New Patient Packet – Please keep this top sheet for your information.

Dear New Patient,

Welcome to LifeSource Wellness Care! We are looking forward to partnering with you to improve your health. Enclosed you will find several forms. Each of these is important to aid in your initial consultation. **Please set aside ½ hour to complete the forms and bring them with you on the day of your appointment. Waiting until your scheduled appointment time to fill out the forms will result in having less time with the doctor.**

Enclosed forms:

1. Disclosure: I, Dr. Alexander Thermos, am a Doctor of Osteopathy. I can function as your consultant with regard to your health, and assist you and your Primary Care Physician in your care.

2. The HIPAA Policy document explains your patient rights to privacy and describes what LifeSource Wellness Care will do to ensure that your records and all information pertaining to you are kept confidential.

3. The Health Evaluation Profile is very important for us in evaluating your health needs. Please fill out each of the sections based on your health during the past month.

4. The 'Authorization to Release Medical Records' allows us to communicate with your other health care providers on your behalf.

FOR YOUR INITIAL VISIT AND ALL SUBSEQUENT VISITS REQUIRING MICROSCOPY YOU MUST BE FASTING. TAKE ALL OF YOUR REGULAR MEDICATIONS AND VITAMINS ON THE DAY OF YOUR APPOINTMENT. Take them with water. No coffee, tea or any other beverage. Please bring a copy of your most recent lab work with you, any X-Ray, MRI/CT Scan results, Pathology and Biopsy Results, and any available notes from another Physician.

Please be considerate if it is necessary to cancel your appointment and give us 48 hours notice so we may reschedule the time with another patient. **We reserve the right to charge $75 for missed appointments without sufficient notice.**

If you have any questions do not hesitate to call us at 949-916-0089.

To your good health,
Dr. Alexander Thermos, D.O.

FEE SCHEDULE

The first visit with Dr. Thermos is billed as an extended comprehensive visit at the customary rate of $300.00. Dr. Thermos routinely spends 60 minutes with each new patient, reviewing history, medication and symptoms. Additionally, an abbreviated physical exam will be conducted. Appointment time is somewhat determined by the depth and complexity of each individual's history and symptoms. During the evaluation, Dr. Thermos will perform a live blood analysis, lipid panel and glucose screening. You will leave this visit with Dr. Thermos' recommendations for the supplements that will best target your health and/or wellness concerns.

A follow up visit is typically scheduled within the next 3 to 4 weeks. Follow up visits are generally 30 minutes and are $200.00. After that, visits are scheduled based on the needs of the individual.

Regarding insurance, Dr. Thermos is not part of any Medicare, Medical, PPO, HMO, IPA or IPP group. For medical 'Flex Spending' Accounts, your medical visits may be covered. We can provide you with a Superbill for you to submit for possible reimbursement.

BASIC FEES

Initial Visit $300.00
Follow-up Visit $200.00

At our discretion, a $200.00 deposit may be required at the time the appointment is made in order to reserve the 2 hour time slot. This will be applied to your visit at the time of checkout. If you are unable to keep the appointment**, a 48 hour cancellation notice is required**, at which time your deposit will be refunded.

ADDITIONAL INFORMATION

Don't forget to fast at least 12 hours prior to the appointment. You can drink as much water as you want and take your medication/supplements like you normally do. Bring a list of them along with a copy of any recent labs. Please bring a note pad and pen to take notes for your visit as the information is copious. Additionally, feel free to bring a snack.

We look forward to meeting you. We will give you a courtesy call reminder prior to your appointment to confirm. Please have your new patient packet filled out.

Health Evaluation Profile

PART 1: GENERAL INFORMATION

Name____Age:__________
Address: ____________________City____________State:________Zip:__________
Phone (home): ____________________(cell):________________(work):______________
Email (for our use only):______________________________ Date of Birth: ______________
Weight: __________ Height:____________ Are you satisfied with your weight?______________
____
Do you currently take vitamins or other supplements? No [ ] Yes [ ] If Yes, please list:____________________
____
Have you had anything to eat during the past three hours? No [ ] Yes [ ] If Yes, what did you eat? ______________

Have you ever been diagnosed with H. Pylori? No [ ] Yes [ ]

Referred by:______________________

Reason for seeking help:____
____
Primary Care Physician: ______________Phone:____________May we contact your physician regarding your health? Yes: ______No:________

Part 2: MEDICATIONS
Check any of the following conditions or medications you are currently taking:

[ ] Antacids
[ ] Antidepressant
[ ] High Blood Pressure Medication
[ ] Antibiotics
[ ] Anti-inflammatory Medications
[ ] Pain Medications
[ ] Water Retention
[ ] Heart Murmurs
[ ] Hormones
[ ] Oral Contraceptives
[ ] Radiation and/or Chemotherapy
[ ] Ulcer Medications
[ ] Steroids
[ ] Laxatives
[ ] Thyroid

The following information is provided to this facility for nutritional information. The information being sought is of nutritional nature and not a medical diagnosis, treatment, disease prevention or health assessment. I understand: According to the Federal Food, Drug and Cosmetic Act, as amended Section 201 G1 the term "Drug" is defined to mean Articles intended for the use in the DIAGNOSIS, CURE, MITIGATION, TREATMENT, or PREVENTION of disease. In other words, to "say" that a vitamin mineral trace element or amino acid will have any effect on disease or symptoms thereof, means that particular nutrient then becomes a DRUG under the laws as written. Therefore, any suggested nutrition is not intended as primary therapy for any disease or symptom, but is provided solely to upgrade the quality of foods delivered through the diet.

Signature:______________________________Date:______________________

PART 3: SYMPTOMATIC SELF-EVALUATION
Each of the following sections contains questions regarding your evaluation of conditions that may be affecting your health and personal well-being. Circle the number in each column that describes your situation. Leave questions blank that you are not sure of. For questions with only a "No" or "Yes", use column 1 for "No" and column 2 for "Yes".

Section 1:
Please list the foods you ate yesterday and what you eat for a normal diet:

Foods you ate yesterday:
Breakfast ______________________
Lunch ______________________
Dinner ______________________
Snacks ______________________

Your normal diet foods:
Breakfast ______________________
Lunch ______________________
Dinner ______________________
Snacks ______________________

How often do you do a strength training program: [ ] Never [ ] Sometimes [ ] Often

How often do you do an aerobics program: [ ] Never [ ] Sometimes [ ] Often

Section 2:

Lifestyle Choices	*No*	*Yes*	*Often*
1. Do you eat cooked/or processed food?....................	0	1	2
2. Do you eat rapidly, without chewing thoroughly?..	0	1	2
3. Do you eat until you feel full?................................	0	1	2
4. Do you drink carbonated beverages?.....................	0	1	2
5. Do you drink coffee or tea?....................................	0	1	2
6. Do you drink alcoholic beverages?........................	0	1	2
Symptoms			
7. Do you experience bloating?.....................................	0	1	2
8. Do you feel too full after eating?............................	0	1	2
9. Do you feel sleepy or have low energy after eating?...........	0	1	2
10. Do you have any uncomfortable or adverse reactions after eating?...	0	1	2
11. Do you have a need to eliminate too soon after eating?........	0	1	2
12. Do you have diarrhea after eating?..........................	0	1	2

13. Do you feel flush after eating?...... 0 1 2

Section 2: continued

	No	Yes	Often
14. Do you have difficulty breathing after eating?..	0	1	2
15. Does your food pass through undigested?.........	0	1	2
16. Do you get indigestion after eating?..................	0	1	2

Total: ________________

Section 3:

Lifestyle Choices

1. Do you live or work where there is pollution?........	0	1	2
2. Do you work on a computer?................................	0	1	2
3. Do you use TV's and /or microwave ovens?........	0	1	2
4. Do you exercise excessively?.............................	0	1	2
5. Do you consume hydrogenated fats?..................	0	1	2
6. Do you drink fluoridated water?……………........	0	1	2
7. Do you avoid vegetables? (cauliflower, brussel sprouts, asparagus)?			
8. Do you have stress in your life?…...…………	0	1	2
9. Do you avoid red fruits or vegetables?..............	0	1	2
10. Do you smoke or are you exposed to secondhand smoke or smog?..	0	1	2

Symptoms

11. Do you have age spots?....................................	0	1	2
12. Do you have hemorrhoids?...............................	0	1	2
13. Do you get bloody noses?.................................	0	1	2
14. Do you bruise easily or have varicose veins?................	0	1	2
15. Do you have deteriorating eye sight?...............	0	1	2
16. Do you experience hyperactivity or excessive nervousness?..	0	1	2
17. Do you have bleeding gums?..	0	1	2
18. Do you have excessive wrinkling of the skin/ premature aging?...	0	1	2
19. Do you have stiff joints?..................................	0	1	2

Total: ________________

Section 4:

Lifestyle Choices

1. Do you eat less than four servings of grain each day?...	0	1	2
2. Do you eat less than three servings of fresh fruit a day?	0	1	2
3. Do you eat less than two servings of fresh, dark colored vegetables each day?...	0	1	2
4. Do you eat less than two servings of dairy products each day?	0	1	2
5. Do you eat food that is not organically grown?.............	0	1	2

Symptoms

6. Do you have persistent leg cramps?..................	0	1	2
7. Do you have poor stamina?...............................	0	1	2
8. Do you have excessive hair loss?......................	0	1	2
9. Do you have graying of the hair?.......................	0	1	2
10. Do you have trouble sleeping?..................................	0	1	2
11. Do you feel weak after performing usual daily activities?..	0	1	2
12. Do you have a craving for alcohol?..................	0	1	2
13. Do you have a small appetite?..........................	0	1	2
14. Do you feel nervous or are you unable to concentrate?	0	1	2

Total: ________________

Section 5:

Lifestyle Choices	*No*	*Yes*	*Often*
1. Do you avoid exercise?..................................	0	1	2
2. Do you eat fatty foods?...................................	0	1	2
3. Do you eat white bread?.................................	0	1	2
4. Do you eat candy or sweets?...........................	0	1	2
5. Do you drink sweet beverages?.......................	0	1	2
6. Do you have stress in your life?.......................	0	1	2

Symptoms

7. Do you have cravings for sweets or sugars?.....	0	1	2
8. Do you experience weakness of faintness between meals?...	0	1	2
9. Are you unable to gain weight or lose unwanted fat?.....	0	1	2
10. Do you experience excessive fatigue during workouts?	0	1	2
11. Do you feel you have unstable blood sugar levels?.	0	1	2
12. Do you have feelings of dizziness or ringing in the ears?	0	1	2
13. Do you crave fatty foods?...............................	0	1	2
14. Do you have an excessive appetite?................	0	1	2
15. Does it seem difficult to strengthen your muscles?......	0	1	2
16. Do you have pains in the upper middle quadrant of the stomach?..	0	1	2
17. Is your triglyceride level above 115?...............	0	1	2
18. Do you experience mood swings?...................	0	1	2
19. Do you experience nervousness or shakiness?.	0	1	2

Total: ________________

Section 6:

Lifestyle Choice

1. Are you taking or have taken antibiotics with the last 90 days?...	0	1	2
2. Do you eat commercially raised meat products?...	0	1	2
3. Do you eat commercially produced dairy products?	0	1	2
4. Do you drink non-filtered water?.....................	0	1	2
5. Do you drink chlorinated water?......................	0	1	2
6. Do you drink carbonated beverages?...............	0	1	2
7. Do you drink coffee or tea?..............................	0	1	2
8. Do you drink alcoholic beverages?..................	0	1	2
9. Have you undergone surgery within the last 90 days?.	0	1	2
10. Have you done any foreign travel within the last 90 days?	0	1	2

Symptoms

11. Do you have persistent diarrhea?..........................	0	1	2
12. Do you get sick often?...	0	1	2
13. Do you get frequent cold sores?............................	0	1	2
14. Do you have a history of food poisoning?............	0	1	2
15. Do you have persistent flatulence or gas?.............	0	1	2
16. Do you have bad breath?..	0	1	2

Total: ________________

Section 7:

1. Do you feel that you have PMS?...........................	0	1	2
2. Are you moody?...	0	1	2
3. Do you have monthly cramps?...............................	0	1	2
4. Do you have a low sex drive?................................	0	1	2
5. Do you have anemia?...	0	1	2
6. Do you experience a persistent level of low energy?....	0	1	2

Section 7: continued

		No	Yes	Often
8.	Do you have pale skin?	0	1	2
9.	Do you have depression?	0	1	2
10.	Are you uncomfortable no matter what?	0	1	2
11.	Do you have cracking around lips or a white tongue?	0	1	2
	treatment?	0	1	2

Total: ________________

Section 8:

		No	Yes	Often
1.	Are you under 18 years old, pregnant, or an endurance athlete?	0	1	2
2.	Do you have anemia?	0	1	2
3.	Do you have low energy, fatigue?	0	1	2
4.	Do you eat a low fiber diet?	0	1	2
5.	Do you eat a low carbohydrate diet?	0	1	2
6.	Do you have clammy skin?	0	1	2
7.	Do you have persistent shortness of breath?	0	1	2
8.	Do you have frequent headaches?	0	1	2
9.	Do you have ridges in your fingernails?	0	1	2
10.	Do you experience excessive menstrual cramps?	0	1	2

Total: ________________

Section 9:

		No	Yes	Often
1.	Do you have high cholesterol above 200?	0	1	2
2.	Do you have pain in the upper right quadrant of your stomach?	0	1	2
3.	Do you experience distress from eating fatty foods?	0	1	2
4.	Do you have dry skin?	0	1	2
5.	Do you experience an unpleasant taste in your mouth?	0	1	2
6.	Do you have a persistent burning in your stomach?	0	1	2
7.	Do you have flatulence or gas after meals	0	1	2
8.	Do you eat a high fat diet?	0	1	2
9.	Do you have a diet high in hydrogenated fats?	0	1	2
10.	Do you eat red meats?	0	1	2

Total: ________________

Section 10:

		No	Yes	Often
1.	Have you had a recent traumatic injury within the last 90 days?	0	1	2
2.	Do you have muscle pain?	0	1	2
3.	Do you have muscle cramps?	0	1	2
4.	Do you have cold hands and cold feet, or experience poor circulation?	0	1	2
5.	Do you have pain in the joints in your legs, arms, hands or feet?	0	1	2
6.	Are your injuries slow to heal?	0	1	2
7.	Do you have disc problems?	0	1	2
8.	Are you experiencing difficulty in strengthening muscles?	0	1	2
9.	Do you have frequent fevers or infections?	0	1	2
10.	Do you eat a lot of protein (more than 6 oz. per day)?	0	1	2

Total: ________________

Section 11: continued

		No	Yes	Often
8.	Do you have difficulty in thinking clearly?	0	1	2
9.	Do you have discoloration of the gums?	0	1	2
10.	Do you have difficulty responding to conventional drug therapies?	0	1	2

Total: ________________

Section 12:

		No	Yes	Often
1.	Do you have persistent illnesses?	0	1	2
2.	Do you get yeast infections?	0	1	2
3.	Are antibiotics ineffective for you?	0	1	2
4.	Do you seem to get sick easily?	0	1	2
5.	Do you have candida?	0	1	2
6.	Do you have fungus problems?	0	1	2
7.	Do you have athletes foot?	0	1	2
8.	Do you have anal itching?	0	1	2
9.	Do you have food allergies?	0	1	2
10.	Do you have joint pain anywhere in your body?	0	1	2

Total: ________________

Section 11:

1.	Do you work around toxic or nauseous chemicals?.....	0	1	2
2.	Do you smoke or are you exposed to second hand smoke or smog?..	0	1	2
3.	Have you taken prescription drugs in the last 90 days?	0	1	2
4.	Do you regularly experience constipation?......	0	1	2
5.	Do you have symptoms of bowel irritation?....	0	1	2
6.	Are you a heavy red meat eater?.......................	0	1	2
7.	Do you have stomach aches in the navel area?.	0	1	2

NOTES & COMMENTS:

LifeSource Wellness Care – Alexander Thermos, D.C, D.O.
24421 Calle De La Louisa, Suite 100
Laguna Hills, CA 92653

For appointments Call: 949-916-0089

LifeSource Wellness Care Patient Clinical Update

This document helps us find out what's new with you and your health.

Patient Name ____

My last meal was: **BREAKFAST LUNCH DINNER SNACK DRINK** @__________ AM/PM

Please give us your current HOME ADDRESS / HOME & CELL PHONE / E-MAIL Address:

Home Phone ________________ Cell Phone _______________ E-Mail __________________

Home Address ____

The MAIN REASON FOR TODAY'S OFFICE VISIT:

What makes the problem:
Better? Worse? What doesn't work? For how long has this been happening?

Three other Health Concerns I would like to discuss today are:

1. ____
2. ____
3. ____

Additional concerns can be discussed at another appointment when we have time dedicated to that specific concern.

We are trying to get to the root of your Problem – please circle below any of these symptoms:

Constitutional Symptoms: Fever Chills Recurrent Infections Weight Loss / Gain Fatigue Malaise Appetite +/- Depression Anxiety *History of HIV Epstein-Barr Virus LYME Disease Hepatitis A / B / C / D Herpetic Infections Shingles Mouth Sores Genital / Other Sores

Skin Problems: Rash Sores Bug-Bites Eczema Psoriasis Contact Allergy

H-ENT:
Headache: Sinus / Tension / Migraine / Menstrual
History of Head Trauma: Loss of Consciousness / Fainting
Eye Pain: Discharge / Irritation / Blurred Vision
Ear Pain: Discharge / Tinnitus / Sensitivity
Nasal Discharge: Congestion / Post Nasal Drip / Bloody Nose
Trouble Swallowing: Sore Throat / Voice Changes / Neck Pain / Swollen Glands

Respiratory: Cough / Short of Breath / Wheezing / Chest Pain PND / Asthma / Smoker / Short of Breath when Sleeping

Blood / Blood Vessels: Easy Bruising, Excessive Bleeding, Painful Veins, Muscle Cramping, Leg Swelling

Heart: History of Heart Issues, Chest Pain, Short of Breath with Exertion, Palpitations, Irregular Beat, Fainting

Gastro-Intestinal: Abdominal Pain, Nausea / Vomiting, Diarrhea, Spitting Up Blood, Constipation, Passing Gas, Heartburn / GERD

Genito-Urinary: Increased Frequency of Urination / Burning Blood in Urine Penis / Vagina Problems / Discharge Incontinence

Neuro-Muscular: Neck/ Back Pain, Disc Issues, Arthritis, Joint Pain, Headaches, Numbness, Radiating Pain, Seizures

Stressors: Health, Work, Financial, Spouse / Partner, Parents, Kids, Anxiety, Mood Swings, Insomnia, Depression, Fatigue

Hormones: Hot Flashes, Night Sweats, Insomnia, Moody, Fatigued, Depressed, Memory Issues, Brain Fog, Low Libido, Heat / Cold Problems

Women: Breast Problems, Vaginal Dryness, Painful Intercourse, Vaginal Discharge, Breast Tenderness, Climax Problems

Men: Penis/ Erection Issues, Discharge, Testicle Pain, Testicle Lump

Breast Issues: History of Breats Implants, New Lump, Swelling, Nipple Discharge, Painful Breasts w/ Menses, Enlarging Breasts (Men)

History of Environmental Exposure: Heavy Metals, Smoke, Infections, Toxins, Mold, Pet Allergies, Food Allergies

Please explain ANY of these that apply to you:

Please tell me how many:

- Hours do you sleep at night? Wake up Tired or Rested?
- Times do you get up at night to urinate? Because your Spouse is snoring?
- Meals / day do you consume 0 1 2 3 4 5+ Candy? Snacks? Coffee? Soda? Energy Drinks?
- Bowel Movements do you have per week? Daily 3x per week 2-3x per day

Please indicate any Medical Contacts prior to your office visit with us today:
Primary Care OB/GYN Hospital / ER Specialist _________________
Chiropractor Acupuncturist

When? What was that office visit for?

Please list any tests that you've had done: Blood Work CT/MRI Scan X-Ray Biopsy

Have you started any new medications? Yes No

If so, what is it for? ____

Allergies to Medications: No Medication Allergies

Food or Environmental Allergies? ____

My Current Medications (Rx and Over the Counter) are:

My Current Supplements **that I am taking** are:

Vitamin D3
Vitamin C
Vitamin B-Complex / 12
Cholestaless Polycosanol
Diaxinol Co-Q10
Immunokinoko
CSI MSM Oxygen Boost

FOR NEW PATIENT ONLY / or have not been seen in > 2 years

Patient Name ____Date_____________

Your Past Medical History that can be very helpful:

- Please list all of your Hospitalizations

- Please list all of your Surgeries

- Please list any Birth Control that you are currently using / Tubal Litigation or Vasectomy

- Please list all cosmetic surgeries you may have had and when they were performed

    - Any Implants – Silicone or Saline?

    - Have you been receiving any BOTOX Treatments?

- Please tell me anything significant about your
    - Mother's health history
    - Father's health history
    - Brother's health history
    - Sister's health history
- Are there any disease / conditions that run in your family?
    - Diabetes
    - Heart Disease
    - Blood Pressure Issues
    - Cancer? Type:
    - Auto-Immune Diseases
    - Known Genetic Problems
    - Other:
    - Other:
- Any significant INFECTIONS in the past?
    - Monouncleosis? Epstein Barr Virus, Herpes Infection, CMV, Shingles
    - STD's Hepatitis, HIV, etc.
    - Chronic Infections
    - Lyme Disease, etc.
    - Other?
- Any current /past issues with MOLD where you live / have lived?

LIFESOURCE
WELLNESS CARE
HIPAA
PRIVACY POLICY

As of April 14, 2003 we are required by applicable federal and state law to maintain a policy regarding the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice, while it is in effect.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices we will update this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact our office.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for the following reasons:

TREATMENT: We may use or disclose you health information to other healthcare personnel providing treatment to you.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the patient's rights section of this notice. We may disclose your health information to family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree to do so.

PERSONS INVOLVED WITH YOUR CARE: We may use or disclose your health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with the opportunity to object

to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

REQUIRED BY LAW: We will use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders i.e.: voicemail messages, or letters.

PATIENT RIGHTS:

ACCESS: You have the right to look at or get copies of your health information with, limited exception. The request for your health information must be requested in writing. A fee of 15 cents per page and $15.00 per hour staff time will be assessed. If your request is to mail your records, postage will be added to the other costs. A formal report written by Dr. Thermos must be requested by you in writing and the fee will be $100.00 per hour.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, healthcare, operations and certain other activities since April 14, 2003.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be made in writing. Your request must specify the alternative means or location.

AMENDMENT: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. Your request may be denied in certain circumstances.

Should you have any complaints regarding our privacy policies, you have the right to complain to us through our office. If you feel we have violated your privacy rights or denied you any of the patient's rights which you feel you are entitled, you may submit your complaint to the U.S. Department of Health and Human services.

LIFESOURCE WELLNESS CARE / DR ALEXANDER THERMOS, DC, DO
24421 Calle De La Louisa, Suite 100
Laguna Hills, CA 92653
949-916-0089

I understand LifeSource Wellness Care / Dr. Thermos will comply with the best of their ability to maintain my patient rights to privacy in all matters pertaining to my health care. I understand the instances in which information regarding my health can be disseminated. I understand that should I be displeased with the care of my health information I may complain in writing to Dr. Thermos, as well to the U.S. Department of Health and Human services.

Printed name____

Signature____

Date____

PLEASE INITIAL ONE OF THE CHOICES BELOW REGARDING MESSAGES:

X____
I agree that information regarding my health may be left on voice-mail.

Phone number for messages: ____

X____
I want all information regarding my health to be given to me personally. It is not to be left on voicemail or with anyone.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ________________________hereby authorize (Primary Physician)
Dr. ______________________________ Phone ( )____________________
Fax ( ) _______________________

to release the following:

__Lab Work
__Patient History
__Reports, Progress Notes, Etc
__Diagnosis/Treatment
__Other _____________________________

Please release this information with my consent to:

Dr. Alexander Thermos, D.C, D.O
24421 Calle De La Louisa, Suite 100
Laguna Hills, CA 92653
(949) 916-0089
FAX (949) 916-3405

According to Section 123.110 of The California Health and Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: __________________________________ Date: _______________

Name (Print): ________________________________ DOB: _____________

Address: ____

City: ___________________________ State: ____ Zip Code: ___________
Medical Records Number (if applicable): __________________________

LIFESOURCE WELLNESS CARE / ALEXANDER THERMOS, DC, DO

24421 Calle De La Louisa, Suite 100

Laguna Hills, CA 92653

949-916-0089

I understand that Dr. Alexander Thermos is an Osteopathic Medical Physician, but will not be functioning as my Primary Care provider. Dr. Thermos will function as a health consultant and provide treatment that I agree to, in order to assist me with any health issues that wish to discuss with him.

Signature: ______________________________

Print Name: ______________________________

Date: ______________________________

My Primary Care Physician is: ______________________________

The Specialist that I see is: ______________________________