ROCHESTER LIFESTYLE MEDICINE, PLLC
DISCLOSURE AND CONSENT

You have the right to be informed about all procedures being conducted so that you can make an educated decision whether or not to undergo the procedure. This consent form contains information in an effort to make you better informed so that you may give or withhold your consent.

SERVICES AND PROCEDURES

While implementing various lifestyle related services and programs including but not limited to the Complete Health Improvement Program referred to herein as CHIP; RLM may use the following tools and measurements:

- Blood Tests handled by a local clinical lab including but not limited to total cholesterol, HDL, LDL, ratios, triglycerides, fasting blood glucose, Hemoglobin A1c;
- Lifestyle Evaluation including but not limited to blood pressure, body mass index, frame size, age, lifestyle choices such as food, rest, stress, exercise and breathing, medication review;
- Instructional Services and Materials including but not limited to textbook, workbook, cookbook, pedometer, educational videos, group discussion, exercise demonstrations and/or instruction, food demonstrations and/or samples, "5-day jumpstart".

I authorize the providers of Rochester Lifestyle Medicine, PLLC referred to herein as RLM and whomever they may designate, to perform the procedures described on this form. I authorize the provider to use his/her judgment for procedures in addition to, or different from, those now contemplated and that he/she do as he/she deems advisable and appropriate to the situation.

PRIVACY AND PRIVACY LIMITATIONS

I understand that my medical conditions, lifestyle evaluation, medication list, lab results, and other Protected Health Information may be shared by RLM staff and business associates during group discussion time. I have consented to the use of my Protected Health Information during group sessions. I acknowledge that while each patient in the group visit has signed a similar confidentiality pledge, RLM staff and business associates cannot guarantee the confidentiality of Protected Health Information received by the other group members. I agree that I will keep confidential and not disclose or discuss, outside of my CHIP group, the Protected Health Information of others in the group. I understand that group visits are not mandatory and that traditional office visits are available for patients who refuse the group, or decide to leave the group.

DISCLOSURE OF PARTICIPATION

I authorize the disclosure of my name for identifying purposes such as social interaction, attendance, name tags, etc. I understand that due to the group environment and social nature of CHIP, I may be referred to by name, and identified as a CHIP participant during the normal course of daily interaction in the community by RLM staff, business associates, other CHIP participants, and/or various others. Conversations may include information that I have shared regarding my participation in CHIP. Such interactions could include but are not limited to the following types of statements: "John did great in CHIP; he always had the highest steps on his pedometer.", "John was such an encouragement to others." ,"John showed us his results and they were amazing, his cholesterol is below 150. He's so excited, he says he's heart attack proof now!" I understand and agree to these and similar types of interactions with RLM staff, business associates, other CHIP participants, and/or various others.

FOOD ALLERGIES

I understand that food may be provided. I take full responsibility for any food allergies or intolerances I may have. This involves my personal inquiry about the ingredients of any food served and possible abstinence from food offered.

JUMPSTART WITHDRAWAL SYMPTOMS

I understand that the "5-day jumpstart" is designed to prepare me physically and mentally to experience the benefits of improved health. Even though considerable testing has shown this plan to be a sensible, prudent, and safe approach, if I have significant health problems, such as diabetes or other chronic diseases, I will obtain the approval of my primary care provider before beginning. If I have diabetes, I will start the "5-day jumpstart" on day three instead of day one. My five days will not include items listed for days one and two. I understand that most people experience some degree of withdrawal for two to five days as a result of food and/or caffeine or nicotine addictions. Transient symptoms my include headache, nausea, fatigue, depression, generalized aching, excessive gas and diarrhea. Headaches will be worse if I am addicted to caffeine and nicotine.

GUARANTEE AND CONTINUATION OF TREATMENT

I understand and acknowledge that lifestyle medicine is not an exact science. No guarantee or assurance has been made to me as to the results of CHIP. I recognize there is no guarantee of outcome, and I need to continue treatment for diabetes, heart disease, and all other medical conditions until instructed otherwise by my primary care provider or other treating physician. No guarantees have been

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given to me by any of the staff or business associates of RLM as to any particular health outcome.

PRIMARY CARE PROVIDER NOTIFICATION AND APPROVAL

I accept full responsibility for informing my primary care provider of my participation in CHIP. I understand that CHIP is not a substitute for medical advice and RLM does not replace my primary care provider. I will remain with my primary care provider for continuing medical care. I understand that CHIP is an educational program designed to support the process of disease reversal. I will seek the advice of my primary care provider prior to participation and throughout the program. I will let my provider(s) and CHIP staff know if there have been any changes to my health while I am in CHIP. I will obtain the approval of my primary care provider before making changes to my medications.

CONSENT TO DOWNLOAD MEDICATION HISTORY

I authorize RLM to download my medication history from the pharmacy benefit managers (PBMs) via Surescripts into my chart. I understand that the initial medication history download includes data from the past 13 months. After the initial download, medication history downloads include data from 7 days prior to the previous medication history download to the current date.

PAYMENT AND PATIENT REIMBURSEMENT

I understand that payment for ancillary program items is due prior to receiving services offered by RLM. I may request financing options at the time of registration.

CONSENT TO BILL

I authorize RLM to submit claims to my insurance companies on my behalf, and my insurance companies to make payments directly to RLM for services rendered by RLM.

LOCAL CLINICAL LAB FEES

I understand that my blood tests will be performed by a local clinical lab that RLM has selected. Unless I have selected the lab package, the lab will bill my insurance. I will be responsible for any amounts billed by the lab that my insurance plan(s) do not cover.

CANCELLATION POLICY

I understand that RLM charges a $50 fee for missed appointments that are cancelled with less than 24 hrs notice.

RELEASE OF INFORMATION

I authorize the release of any information regarding the treatment rendered to me, to third party payers and/or other health practitioners according to the terms of the RLM Privacy Policy. I authorize RLM to submit a referral request to my primary care provider as well as other providers and specialists who are members of my care team.

METHOD OF CONTACT

I understand that the primary method of contact with RLM will be phone, fax, and the patient portal. However, I agree to receive unencrypted emails and texts from RLM under certain circumstances. I understand that I may be contacted by unencrypted email or text for registration confirmation, if I have not registered for the patient portal, if I am unresponsive to requests in the portal or by phone, to facilitate appointment scheduling, for document collection, for notice of CHIP related events, answers to my unencrypted emails and/or texts to RLM, etc. I understand that communication about any sensitive PHI will be restricted to the patient portal, fax, and phone. I agree to receive automated emails and phone calls to my home and/or mobile phone for appointment reminders, inclement weather cancellation notices, etc.

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have received, understand, and agree to the terms of the RLM Privacy Policy.

I certify that I have read, and/or have had read to me the above contents, and that I understand them fully. Where I had any questions about any of the above, explanations have been provided to me.

Print Name: _____ Signature:_____ Date: _____