SYNERGY HEALTH ASSOCIATES
80 FIFTH AVENUE, SUITE #1204
NEW YORK, NY 10011

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
   a) A postcard mailed to me at the address provided by me; and
   b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)________________________________

Signature of Individual______________________________

Signature of Legal Representative*__________________ Relationship

Date Signed ____/____/____ Witness: _________________________

*Attorney-In-Fact, Guardian, Parent if a minor

File Number: ___________

Agreement Concerning Scope of Care

Dear Patient,

You have to come to us with the desire to improve your general health through nutrition. You may or may not at the same time be under the care of another physician for primary care or for a specific ailment. It's important to understand clearly the scope and extent of the medical services, which we expect to render in your case. Since a nutritional deficiency may or may not be associated with a specific disease, or may be the cause of that disease, or may occur as a result of that disease, our concern with your case will be with your nutritional program and your ability to metabolize and utilize the nutrients you consume. If you have a specific disease and desire treatment for that specific disease entity, you should place yourself under the care of a specialist for such diagnosis and treatment as may be indicated or desired by you.

In our nutritional management of your case we may prescribe vitamins, minerals, enzymes, and other nutritional supplements. The purpose of these natural prescriptions is limited to

- Improvement of your overall nutritional status
- Improvement of your metabolism
- Increasing your sense of well-being
- Normalizing your appetite
- Reducing your pain and discomfort

It is important to understand that you may not receive any of these benefits. Results do not occur predictably in every patient, and in some cases they do not occur at all.

The American Medical Association, the Food and Drug Association, the American Cancer Society, the Arthritis Foundation, the American Heart Association or similar agencies or organizations, do not necessarily share our viewpoint concerning nutrition and the diagnostic evaluation of disease. Though significant evidence exists to consider such diagnostics and natural treatments safe and effective, the above agencies of organizations may consider them unproved, investigational or experimental. Signing below you acknowledge that, with full knowledge of these disagreements, you desire to undertake diagnostic evaluation and have prescribed in your case such nutritional supplements and natural treatments which, in our opinion, appear to be indicated for your condition.

Sincerely,

I have read and understand the above. Under the conditions indicated, I hereby place myself under your care for such diagnosis, care, treatment, prescriptions, and therapies as may appear to be indicated in your medical judgement.

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Patient Date

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Witness Notary

Synergy Health Associates
Dr. Loretta T. Friedman
80 Fifth Ave. Ste 1204
New York, NY 10011

I AGREE TO PAY FOR ALL SERVICES RENDERED AT THE TIME OF SERVICE.

PLEASE BE ADVISED THAT THIS OFFICE DOES NOT ACCEPT ASSIGNMENT AS PAYMENT FROM ANY INSURANCE COMPANY INCLUDING MEDICARE / MEDICAID WORKER'S COMP. & PERSONAL INJURIES CLAIMS.

PLEASE BE ADVISED THAT THERE IS A 48HR CANCELLATION NOTIFICATION POLICY FOR ALL MISSED APPOINTMENTS. (Failure to give us 48hr notice will result in a fee based on the length of time of the appointment.)

ALL TELEPHONE CALLS WILL BE ANSWERED AS SOON AS THE DOCTOR IS FREE TO CALL.
ALL EMERGENCY CALLS WILL INTERRUPT THE DOCTOR FOR AN IMMEDIATE RESPONSE.

****DO NOT CALL, TEXT OR EMAIL THE DOCTOR FOR ANY APPOINTMENTS OR CANCELLATION OF ANY APPTS. CALL THE OFFICE AND LEAVE A MESSAGE*****

ALL CALLS REQUIRING MORE THAN 5MIN OF ON-LINE TIME WILL GENERATE A CHARGE, REFLECTING THE TIME SPENT ON THE PHONE

NOTE: THESE ARE FEES FOR SERVICE AS WELL THIS IS NOT PAYABLE BY INSURANCE

NOTE: ALL ACCOUNTS NOT PAID WILL AUTOMATICALLY BE PROCESSED ON YOUR CREDIT CARD.

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PATIENT SIGNATURE **DATE**