PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

- I received the Notice of Privacy Practices and I have been provided an opportunity to review it.
- I acknowledge that I am willing to receive appointment reminder emails and text messages from your practice.
- I authorize the release of any medical or other information necessary to process any insurance claims or life insurance requests
- I understand the terms of my insurance, and accept financial responsibility for any labs drawn, either at this office, or at other laboratories. I have had the opportunity to ask questions regarding this.
- I understand if I need records after my appointment that there will be a charge. But I am free to ask for records during my appointment.
- I understand if I cancel an appointment with less than 24 hours notice, or do not show up for my appointment, there will be a charge of $35.

Name (printed)_____**Birthdate**_____

Signature_____

Date_____

Dr. Keri Topouzian
Dr. Jacqueline Chirco

ACAM PATIENT INFORMED CONSENT

I have specifically sought out the services and perspective of Dr. Keri Topouzian and/or Dr. Jacqueline Chirco for the way in which they practice Complementary and Holistic Medicine. The doctor has explained to me and I fully understand the following:

1. Some of the doctors treatments being recommended are not recognized as traditional, but more of a Holistic approach. Complementary and Holistic Medicine, like any other treatment or medication, may or may not alleviate or cure the condition(s) for which it is offered.
2. Your physician believes that Complementary and Holistic Medicine may be valuable to your health. However, as with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing, as well as whether available medical analysis and possible treatment provided by Dr. Topouzian and/or Dr. Chirco is right for you. It is important that you read and understand the information contained in this form so that you can make an informed choice about being treated by these doctors. If after reading this form, you have any concerns or questions regarding this testing, you should talk to your provider.
3. The federal government, including Medicare and Medicaid, and most insurance companies, do not generally pay or reimburse for intravenous treatment and vitamin and mineral supplementation.
4. Much of the testing being recommended by Dr. Topouzian and/or Dr. Chirco are not recognized as traditional, but are holistic testing methods.
5. The United States Food and Drug Association (FDA) reviews the safety and effectiveness of particular uses or drugs but does not forbid physicians to use approved medications for off-label use
6. Some of the treatments being offered at our office are not FDA approved.
7. Some of the treatments prescribed at our office are not FDA approved.
8. Some of the formulations prescribed at our office have never been tested by the FDA for determination of the actual contents or the medical effectiveness of the formulations. Though scientific studies may be available that show the possible benefit of the treatments.
9. The medical/scientific proof of effectiveness/therapeutic value of some of the treatments may be disputed, though there may be studies that show possible benefits.
10. While your treating physician believes that the holistic and complementary treatments may be beneficial to your health and well-being, the traditional medical and scientific communities may dispute the medical/scientific proof of the effectiveness or therapeutic value of the treatments. You are free to contact any medical group, doctor or association on their view of any testing or treatment before you begin. Dr. Topouzian and/or Dr. Chirco believes the testing and treatment they oversee is valuable and might improve your health.
11. I may leave the care of Dr. Topouzian and/or Dr. Chirco at any time. It was my independent choice whether to see these physicians and it is always my choice whether to continue with them. I also understand that Dr. Topouzian and/or Dr. Chirco reserve the right, at any time and without cause, to discontinue any patient due to poor compliance with his recommended program or for any other reason

I, THE UNDERSIGNED, HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT, MY RIGHTS AND RESPONSIBILITIES, AND HEREBY GIVE CONSENT TO UNDERGO HOLISTIC AND COMPREHENSIVE TREATMENT WITH DR. TOPOUZIAN AND/OR DR. CHIRCO

INFORMATION ABOUT ME AND MY RECORDS WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.

DATE: _____ SIGNATURE _____

Dr. Keri Topouzian DO
Dr. Jackie Chirco DO
1900 S. Telegraph, Suite 102
Bloomfield Hills, MI 48302
248-302-0473

HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REIVEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) use do disclose to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, records review or cost-management analysis, and customer service.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or to provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you.

- We will use and disclosed your protected when we are required to do so by federal, state or local law.
- We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited: response to a court administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law.
- We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the

public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

- We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs, or your requests for life or health insurance. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights regarding your PROTECTED HEATLH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer/Office Manager at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to the requested restrictions. If we do agree to the restrictions, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operation.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
877-696-6775 (toll free)