

PATIENT AGREEMENT
Megan Weigel, DNP, L.L.C. d/b/a First Coast Integrated Medicine

This agreement (this "Agreement") between MEGAN WEIGEL, DNP, L.L.C. d/b/a First Coast Integrative Medicine, a Florida professional limited liability corporation ("FCIM"), located at 14215 Spartina Court, Ste 200, Jacksonville, FL, 32224 and you, (the person signing below, referred to as "You") is effective as of the date of Your signature.

Background

FCIM specializes in Integrative Medicine. Integrative Medicine is a healing-oriented medicine that focuses on the least invasive, least toxic, and least costly evidence-based methods to help facilitate whole- person healing by integrating both allopathic (traditional or Western medical model) and complementary therapies, emphasizing the therapeutic relationship between the practitioner and patient. Services are provided by an advanced practice registered nurse ("NP"). In exchange for certain fees paid by You, You and FCIM agree to the Services described in this Agreement on the terms and conditions set forth in this Agreement.

Definitions

- 1. Services.** As used in this Agreement, the term Services shall mean a package of Integrative Medicine services, both medial and non-medial, and certain amenities (collectively "Services"), which are set forth in Appendix 1, attached hereto and incorporated herein.
- 2. Fees.** In exchange for the services described herein, You will pay FCIM the amount as set forth in Appendix 1. This fee is payable upon execution of this agreement. If this Agreement plan is for a concierge plan and is terminated by either party after completion of the 6-month minimum service, then FCIM shall refund your pro-rated share of the monthly payment remaining after deducting individual charges for services rendered to Patient up to cancellation.
- 3. Non-Participation in Insurance.** You acknowledge that FCIM and its nurse practitioner do not participate in any health insurance or HMO plans or panels and has opted out of Medicare. Nothing herein or verbally discussed is to be construed as a representation that any fees due under this Agreement for anything are covered by your health insurance or other third-party payment plans applicable to you. You shall retain full and complete responsibility for any such determination. If you are eligible for Medicare, or during the term of the Agreement become eligible for Medicare, then you will sign the Agreement attached as Appendix 2 and incorporated by reference. This Agreement acknowledges your understanding that the nurse practitioner at FCIM has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for you by the NP. You agree not to bill Medicare or attempt Medicare reimbursement for any services whatsoever provided hereunder. You will renew and sign the Agreement in Appendix 2 yearly.
- 4. Not Insurance.** You acknowledge and understand that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services or any services not personally provided by FCIM. You acknowledge that FCIM has advised You to obtain or keep in full force your health insurance policy(ies) or plans that will cover You for general healthcare costs. You acknowledge that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health

insurance or health plan coverage that You may carry.

5. **Terms/Termination.** This Agreement will commence on the date first written above and will automatically renew monthly thereafter. Concierge contracts are 12-month contracts with a consecutive 6-month minimum participation. If this Agreement is for a concierge plan and is terminated by either party after completion of the 6-month consecutive participation, then FCIM shall refund your pro-rated share of the monthly payment remaining after deducting individual charges for services rendered to You up to cancellation. Notwithstanding the above, both You and FCIM shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. FCIM may terminate this Agreement for cause if you fail to pay within ten days of renewal date, if you are disruptive or abusive or violate the law, in FCIM's sole discretion.
6. **Communications.** You acknowledge that communications with FCIM (including but not limited to with its NP) using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communication. As such, You expressly waive the NP's obligation to guarantee confidentiality with respect to correspondence using such means of communication. You acknowledge that all such communications may become a part of your medical records.

By providing Your e-mail address on the Agreement, You authorize FCIM to communicate with You by e-mail regarding your "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations). You acknowledge that:

- a. E-mail is not a secure medium for sending or receiving PHI, and there is always a possibility that a third party may gain access;
- b. Although FCIM will make all reasonable efforts to keep e-mail communications confidential and secure, FCIM cannot assure or guarantee the absolute confidentiality of e-mail communications;
- c. In the discretion of FCIM, e-mail communications may be made a part of Your permanent medical record; and
- d. **You understand and agree that e-mail is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. In the event of an emergency, or a situation in which You could reasonably expect to develop into an emergency, You shall call 911 or go to the nearest emergency room and follow the directions of the emergency personnel.**

Response time is not guaranteed. If You do not receive a response to an e-mail message within one day, You agree to use another means of communication to contact FCIM. FCIM will not be liable to You for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to You as a result of technical failures, including, but not limited to, (i) technical failures attributable to any internet service provider, (ii) power outages, failure of any electronic messaging software, or failure to properly address e-mail messages, (iii) failure of FCIM's computers or computer network, or faulty telephone or cable data transmission, (iv) any interception of e-mail communications by a third party; or (v) your failure to comply with the guidelines regarding use of e-mail communications set forth in this paragraph.

- 7. Change of Law.** If there is a change of any law, regulation or rule, federal, state or local, which affects this Agreement, which are incorporated by reference in the Agreement, or the activities of either party under the Agreement, or any change in the judicial or administrative interpretation of any such law, regulation or rule, and either party reasonably believes in good faith that the change will have a substantial adverse effect on that party's rights, obligations or operations associated with the Agreement, then that party may, upon written notice, require the other party to enter into good faith negotiations to renegotiate the terms of the Agreement. If the parties are unable to reach an agreement concerning the modification of the Agreement within ten days after date of the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party.
- 8. Severability.** If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.
- 9. Reimbursement for Services Rendered.** If this Agreement is held to be invalid for any reason, and if FCIM is therefore required to refund all or any portion of the fees paid by You, You agree to pay FCIM an amount equal to the reasonable value of the Services actually rendered to You during the period of time for which the refunded fees were paid.
- 10. Amendment.** No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all parties. Notwithstanding the foregoing, FCIM may unilaterally amend this Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending You 30 days' advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by FCIM, except that You shall initial any such change at FCIM's request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in the Agreement.
- 11. Assignment.** This Agreement, and any rights You may have under it, may not be assigned or transferred by You.
- 12. Legal Significance.** You acknowledge that this Agreement is a legal document and creates certain rights and responsibilities. You also acknowledge having had a reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and are satisfied with the terms and conditions of the Agreement.
- 13. Miscellaneous.** This Agreement shall be construed without regard to any presumptions or rules requiring construction against the party causing the instrument to be drafted. Captions in this Agreement are used for convenience only and shall not limit, broaden, or qualify the text.

14. Entire Agreement. This Agreement, along with the appendices, contains the entire agreement between the parties and supersedes all prior oral and written understandings and agreements regarding the subject matter of this Agreement.

15. Jurisdiction; Attorneys and Other Fees. This Agreement shall be governed and construed under the laws of the State of Florida and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction in Duval County, Florida. In the event that suit is filed against You for fees required herein or any other reason, you agree to pay for FCIM's attorney's fees and other costs related to the action if FCIM prevails.

16. Service. All written notices are deemed served if sent to the address of the party written above or appearing in Appendix 1 by First Class U.S. Mail.

By signing below, You represent that You understand that Integrative Medicine is a healing-oriented medicine that focuses on the least invasive, least toxic, and least costly methods to help facilitate healing by integrating both allopathic (traditional or Western medical model) and complementary therapies. It emphasizes the therapeutic relationships between the practitioner and patient and is informed by evidence. Therapies are recommended based on an understanding of the physical, emotional, psychological, and spiritual aspect of the individual, or the whole person. Integrative Medicine principles maintain that healing is possible, even when curing is not. You promise that the information You have provided to FCIM is correct, will be used for Your benefit and FCIM is relying on its accuracy. You are responsible for providing FCIM with any necessary information, changes in information, and prompt completion of forms. You understand that in the event that financial obligations cannot be met, FCIM has the right to terminate treatment regardless of whether or not the treatment objectives have been met.

The parties have signed duplicate counterparts of this Agreement effective as of the date of Your signature below.

Megan Weigel, DNP, LLC
d/b/a First Coast Integrative Medicine

Megan R. Weigel, Manager; Date

Patient Name

Patient Signature; Date

Patient Address

Patient Phone Number

Patient Email

Appendix 1

Services and Payment Terms

1. **Medical Services.** As used in this Agreement, the term Medical Services shall mean those medical services (integrative or otherwise) that the FCIM providers are permitted to perform under the laws of the States of Florida and Hawaii, and that are consistent with their training and experience as a family nurse practitioner (“NP”).

To account for vacations, sick days, and other similar situations, your usual nurse practitioner may not be the person providing services hereunder. During such times, Your calls to FCIM will be directed to a provider who is covering for FCIM. FCIM will make every effort to arrange for coverage and to accommodate your in-person visit needs but cannot guarantee such coverage. There will be no extra charges for substitute coverage. Notice of absence or substitute will be provided.

2. **Non-Medical, Personalized Services.** FCIM shall also provide You with the following non-medical services (“**Non-Medical Services**”):

(a) **24/7 Access.** Subject to Section 1, if You elect the Concierge Plan, You shall have access to FCIM via instant messaging and video chat. You shall also have direct telephone and text access to FCIM and its provider on a twenty-four hour per day, seven day per week basis, subject to Section 1. During the absence for vacations, continuing medical education, illness, emergencies, or days off, the NP will provide the services of an appropriate licensed healthcare provider for assistance in obtaining medical services. You shall be given instructions as to how to contact such healthcare provider. Such provider shall be available to You to the same extent as would the NP. If you do not elect the Concierge Plan, you will have telephone access to the NP during noted clinic hours only and can expect a call back within 24 hours.

(b) **Email Access.** You shall be given an email address; *the FCIM provider will read and respond* to non-urgent communications. Such communications shall be responded by FCIM in a timely manner. **You understand and agree that email and the internet should never be used to access medical care in the event of an emergency, or any situation that You could reasonably expect may develop into an emergency.** You agree that in such situations, when You cannot speak to a licensed professional at FCIM immediately in person or by telephone, that You shall call 911 or the nearest emergency medical assistance provider, and follow the directions of emergency medical personnel.

(c) **No Wait or Minimal-wait Appointments.** Every effort shall be made to assure that You are seen immediately upon arriving for a scheduled office visit or after only a minimal wait. If FCIM foresees a minimal wait time, You may be contacted and advised of the projected wait time.

(d) **Home or Office Visits.** If You elect the Concierge Plan, You may request that the visit occur in your home. In situations where FCIM considers such a visit reasonably necessary and appropriate, FCIM will make every reasonable effort to comply with Your request. Similarly, if you are a fee-for-service patient and request a home visit, and it is thought to be reasonably necessary and appropriate, an effort to comply with the request will be made. For non-concierge patients, an additional fee may apply.

(e) **Specialists.** The NP shall coordinate with medical specialists to whom You are referred to assist You in obtaining specialty care. You understand that fees paid

under this Agreement do not include and do not cover specialists' fees or fees due to any medical professional other than the First Coast Integrative Medicine NP.

f) Cancellations and terms of plans.

Concierge Plan: A Concierge Plan includes a 2-hour initial consultation, 1-hour follow-up visit to discuss an Integrative Medicine plan, all additional visits per year as per specified plan (may be done virtually), and 24/7 phone and text access to the NP. Concierge plans are 12-month contracts with a consecutive-6-month minimum participation. If You elect a concierge plan, a payment schedule must be set up at time of election of plan. Charges are automatically deducted from the credit card on file at the time chosen at your initial visit: once yearly, quarterly, every 6 months, or once monthly on the date of the month closest to the date of your first appointment (1st, 5th, 10th, 15th, 25th, or 30th). Check here to pick your payment schedule:

- Yearly**
- Twice a year**
- Quarterly**
- Monthly**

Appointments do not carryover after the anniversary of your first visit. Memberships cannot be backdated to include previous appointments. Twenty-four hours-notice is required for cancellation of appointment. There is a \$150 cancellation fee for cancellation of an Initial Consult visit, and a \$50 fee for cancellation of other appointments. If You cancel this agreement prior to the end of the one-year term, You will be charged for the remaining consecutive 6-month commitment if not previously fulfilled. Requests for cancellation of membership and refund will be dealt with on an individual basis. FCIM does not accept insurance. If requested, an invoice will be given to the patient to submit to the commercial insurance company. FCIM will not intervene with the commercial insurance company. Persons with Medicare and Medicaid are not eligible for reimbursement.

Fee-for-service appointments: Payments must be made at time of service. Unless otherwise requested, payment will be made by a charge to the credit card on file. Twenty-four (24) hours-notice is required for cancellation of appointment. There is a \$150 cancellation fee for cancellation of an Initial Consult visit, and a \$50 fee for cancellation of other appointments. FCIM does not accept insurance. If requested, an invoice will be given to the patient to submit to the commercial insurance company. FCIM will not intervene with insurance company. Persons with Medicare and Medicaid are not eligible for reimbursement.

Plan Chosen:

- Basic "Fee For Service"
- Quality Concierge
- Deluxe Concierge
- Premier Concierge



Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

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Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
 - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
 - We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety
-

Do research

- We can use or share your information for health research.
-

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
-

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.
-

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
-

Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers’ compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services
-

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Megan Weigel, DNP, LLC/dba First Coast Integrative Medicine

14215 Spartina Ct., Ste 200 Jacksonville, FL 32224

Phone (904) 543-3510 Fax (904) 990-1331

I hereby acknowledge that I have received a copy of First Coast Integrative Medicine's Notice of Privacy (NPP).

Signed: _____ Date: _____

Print Name: _____ DOB: _____ Phone: _____

If not signed by the patient, please indicate the relationship:

____ Guardian or conservator of an incompetent patient

____ Beneficiary or personal representative of deceased patient

Name of patient: (Please Print) _____ DOB: _____

For office use only:

Signed form received by (Print Name): _____ Initials: _____

____ Patient refused to sign acknowledgment:

Efforts to obtain signature: _____

Reason patient refused: _____

Megan Weigel, DNP, LLC/dba First Coast Integrative Medicine

14215 Spartina Court, Ste 200 Jacksonville, FL 32224

Phone (904) 543-3510 Fax (904) 990-1331

COMMUNICATION RELEASE FORM

I hereby give permission to Megan Weigel, DNP, LLC/dba First Coast Integrative Medicine to notify me by telephone, text, or email of the following: (check all that apply)

Yes _____ No _____ Appointment reminder, either by personal message, recorded message, text or email.

Preferred Phone Number: _____

Preferred email: _____

Yes _____ No _____ A recorded message, text, or email to call the office for test results

Yes _____ No _____ Communicate in person, or via phone, text, or email to anyone listed below regarding my health condition, test results (normal or abnormal), and medical history.

The individual(s) listed below are authorized to receive the above information on my behalf:

I understand this form is intended to guard my privacy and is a release of general medical information.

Patient Signature (Responsible Party) _____

Date _____

Witness Signature _____

Date _____

First Coast Integrative Medicine
Megan Weigel, DNP, LLC

DATE: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Megan Weigel, DNP, LLC/dba First Coast Integrative Medicine to disclose or obtain the information described below.

Patient Information	Name _____ Date of Birth _____ Address _____ Telephone Number: _____
Type of Authorization <input type="checkbox"/> Self <input type="checkbox"/> Disclose medical information to: <input type="checkbox"/> Obtain medical information from:	Name _____ Address _____ Telephone Number _____
Purpose for Request	<input type="checkbox"/> At Request of the Patient <input type="checkbox"/> Moving <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Attorney <input type="checkbox"/> Change of Insurance <input type="checkbox"/> Other _____
Requested Information	<input type="checkbox"/> Entire Medical Record: Patient histories, test results, referrals, consults, billing records, insurance records, and records sent to you by other health care providers <input type="checkbox"/> Portions of Medical Record from _____ [Insert date] to _____ [Insert date]. <input type="checkbox"/> Alcohol/Drug Treatment <input type="checkbox"/> HIV-Related Information <input type="checkbox"/> Other: _____ _____

EXPIRATION DATE: This authorization will expire **thirty (30) days** from the date listed at the top of this form unless a different expiration date or expiration event is written here: _____.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy. Written notice should be directed to Megan Weigel, Privacy Officer.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Signature: _____ Patient Personal Representative

NOTICE THAT SERVICES ARE NOT PRIMARY CARE

I understand that Megan Weigel, DNP is not acting as my primary care provider. I understand that even though she may address issues affecting my general health, the practice is focused on a complementary, holistic or integrative approach to medicine. It is in my best interest to also have a primary care provider to ensure that I am fully informed about all available conventional means to address any medical conditions I may have. I understand that FCIM does not provide emergency, on-call assistance. Even should Dr. Weigel provide treatment for a condition, I understand this assistance does not mean she is taking primary responsibility for managing that condition, but is complementing the care I receive from my primary care provider. I understand that in addition to a primary care provider, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility on an ongoing basis to inform FCIM of the name of and contact information for my primary care provider and treating specialists, of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I also understand that it is important for me to let my primary care provider know about any recommendations/treatments performed by Dr. Weigel in order to ensure that my care is properly coordinated.

My primary care provider is:

Name _____

Address _____

Phone _____

Patient Name _____

Patient Signature _____ Date _____

NOTICE AND CONSENT AS TO NATURE OF SERVICES

I understand that care I receive from FCIM may be non-traditional or non-conventional. Such services are commonly referred to as complementary or alternative medicine (ACM or CAM), holistic care, or integrative medicine. This can include a variety of innovative medical treatments as well as nutritional and herbal consultation, and mind-body approaches to care. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigational or experimental. I am seeking care from FCIM in order to benefit from Dr. Weigel's special training in integrative medicine and receive advice and treatment about such care.

Nutritional and Herbal Guidance: Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will let Dr. Weigel and other providers know what herbs I am taking. I agree to notify FCIM if I experience any interactions or adverse experiences or reactions; if they are not serious, I will notify her to ask for her assistance and if serious, I agree to seek emergency care first before notifying FCIM.

Recommendations could include fasting and other forms of detoxification. While this is generally safe, some people may experience a healing crisis, which may be a short period in which ones symptoms increase, or a period of a flu-like illness during which there could be some mild fever, chills, dizziness, loss of appetite, and so forth. Such an experience, while unpleasant, can signal that the body is effectively detoxifying or undergoing a healing effort.

Mind/Body Medicine: Mind/body medicine is an emerging medical view intended to improve patient well-being by improving lifestyle, capacity to function in a meaningful and effective way, and reversing the impacts of stress. Because stress and emotional states may play an important role in my medical conditions, Dr. Weigel may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as meditation, massage, or other stress management techniques.

Patient Name _____

Patient Signature _____ Date _____

Megan Weigel, DNP, LLC/dba First Coast Integrative Medicine

14215 Spartina Court, Ste 200 Jacksonville, FL 32224

Phone (904) 543-3510 Fax (904) 990-1331

Functional Medicine Laboratory Testing Informed Consent

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for, or our interpretation of, these tests. Please be advised that it is the responsibility of the patient to check with insurance regarding coverage for laboratory testing. Any charges, or copays associated with laboratory testing ordered through First Coast Integrative Medicine is solely the responsibility of the patient. If you have any questions or concerns, please discuss them with our providers.

Please understand: First Coast Integrative Medicine may charge a lab management fee for diagnostics. In addition, we may charge a fee for interpretation of externally ordered diagnostics. Patient will be advised of any lab management or interpretation fees prior to applying charges.

I have read and understand all of the above:

Signature _____

Date _____

Witness _____

Date _____