REGISTRATION INFORMATION

(PLEASE PRINT)

Date:_____ Home Phone :(____)_____

Patient:_____

(LAST NAME) (FIRST NAME) (MIDDLE INITIAL) (NICKNAME)

Street Address:_____

City:_____ State:_____ Zip Code:_____

Cellular Phone:_____ Email:_____

Sex: ☐ M /☐ F / ☐ Non Binary Birth date:____ Age:_____ Social Security #:_____

☐Single /☐ Married /☐ Widowed /☐Separated /☐Divorced Occupation:_____

Employed by:_____ Business Phone :(____)_____

Business Address:_____

Name of Responsible Party (if a minor):_____

Spouse Name:_____ Occupation:_____

Spouse Employer:_____ Spouse Business Phone:_____

Emergency Contact?_____ Phone:_____

Pharmacy Name:_____ Location:_____ Phone:_____

Compounding Pharmacy:_____ Location:_____ Phone:_____

INSURANCE INFORMATION

Primary Insurance Co. Name:_____ ID #:_____

Subscriber Name:_____ Patient Relationship to Responsible Party? SELF ☐/ SPOUSE☐/ CHILD ☐

Secondary Insurance Co. Name:_____ ID#:_____

Subscriber Name:_____ Patient Relationship to Responsible Party? SELF☐/ SPOUSE☐/ CHILD ☐

VOICE MAIL CONSENT

In order to get back to our patients as soon as possible, we sometimes need to leave a voice message. However, we wish to respect your privacy and confidentiality. Please indicate which numbers can have which types of messages left at them, and we will be better able to serve you.

Is it okay to leave messages concerning appointments (scheduling and confirmation) at:

1. Home Yes☐ No☐ Phone #:_____
2. Work Yes☐ No☐ Phone #:_____
3. Cell Yes☐ No☐ Phone #:_____
4. Email Yes☐ No☐ Email:_____

Is it okay to leave messages concerning prescriptions and other medical questions or information at:

1. Home Yes☐ No☐ Phone #:_____
2. Work Yes☐ No☐ Phone #:_____
3. Cell Yes☐ No☐ Phone #:_____
4. Email Yes☐ No☐ Email:_____

By signing below, I authorize that I have read and understand the Voice Mail Policies for Beverly Medical Center, and I agree to the above terms and conditions.

Name (Print)_____

Signature_____ **Date**_____

Witness_____ **Date**_____

Patient:_____

(LAST NAME) (FIRST NAME) (MIDDLE INITIAL) (NICKNAME)

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. Beverly Medical Center is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Beverly Medical Center promises to maintain the privacy of your health information as required by law.

_____ _____

Authorized signature of Subscriber Date

Consent for Services

As a condition of your treatment by this office, payment in full is expected and must be paid at the time services are rendered.

Patients who carry medical insurance understand that all medical services furnished are charged directly to the patient and that he or she is personally responsible for payment of all medical services. This medical office cannot render service on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for the medical care is subject to change at any time.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay the fee of said services to said doctor, or his assignee, at the time said services are rendered. I further agree that a waiver of any breech of any time or condition hereunder shall not constitute a waiver of any further term or condition. I further agree to pay all collection costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee to telephone me at home or at work to discuss matters related to the form.

I have read the above conditions of treatment and agree to their content.

_____ _____

Signature of patient or responsible party if minor patient Date

Whom may we thank for referring you to our practice?

❑ Another Patient ❑ Relative ❑ Friend ❑ Medical Office ❑ Yellow Pages ❑ Newspaper

❑ School ❑ Work ❑ Health & Healing ❑ Other_____

Specify name of person referring you if our patient_____

NOTICE OF PRIVACY PRACTICES FOR BEVERLY MEDICAL CENTER

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.

Protected health information is in the information we create and obtain in providing our services to you. This information may include documenting your symptoms, vital signs, examination and test results, diagnoses, treatment, and future care or treatment.

Beverly Medical Center is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations.

Examples of using your health information for treatment purposes:

- The nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines she will need to refer you to a specialist for further consultation/tests. Beverly Medical Center will share your information, relating to the specific condition, with the specialist.

An example of using your health information for payment purposes:

- Health insurance companies will submit medical record requests in order to complete claim processing for repayment to the patient for paying out of pocket. Beverly Medical Center will then provide information to them about you and the care given.

An example of using your health information for health care operations:

- We obtain services from our insurers or other business associates such as quality improvement, training programs, credentialing, medical review, legal services, and insurance. Beverly Medical Center will provide such associates or insurers with patient's information as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of Beverly Medical Center. The information in it, however, belongs to you, the patient. You have a right to

- request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- obtain a paper copy of the Notice of Privacy Practices by making a request at our office.
- request that you be allowed to inspect and copy your health record and keep invoice records. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivery of a written revocation to our office.

If you want to exercise any of the above rights, please contact the Office Manager at 919-844-4552 or 6008 Creedmoor Rd, Raleigh, NC 27612 in person or in writing during normal business hours. He/she will provide you with assistance on the steps to take to exercise your right.

Our Responsibilities

Beverly Medical Center is required to

- maintain the privacy of your health information as required by law
- provide you with a notice as to our duties and Privacy Practices as to the information we collect and maintain about you
- abide by the terms of this notice
- notify you if we cannot accommodate a requested restriction or request, and;
- accommodate your reasonable requests regarding methods to communicate health information with you

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our "Notice." You are entitled to receive a revised copy of the "Notice" by calling and requesting a copy or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the Office Manager at 919-844-4552 or in writing or person at 6008 Creedmoor Rd., Raleigh, NC 27612.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Office Manager. You may also email your complaint to info@beverlymedicalcenter.com.

I have read and understand the above Notice of Privacy Practices for Beverly Medical Center, and agree to their content.

_____ _____

Signature of patient or responsible party if minor patient Date

_____

Printed Name of patient or responsible party if minor patient

INFORMED CONSENT

Please be informed that we make no claims of cure. Our purpose in treatment is to decrease toxicity by giving less priority to drug and surgery treatment and more priority to nutrition and other aspects of lifestyle.

We will always attempt to give you the clear option of selecting from other approaches regarding your medical problems or goals. THERE ARE OPTIONS AND ALTERNATIVES TO EVERY TREATMENT THAT WE RECOMMEND.You are free to question to the fullest any suggestions that we give. We encourage this because, as a practical matter, it is impossible to discuss all available options and opinions in medical care. We recommend that you seek a second opinion from any other physician for any medical problem that is even the least bit controversial. We encourage you to question my reasons, qualifications, and expectations. Do not remain unclear about any treatment you may chose, as any treatment you undertake will be at your discretion. Please be clear that we will never attempt to order you to do anything. We make recommendations and will attempt to aid you to understand these recommendations fully before you embark on a course of treatment.

Risks, therefore, include foregoing other treatment like certain surgeries verses an alternative upon which you and our providers may agree. Vitamin, hormone and herbal therapy including administration of these substances by intramuscular, embedded pellets and intravenous routes, may not be widely accepted by medical authorities. Some medical experts, in fact, claim that by choosing an alternative like vitamin and herbal therapy, you endanger your life and health because of the delay in receiving what they consider proper therapy. Vitamin and herbal therapy is a clear example of alternative treatment. Some authorities consider vitamin and other alternatives done in this office as experimental. It is well to note, parenthetically, that there is wide disagreement among medical experts about most details of orthodox therapies as well as alternatives.

We wish to make special note of incurable cancer and other diseases. We absolutely make no claim of any cure or improvement of any diseases. Any patient who comes to me with such a condition will receive only nutritional support and lifestyle changes in addition to their other therapy. They must maintain their relationship with their oncologist or any specialist by whom they may be treated.

All patients must maintain their relationship with their primary care physician no matter what their condition. The physician in this office is not on call twenty-four hours a day, and therefore cannot serve as your primary care physician for emergencies.

Our practice agrees that we will not record our conversations or any audio or take video of anything in or around Beverly Medical Center without direct written permission from a Practitioner. That doing so may be subject to discharge from the care of the practice at Beverly Medical Center as well as potential legal consequences.

Please understand that if the patient has not had an appointment in over a year, Dr. Beverly Goode and Beverly Medical Center are no longer responsible for the patient's medical care. This includes prescription medications, illnesses, etc. The patient must make a yearly appointment to maintain a doctor-patient relationship.

I understand and agree to have a visit a minimum of once per year or more often depending on the practitioner's opinion in order for Beverly Medical Center to continue prescribing medications they have prescribed in the past. New patients must be seen for the first visit, do laboratory testing, and have a second visit before prescriptions will be provided. For all patients a minimum of yearly blood work and visits, depending on the type of prescriptions, are required for ongoing and new prescriptions.

Dangers of treatment in this office: Please understand that any time a needle for injection or diagnosis is inserted into the body, there is danger of infection, allergy, toxicity, bleeding or structural damage to some tissues, like nerves and arteries. This damage may result in permanent injury, crippling, disfigurement or death. This is true of any treatment administered in this office. This is especially true of the intravenous therapies, pellets and PRP treatments.

Patient Acknowledgement

I, (print name)_____, have read this informed consent notification. I understand it and agree to its conditions.

Signature_____ Date_____

BEVERLY MEDICAL CENTER
Dr. Beverly R. Goode-Kanawati
Board Certified Family Practice and Emergency Medicine (ABPS)
6008 Creedmoor Road
Raleigh, NC 27612
Website: beverlymedicalcenter.com
Phone 919.844.4552 E-Mail: bmcstaff@beverlymedicalcenter.com Fax919.844.4556

BEVERLY MEDICAL CENTER INSURANCE POLICIES

I understand that Beverly Medical Center's Insurance Policy is as follows:

1. We do not send medical records to insurance companies.
2. We do not send letters for authorizations to insurance companies
3. We do not file with, honor, or accept any insurance companies payments
4. Beverly Medical Center is not responsible for preauthorizing any bloodwork, labs, Xrays, or any other diagnostic tests ordered by the physician

We encourage patients to check with their insurance companies before having any bloodwork or diagnostic tests performed to verify coverage.

Some questions to ask your insurance include:

1. If bloodwork is ordered by an out-of-network physician but is performed at an in-network lab, will these lab tests be covered the same as if an in-network physician was ordering?
2. What are the names and locations of some in-network labs?
3. What are my out-of-network benefits?
4. Have I met my out-of-network deductible yet?

Please note that if your insurance will not cover any bloodwork ordered by the physician that we will offer the same lab tests to you at a substantially discounted rate.

I understand and fully comprehend the above and agree to abide by these policies.

_____ _____
Patient Signature Date

_____ _____
Patient Printed Name Date

Beverly Medical Center Office Policies

- Our office has a $45 minimum charge for extra services such as: letters of medical necessity, short forms, additional superbills.

- Any questions about lab work or Hormones will require an appointment unless requested by a provider

- Our office has a $25 minimum charge for labwork requested in between full panels *not requested by the practitioner*, questions regarding any and all medication changes or adjustments requested in between appointments, etc. Included in this are requests for re-evaluations for hormone treatments and other treatments in between appointments. This is to cover the extra time by the practitioners and staff to address your specific needs. Please note that the practitioner may determine that your medical issues and/or requested changes may require an appointment to fully evaluate in order to provide the best medical care for you.

- Refill requests for any prescriptions that are not faxed by your pharmacy will require a $15 fee

- Our office has a **pregnancy monitoring of thyroid and nutrition,** which is a $700 flat fee that covers the duration of pregnancy. This includes all outside lab requisition requests, lab work reviews with medication changes as needed, and any questions you may have outside of your scheduled appointments. These tests and evaluations are done an average of eleven times throughout the pregnancy. You are also required to have follow up appointments every 3 months during the pregnancy or more often if needed, the cost for follow up appointments are **not** included in the flat fee. **You are required to obtain standard prenatal care from your OBGYN or specialized healthcare practitioner. This does not take the place of standard prenatal care from your OBGYN or specialized healthcare practitioner.**

- Please allow at least 48 hours for all prescription refills and blood work requests. These **must** be approved by a Practitioner.

- Please understand that it is the policy of Beverly Medical Center not to give out any lab results to patients prior to their visit with the practitioner that have not been reviewed in the past. At the time of your visit you will be given a copy of your results and the results will be explained to you. A Practitioner can address any questions or concerns about your lab results during the visit.

- Any returned checks will result in a $50 returned check fee and we will be unable to accept further checks for future services.

- Anyone that has not been seen for follow up within one year from their last appointment is considered an inactive patient. Due to this we will be unable to fill prescriptions or handle other secondary requests until another appointment has been scheduled.

I, _____understand that if I refuse to abide by these policies I can be released from the practice.

(Signature of Patient) (Date)

Email and Phone Call Policy

It is Beverly Medical Center Policy that our practitioners answer only medically urgent questions outside of scheduled appointments. Any medically urgent questions please call and email so we can get you scheduled for an appointment as soon as possible or refer you for the appropriate care. The service of answering multiple questions from patients outside of an appointment that are not medically urgent can create misunderstandings in comments back and forth. This is less beneficial to the patient than meeting with a practitioner in an appointment.

Please collect your questions that are not medically urgent and contact our office to schedule a follow-up appointment with one of our practitioners. You may be charged $25 for the following requests: lab work requested in between full panels if not requested by a provider, questions regarding any and all medication changes or adjustments requested in between appointments. Included in this are requests for re-evaluations for hormone treatments and other treatments in between appointments. Refill requests for any prescriptions that are not faxed by your pharmacy will be a $15 charge.

Please note that the practitioner may determine that your medical issues and/or requested changes may require an appointment to fully evaluate in order to provide the best medical care for you. This is to cover the extra time by the practitioners and staff to address your specific needs.

I, _____understand that if I refuse to abide by these policies I can be released from the practice.

_____

(Signature of Patient) (Date)

Beverly Medical Center Fee Schedule

Dr. Beverly Goode-Kanawati

New Patient Comprehensive- Up to 90 minutes	$795.00
Follow Up Dr. Goode:	
15 minutes to 30 minutes	$160.00
31 minutes to 45 minutes	$244.00
46 minutes to 60 minutes	$325.00
61 minutes to 1 hour and 15 minutes	$399.00
1 hour and 16 minutes to 1 hour and 30 minutes	$458.00
1 hour and 31 minutes to 1 hour and 45 minutes	$565.00
1 hour and 46 minutes to 2 hours	$650.00
Each additional up to 15 minutes	$80.00

Sandy Britt Adult Nurse Practitioner

New Patient Comprehensive- Up to 90 minutes	$695.00
Follow Up Sandy Britt:	
15 minutes to 30 minutes	$150.00
31 minutes to 45 minutes	$230.00
46 minutes to 60 minutes	$285.00
61 minutes to 1 hour and 15 minutes	$355.00
1 hour and 16 minutes to 1 hour and 30 minutes	$425.00
1 hour and 31 minutes to 1 hour and 45 minutes	$495.00
1 hour and 46 minutes to 2 hours	$570.00
Each additional up to 15 minutes	$70.00

Established, After hours phone calls (Urgent)	$50.00
Established, After hours phone calls (Non-Urgent)	$75.00

All above prices reflect in-office visits and remote consults (phone or video)

PRP Treatment:

One Knee $395

Both Knees treated at the same time is $595

Shoulder $495

Trigger point injections will be $395 per region; additional areas done at the same time will be $95 per area

PRP Full Facial with injections and micro needling $995

- **Partial Facial** eyes to forehead $395
- **Partial Facial** chin to nose $395
- **Partial Facial** or neck and decollete $395
- **PRP for Hair Rejuvenation** $495 for a single treatment or package of 3 treatments for $1275 paid at the same time as the first treatment.

PRP Facial with micro needling and PRP Hair Combo before $1390 after $100 discount $1290

Hormone Pellets:

Initial screening appointment by phone 10-15 minutes	Complementary
Visit with practitioner for exam and ordering of lab testing	$175.00
Men's procedure (Includes 4 Pellets):	$695.00
Women's procedure:	$420.00
Each additional Pellet:	$29.00

IV Nutrition Consultation Plus Lab

Consultation with provider	$175.00

Pregnancy Monitoring of Thyroid and Nutrition $700

-See policy for more information

Office Letters and Forms $45

Prescription Refill Requests not faxed $15

Billing and Cancellation Policy

Billing fees are determined by the time spent with the practitioner regardless of the amount of time set aside for scheduling purposes. These fees apply to office visits, phone consultations, and video consultations. Fees are subject to change without individual notice. Visit fees are non-refundable under any circumstance.

1. Payment is expected at the time of service. Our staff will provide you with a superbill which you may submit to your insurance company for reimbursement. We do not send medical records to insurance companies. We do not send letters for authorizations to insurance companies. We have opted out of Medicare; therefore, no claims can be submitted to Medicare for our office or medical procedures.

A ***minimum*** notice of 72 hours is required for appointment cancellations. Failure to fulfill this requirement will result in a cancellation fee of $75.00.

I have read and agree to the above policy.

_____ _____

Signature of patient Date

_____

Printed name of patient

Refund Policy

Processing Fee for Testing Kits

Our test kits are provided to you at no charge. However, a $35 processing fee is required to cover the essential services our staff provides for each kit. This fee is non-refundable and encompasses:

- Filling out necessary paperwork
- Registering the kit in our system
- Explaining the testing process to clients
- Properly storing the kit before and after use

Due to the time and resources invested in these steps, we cannot refund this processing fee under any circumstances, regardless of whether the kit is used or not.

No Return Policy for Test Kits

Please note that we do not accept returns of any test kits once they have been distributed. This policy is in place to maintain the integrity and sterility of our testing materials.

Self-Pay Labs and Parasitology Tests

For self-pay labs and Parasitology tests, we offer a limited refund window:

- Refunds may be requested within 6 months of the original purchase date.
- After 6 months from the date of purchase, no refunds will be issued.

Additional Information

- Approved refunds will be processed using the original method of payment.
- We reserve the right to review each refund request on a case-by-case basis.

We strive to provide high-quality testing services and appreciate your understanding of our refund policy. If you have any questions or concerns, please don't hesitate to contact us at 919-844-4552 or info@beverlymedicalcenter.com

I, _____understand that if I refuse to abide by these policies I can be released from the practice.

(Signature of Patient) (Date)

BEVERLY MEDICAL CENTER

Dr. Beverly R. Goode-Kanawati DO
Board Certified Family Practice and Emergency Medicine (ABPS)
6008 Creedmoor Rd
Raleigh, NC 27612
Phone 919.844.4552 E-Mail:info@beverlymedicalcenter.com Fax 919.844.4556

PRIVATE CONTRACT- Provider Opt-Out of Medicare

Dr. Goode has opted-out of Medicare and as a result if you wish to be treated by Dr. Goode the government requires a private contract between the patient and or beneficiary or the beneficiary's guardian and the physician.

What this means is:
1) That Medicare cannot be billed by Dr. Goode or by the patient for office visits or any other services including lab tests done in the office.
2) That there are no limits placed on the fees that Dr. Goode may charge.
3) That Medicare can be billed for tests ordered by Dr. Goode at outside lab and x-ray facilities as before.
4) That Medicare will not pay towards services but other co-insurances mayor may not pay toward services.
5) That you may obtain care from another physician that has not opted out of Medicare.

_____
Beneficiary Name

_____
Legal Representative (if applicable)

_____
Beneficiary Medicare Number

This private contract agreement is between the physician and beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The physician above has informed the beneficiary or his/her legal representative they have opted-out of the Medicare Program. The current Medicare opt out expiration date is Dec, 14 2025, however the opt out is automatically updated every 2 years indefinitely. The physician noted above is not excluded from participating with Medicare Part B under §§1128, 1156 or 1892 of the Act. 2

The beneficiary or his/her legal representative has read and agree to the following terms of the private contract **by placing their initials** by the items below:

I, or my legal representative, accept full responsibility for payment of the physician's or practitioners charge for all services furnished by this physician/practitioner;

I, or my legal representative, understand that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner;

I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare;

I, or my legal representative, have been informed of the expected or known expiration date of the opt-out period; the current opt out expiration date is Dec, 14 2025, however the opt out is automatically updated every 2 years indefinitely;

I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I, or my legal representative, enter into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out;

I, or my legal representative, understand that Medicare plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;

I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

_____ _____

Beneficiary or Legal Representative's Signature Date

Beverly Goode-Kanawati

Physician's Signature

BEVERLY MEDICAL CENTER

Dr. Beverly R. Goode-Kanawati
Board Certified Family Practice and Emergency Medicine
6008 Creedmoor Road
Raleigh, NC 27612
Phone 919.844.4552 Fax 919.844.4556
E-Mail:bmcstaff@beverlymedicalcenter.com

PERMISSION TO SHARE RECORDS WITH FAMILY

Under HIPAA privacy laws, it is illegal for Dr. Goode's office to disclose a patient's medical information to his/her family without expressed written consent of the patient. By signing this document, you are authorizing the party mentioned to have access to your medical records.

I, _____, authorize _____
to have full access to my medical records as he/she/they see fit.

Relationship: _____

Phone Number: _____

Email Address: _____

_____ _____
Signature Date

Beverly Medical Center and Bevko Vitamins
Email Communication Consent Form/Risks of using Email

For the ease of our patients at Beverly Medical Center and the customers of Bevko Vitamins, we would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with these businesses via email without understanding and accepting these risks. **The risks include, but are not limited to, the following:**

• The privacy and security of email communication cannot be guaranteed.
• Email senders can misaddress, resulting in it being sent to many unintended recipients.
• Employers/online services may have a legal right to inspect and keep emails that pass through their system.
• Even after deletion of the email, back-up copies may exist on a computer or the cloud.
• Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.
• Emails can introduce viruses, generally damage, or disrupt the computer.
• Email can be used as evidence in court.

Conditions of using email

Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however; we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, communication and other related purposes. Consent to use email includes agreement with the following conditions:

• Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access to the medical record/email (e.g. practitioners, support staff, nursing, billing staff).
• Our office may forward emails internally to those involved, as necessary, for healthcare operations and other handling. Our staff or practitioners will not forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
• Although our office will endeavor to read and respond promptly to all emails from the patient, it is not a guarantee that any particular email will be read and responded to within any particular period of time. The patient should not use email for medical emergencies or other time- sensitive matters.
• If the patient's email invites a response from the staff or practitioners and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.
• Please detail any information that the patient *would not like* to be communicated over email: (The patient can add to or modify this list at any time by notifying the physician in writing.)
• Beverly Medical Center and Bevko Vitamins are not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.
• Beverly Medical Center or Bevko Vitamins are not responsible for information loss due to technical failures associated with the practice's email, internet service provider, hacking or loss of equipment such as loss or theft of computers, tablets, phones or other devices that may lead to loss of email information.

Instructions for communication by email

To communicate by email, the patient shall:
• Limit or avoid using an employer's or other third party's computer.
• Inform the office staff of any changes in the patient's email address.
• Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
• Should the patient require immediate assistance or has a serious or worsening condition, the patient should not rely on email. Instead, the patient should call the Beverly Medical Center office for an appointment or take other measures as appropriate such as going to an urgent care or emergency room.

Patient acknowledgment and agreement
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the office and me, and consent to the conditions outlined herein, as well as any other instructions that the office may impose to communicate with patients by email. I acknowledge my right to, upon the provision of written notice, to withdraw the option of communicating through email to the Beverly Medical Center and Bevko Vitamins.

_____
Name of Patient or Customer (Please **Print**)

_____ Date: _____
Name of Patient or Customer (Please **Sign**)

_____
Email address of Patient or Customer

Medication and Supplement Log/Food Diary

Name: _____

Please List Medications First **Date:** _____

Name of Medication or Supplement (if medication, put dosage)	Total Number per Day

Food Diary: List everything you ate and drank for the last three days:

DAY 1

Breakfast: _____

Lunch: _____

Supper: _____

Snack (specify time): _____

DAY 2

Breakfast: _____

Lunch: _____

Supper: _____

Snack (specify time): _____

DAY 3

Breakfast: _____

Lunch: _____

Supper: _____

Snack (specify time): _____

Medication and Supplement Log/Food Diary

Name: _____

Please List Medications First **Date:** _____

Name of Medication or Supplement (if medication, put dosage)	Total Number per Day

Food Diary: List everything you ate and drank for the last three days:

DAY 1

Breakfast: _____

Lunch: _____

Supper: _____

Snack (specify time): _____

DAY 2

Breakfast: _____

Lunch: _____

Supper: _____

Snack (specify time): _____

DAY 3

Breakfast: _____

Lunch: _____

Supper: _____

Snack (specify time): _____

Supplement Log Continued

Name: ______________________________

Please List Medications First

Date: ______________________________

Name of Medication or Supplement (if medication, put dosage) **Total Number per Day**

Supplement Log Continued

Name: ____________________

Please List Medications First

Date: ____________________

Name of Medication or Supplement (if medication, put dosage) **Total Number per Day**