originator & Producer of BR+ NAD Brain Restoration Plus ™

Patient Evaluation Packet

Welcome

Springfield Wellness Center

32900 Pitcher Road, Springfield, LA. 70462

Phone: 225-294-5955 **Fax: 225-294-5944**

E-mail: Springfieldwellnesscenter@gmail.com

Thank you for choosing Springfield Wellness Center.

Contents

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Patient Information Sheet

Patient's Name: _____ Married _____

Street Address/ Apt. # _____

City/State/Zip: _____

Employee: _____

Home Phone Number: _____ Work Phone: _____

Cell Phone Number: _____ Driver's Lic # _____

Social Security Number: _____ Date of Birth _____

E-mail Address: _____

Spouse's/Guardian: _____

Address/City/State: _____

Social Security Number: _____

Relative/Friend Not Living with you:

Name: _____ Relationship _____

Address: _____

Phone Number _____

We require PAYMENT IN FULL prior to treatment. Payment must be received before treatment can begin. We are a fee for service facility. We do not accept payments from insurance companies or file insurance claims. We will provide the necessary documentation in order for you to file or _____ we can refer you to the claims specialist.

Each treatment protocol is individualized. Product orders are made for each individual. **We are not able to provide refunds.**

Are you interested in speaking to an insurance claims Specialist?	YES____	NO ___
I will NOT be filing claims with my insurance company.	YES____	NO ___
I will be filing insurance claims myself.	YES____	NO ___

I have read and understand the Payment Policy and agree to make payment in full prior to treatment.

Signature: of patient: _____ **Date:**_____/_____/_____

Spouse's/Guardian signature: _____ **Date:**_____/_____/_____

NOTICE OF PRIVACY PRACTICES
SPRINGFIELD WELLNESS & THERAPIA ASSOCIATES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide for you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law for lawful processes. We will use disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Public Health Responsibility: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters. In addition, we may contact you to inform you of health screenings, wellness events or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you about seminars or programs that we are providing.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 per page for the first 25 pages and .25 cents per page for 26 and up. If you want the copies mailed to you, postage will be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. Disclosures prior to April 14, 2003 do not have to be made available.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except emergencies.) This request must be submitted in writing. We can

provide you with the following forms to make such requests:

A. Request to review health care information
B. Request to amend health care information
C. List of non-routine disclosures
D. Complaint form
E. Authorization for disclosure of protected health information

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. (Request a complaint form.) We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Therapia Associates/Springfield Wellness, LLC

ADDRESS: 2900 Pitcher Road, Springfield, LA 70462

TELEPHONE: 225-294-5955

Patient Name _____

Signature:_____Date:_____/_____/_____

HIPAA Notice of Privacy Practices
This form does not constitute legal advice.

ADDENDUM TO HIPPA NOTICE OF PRIVACY PRACTICES

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I hereby consent to release information related to my care and treatment at Springfield Wellness center to the following individuals:

1. _____ Relationship_____

2. _____ Relationship_____

3. _____ Relationship_____

Patient Name _____

Signature:_____Date:_____/_____/_____

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Medical Information Release Form

(HIPAA Release Form)

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

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] You may text or e-mail by phone

The best time to reach me is (*day*)_____ between (*time*)_____

Signature: _____ **Date:**_____/_____/_____

Witness: _____ **Date:**_____/_____/_____

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Medical History

Name:_____ **Date of Birth:**_____/_____/_____ Gender:_____

All Current Medication: (Please include dosage / frequency)

_____

_____

_____

_____

_____

Allergies:

Are you currently under the care of a Primary Physician? [ ] Yes [ ] No

Primary Physician:

Name: _____

Address: _____

Phone number: _____

Check all below that applies:

___ High blood pressure	___ Low blood pressure	___ Hepatitis/Liver disease
___ Respiratory Disease/COPD	___ Seizures/Fainting Spells	___ Cardiovascular Disease
___ Migraines	___ Epilepsy	___ Cancer
___ Stomach ulcers/Acid reflux	___ Kidney Disease	___ AIDS or HIV infection
___ Sexually Transmitted Disease	___ Mental Illness	___ Tuberculosis
___ Thyroid Problems	___ Diabetes	___ Immune System Problems
___ Alcohol Dependent	___ Bleeding Problems	___ Asthma/Chronic Bronchitis

___ Do you think you may be pregnant?

Signature: _____ **Date:**_____/_____/_____

Chemical Use History

CHEMICAL TYPE	AGE AT START	AGE OF REGULAR USE	DESCRIBE PATTERN (frequency, duration, amounts, type, method of use)	LAST USE
ALCOHOL Beer, Wine, Liquor				
COCAINE/CRACK				
CANNABINOIDS Marijuana, Pot, Hashish				
AMPHETAMINES Crystal meth, Crank, Speed, Ice, Diet Pills, Benzedrine, Dexedrine, Ritalin, Adderall, Methedrine, Vyvance				
HALLUCINOGENS STP, PCP, LSD, Mescaline, Mushrooms, Ayahuasca, Peytone, Acid, Ketamine, Ecstasy				
CAFFINE Soda, Tea, Coffee				
NICOTINE Tobacco, Dip				
SEDATIVES Downer, Quaaludes, GHB				
SLEEPING PILLS Secinal, Ambien, Dalmane, Restoril, Halcoin				
TRANQUILIZERS Mellaril, Thorazine, Haldol				
BENZODIAZEPINES Valium, Librium, Xanax, Ativan, Tranxene, Klonopin, Serax, Centranx				
OPIATES Heroin, Demerol, Codeine, Methadone, Morphine, Dilaudid, Percodan, Darvon, Lortab, Opium, Percocet, Oxycontin, Soma, Ultram, Vicodin, Hydrocodone				
INHALANTS Gasoline, Glue, Freon				
OVER THE COUNTER MEDS				
HERBAL SUPPLEMENTS STERIODS				
OTHER				

Psychiatric Treatment

Signature: _____ **Date:**_____/_____/_____

Have you been/or currently being treated by a Psychiatrist? [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

_____

_____

Psychiatrist:

Name: _____

Address: _____

Phone number: _____

Please list any past Psychiatric treatment. (Including drug rehabilitation center) Location and dates of treatment.

_____

_____

_____

_____

Why are you seeking treatment today? _____

_____

_____

_____

Self-Rating Depression Scale

Name: _____ **Date:**_____/_____/_____

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Make check mark (✓) in appropriate column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

Adapted from Zung, A self-rating depression scale, *Arch Gen Psychiatry*, 1965;12:63-70.

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Adult Checklist of Concerns

Signature: _____ **Date:**_____/_____/_____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "any other concerns or issues." *This is a strictly confidential patient medical record. Law expressly prohibits disclosure or transfer* You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse--physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Children, child management, child care, parenting
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsion
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use--prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems--overeating, under eating, appetite, vomiting (see also "weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Over-sensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ School problems
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "abuse")
- ❑ Shyness, over sensitivity to criticism
- ❑ Sleep problems--too much, too little, insomnia, nightmare
- ❑ Smoking and tobacco use
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolation
- ❑ Work problems, employment, workaholic/overworking, can't keep a job

Any other concerns or issues:

_____

_____

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with.

_____

_____

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Payment Policies of Our Practice

For services rendered, our practice accepts the following means of payment:

1. Cash, Check or Credit Card
2. Major credit cards: Visa, MasterCard, Discover, American Express

Fees for services are as follows: BR+ Treatment fees:

10 day detox	$13,500.00
10 day detox with bridge device	$14,500.00
4 — 6 day stress	$ 1,350.00 per day
Relapse booster	$ 1,350.00
1 day booster	$ 850.00

Additional Charges:

Staff Overtime: There will be additional charges for nursing overtime and late arrivals. We start at 8:00 AM, please be on time.

Consultation time: Includes phone, e-mail, and other electronic consultation (i.e. Skype, Text) minimum 1/4 hour

Paula Norris, M.Ed, LPC, FAPA $200 per hour

Richard F. Mestayer M.D. $300 per hour

We are a fee for service facility. **Payment is expected at the time services are rendered.**

I agree to pay any remaining balance and any invoices for additional treatment, consultations, or supplements.

We do not accept payments from insurance companies or file insurance claims. We will provide the necessary documentation in order for you to file or we can refer you to a claims specialist. The claims specialist charges a fee for this service.

Each treatment protocol is individualized. Product orders are made for each individual. We are not able to provide refunds.

I have read and understand the Payment Policy.

Signature: _____ **Date:**_____/_____/_____

Individual Responsible for Payment:

Signature: _____ **Date:**_____/_____/_____

The Bridge Device

Enclosed you will find some information on the Bridge device. Please read through the material thoroughly. As you are reading the information, write down all of your questions and concerns so you can discuss them with your provider. It is important for you to work closely with your physicians and counselors and follow their instructions. Working together will empower you with the information and support you need to be successful.

THE BRIDGE

- Reduces pain from withdrawal and withdrawal symptoms within 15-30 minutes
- Relief lasts for up to 5 days while opiates leave the system
- Ideal for people who cannot go to inpatient treatment
- Can resume normal activities such as work, school, and family

The Bridge device, part of the Neuro-Stim System (NSS), is an auricular peripheral nerve field stimulator. This low risk procedure, which provides neuro-modulating signals over 96 hours for a 4-5-day time period is a non-narcotic alternative to address the acute pain of withdrawal.

How long do I wear device?

The device should be left on for the period of time recommended by your treating clinician. The device is designed to provide neuro-modulating signals for 96 hours over 4-5 days.

How many treatments will I need?

The Bridge is designed for a single use.

How soon will I see results from treatment?

Acute pain medication withdrawal symptoms will begin to diminish significantly in less than 30 minutes in most cases.

Are there any normal precautions?

Yes, You need to take special care to not get the device wet while showering or washing your hair. Do not go swimming with the device in place. Do not immerse in water. It is an extremely safe, water resistant, low voltage electronic device that will simply stop working if the batteries get wet. And NO, you won't get shocked if it gets wet.

How do I keep from getting the device wet when showering?

Holding dry washcloth over the device while showering or washing your hair works very well. We've also had patients tell us they use a small empty margarine bowl with a dry cloth inside to hold over the device.

Are there any side effects?

Although extremely rare, there may be some side effects, which may include:

- Skin irritation
- Bleeding or infection at the site of implantation
- Pain at the site of implantation
- A sore ear
- Allergic reactions to the tape and adhesive
- Dizziness
- Fainting

Once the device treatment is over what do I do with the device?

Place the device in a waste bag provided by your treating clinician. Be sure to bring the waste bag containing the used device with you to your next treatment date. The clinician will properly dispose of it.

We hope we have addressed any questions you may have about your treatment and what to expect. If you have any further questions please give us a call at 225-294-5955.