George Guess, MD, DABHM
909 Summit View Ln, Charlottesville VA 22903
434-823-1021/fax 434-823-1637
gguessmd@gmail.com

To Our New Patients,

We would like to take this opportunity to explain some things about our clinical operation. If you have any questions about any aspect of homeopathy or your homeopathic treatment while under our care, please ask. We believe open communication is a necessity between physician and patient. The decision to pursue homeopathic care is yours. Rest assured that your decisions during the course of your treatment will always be respected.

At the beginning of your homeopathic experience it is important to emphasize that homeopathic treatment is best viewed as a process rather than an isolated attempt for a quick cure. Careful monitoring of your progress is required if steady gains are to be achieved. Your homeopathic prescriptions will be adjusted as necessary. Consequently, your follow-up visit(s) are vitally important. The first follow-up is usually scheduled four to six weeks after your initial consultation. Subsequent follow-ups are individually scheduled based upon need. Often, as one's health improves, the interval between follow-up visits lengthens, ultimately resulting in irregular visits as needed.

Please take the time to thoroughly fill out the enclosed forms and, **most importantly, to write a narrative description of yourself and your illness** (an instructional guide is enclosed to help you with this). We need this information to assist in helping you. If at all possible, email your symptom narrative well ahead of time (one week minimum is preferred). This allows time for Dr. Guess to prepare ahead of time, saving you time in the office, and affords adequate time for you to prepare any additional questionnaires that might follow.

If you are seeking only bioidentical hormone therapy (BHRT), when at the office you can anticipate Dr. Guess taking a health history (you do not need to prepare a symptom narrative as mentioned above) and conducting a physical exam (women should be up to date on their annual gynecologic exams with their local health care provider); then relevant laboratory testing will be ordered. Once that information is received, your individualized hormone treatment plan will be recommended. If the treatment plan is complicated, a follow-up office visit is often recommended.

We do not routinely bill insurance carriers for your treatment. We expect you to be responsible for your bill. We will provide you a superbill to file with your insurance company; usually this procedure is effective in obtaining compensation for our office fees from the insurer. Please note that we do not accept/file for Medicare/Medicaid patients, though we are happy to have you as patients (self pay). If, after reading this information, you have any questions, please call. We are glad to have this opportunity to participate in your health care and look forward to working with you.

Sincerely,

George Guess, MD, DHt

Practice Information

George A Guess, MD, DABHM
Mailing Address: 909 Summit View Ln, Charlottesville VA 22903
434-823-1021/fax: 434-823-1637
gguessmd@gmail.com/www.drgeorgeguess.com

FEE SCHEDULE

Initial 90 minute Homeopathic Medical Consultation (homeopathic medicine not included)

Adults $395^{00} **Children** (below 7 years old) $315^{00}

Follow-up visits (30 mins.- in person or telephone): $110^{00}

We have opted out of and do not file/accept Medicare/Medicaid, though we happily welcome all patients!

Initial bioidentical hormone evaluation:$285
(labs are not included)
Combined homeopathic/BHRT consult: $455

Payment in full is due at the time services are rendered. Cash, check or credit card (MC/VISA) are acceptable. A Superbill with required coded information will be provided to you for submittal to your health insurance company for reimbursement. Installment payment plans are available. Contact our office for more information.

Please note! New patients are responsible for calling **48 hours** in advance to change or cancel a first appointment; cancellation of scheduled follow-up or acute visits/calls requires **24 hours** advance notice. **We reserve the right to charge in full for scheduled consultations which are missed!** (excepting emergencies, of course.) **Also, there will be a $35 fee for all returned checks.**

Office Hours: 2:30 p.m. Until 5:30 p.m. Monday
9:30 a.m. until 5:30 p.m. Tuesday, Thursday *(Since establishing my 'perpetual' partial retirement status, with but few exceptions, I only see or consult patients in the afternoons; however, Joanne is always available to answer your calls. Thanks.)*
9:30 a.m. until 12:00 p.m. Friday

Telephone/After hours/Email Policy: Because of our high volume of telephone service, long-distance calls might, with your permission, be reversed. Unscheduled telephone calls and after-hours emergency calls which are lengthy or result in a homeopathic prescription will be charged on a time basis (approx $3.00/minute, $100 maximum usually, unless longer than 30 minutes). Brief informational calls will not be billed.
After Hours/Weekend Urgent Calls: After hours called will be billed in the same manner as unscheduled calls, plus a $30 surcharge.
Emails: Lengthy emails, especially those resulting in a homeopathic prescription, will be also be billed based on time involved.

Directions to 175 S Pantops Drive (Charlottesville VA 22911)

From Charlottesville (via 250 bypass/ Richmond Rd), turn south onto Riverbend Rd. Turn left at the first light onto S. Pantops Drive. 175 S Pantops is on the left just over 0.1 miles after the turn. It's a three story white building. Dr. Guess's office is the first office on the left after entering the front door of the building. The waiting room is at the back of the hall. [Please try to be quiet in the waiting room as there are therapists working in the vicinity.]
From the East or West: Exit I 64 onto 250 West bypass (Exit 124: Shadwell/Charlottesville Exit) toward Charlottesville (East). Turn left 0.3-0.4 miles at the stoplight onto Peter Jefferson Pkwy. Continue on Peter Jefferson Pkwy for 1.5 miles; building will be on the right. The office is the first one on the left after entering front door of the building. The waiting room is at the back of the hall. [Please try to be quitet in the waiting room as there are therapists working in the vicinity.]

George Guess, M.D., DABHM

Mailing address: 909 Summit View Ln, Charlottesville VA 22903

434-823-1021

A BRIEF SUMMARY OF HOMEOPATHY AND HOMEOPATHIC PRACTICE

What is Homeopathy? Homeopathy is a medical therapeutic system founded by Dr. Samuel Hahnemann, a German physician, in the early 19th century. It is still practiced today, and, in this age of science and technology, it is a telling testimony to its validity and effectiveness that increasing numbers of doctors trained in orthodox Western medicine are taking up homeopathy. In many parts of the world homeopathy has achieved substantial popularity and governmental support.

The goal of homeopathic medicine is to restore the health of ill individuals *safely, gently and permanently*. The first step is to arrive at a thorough understanding of exactly what constitutes the "disease" from which a person suffers. To do this the homeopathic physician conducts an extremely thorough and lengthy consultation in which not only physical symptoms are elicited, but also mental and emotional factors which may play an important role in the patient's illness.

One of homeopathy's great strengths is that it *views the patient as a whole* and avoids the narrow specialization that characterizes much of orthodox medicine.

What are homepathic remedies? Once the homeopathic physician arrives at an intimate knowledge of the illness, he then attempts to treat the patient, when appropriate, by orally administering a single select homeopathic medicine, called a remedy. Where indicated, he may also make recommendations about diet, exercise, life style, etc.; however, the prime focus of the system of homeopathic therapeutics is the prescription of the homeopathic remedy.

Homeopathic medicines are prepared from a wide range of substances--animal, vegetable and mineral. Their preparation involves a process of sequential dilution in alcohol/water and succussion (vigorous shaking), a process known as potentization. This process of potentization enables the homeopath to prescribe medicines which possess an enhanced curative effectiveness and essentially no toxic side effects, unlike current orthodox drugs.

What is the Law of Similars? What really distinguishes homeopathy from orthodox medicine is the basic principle upon which homeopathic physicians choose the indicated medicine. This principle is called the Law of Similars, which says: a substance that can produce symptoms in a healthy person can cure the same combination of symptoms in a sick person.

What is the philosophy of homeopathy? Homeopathy recognizes that the human organism possesses an intelligence that directs all of its functions in health and in disease. When we fall ill as a consequence of some life stress (dietary, environmental, hereditary, psychological), specific and unique symptoms are produced in each individual.

Homeopathy asserts that such symptoms are expressions of the organism's effort to heal itself, to overcome the stress. For example, when we contract a cold, the immune response--fever, runny nose, sore throat, cough, etc.--results because it is the best way in which our body can rid itself of the responsible cold virus. In the homeopathic treatment of a cold or any other problem, acute or chronic, a remedy is prescribed which is intended to enhance the patient's own healing effort. In this way, the patient's vitality may be strengthened, and the disease should be overcome gently and safely. The final goal of homeopathic medicine is the restoration of total health--mental, emotional and physical.

What can homeopathy treat? While there are homeopathically incurable patients, there are few "disease categories," per se, that are not responsive to homeopathic treatment. A wide range of problems fall within the province of homeopathy, including gastrointestinal, immune (allergies, etc.), metabolic, hormonal, menstrual, infectious and emotional disorders. Both acute (such as colds and flus) and chronic health problems may be treated, and homeopathic patients can be of any age. Ask your homeopathic physician whether or not homeopathic treatment is appropriate for your condition.

In summary... Homeopathy is an extremely safe and effective alternative medical discipline. Because of its efficacy and the relative infrequency of visits required compared to many other therapies, homeopathy is also the most cost effective, inexpensive medical therapy available. In addition, many health insurance carriers will cover the cost of homeopathic health care.

PATIENT INFORMATION

NAME:_____ Referred by: _____

ADDRESS: _____

_____

AGE:_____
DATE of BIRTH _____
SEX _____
MARITAL STATUS: S M W D SEP

PHONE (home): _____
CELL PHONE: _ _____
EMAIL ADDRESS: _____

EMPLOYER: _____ SOCIAL SECURITY #: _____
ADDRESS: _____ or Driver's License (state)#: _____

_____

PHONE: _____

SPOUSE'S EMPLOYER: _____
ADDRESS:_____
PHONE: _____

PERSON RESPONSIBLE FOR PAYMENT (if other than the above): _____
ADDRESS:_____ PHONE: _____

_____ SOCIAL SECURITY #: _____
EMPLOYER/ADDRESS/PHONE: _____

_____

_____

Please sign below:
I assume full financial responsibility for the cost of homeopathic medical services provided by Dr. Guess.

Date:_____ Signed: _____
(Patient, Parent or Guardian)

Responsibility for Payment for Missed Appointments

Please note that it is your responsibility to cancel any appointment with Dr. Guess that you are unable to keep. As mentioned in our Practice Information sheet, cancellations of any follow-up or acute appointment must be done **at least 24 hours in advance**. Failure to notify the office **at least 48 hours before** the scheduled new patient appointment or 24 hours before a follow-up appointment will result in your being billed for the full amount of the appointment — usually $100 (unless an extended visit was scheduled).

To insure that such fees can be collected, we require a valid credit card number (and expiration date) for each patient to keep on file. Your card will not be billed excepting for missed appointments and, in some cases, delinquent accounts. We will notify you should your card be billed for the above reason(s).

Please sign the following statement.

I have read the foregoing and agree to assume responsibility for any fees resulting from appointments I miss and/or fail to cancel with at least 24 hours prior notice.

_____(signature) Date _____

Credit Card Information:
(Only Mastercard or Visa accepted)
Card Number:_____Expiration:_____Security Code: _____

About Deliquent Accounts: Accounts over 90 days past due will be turned over to a collection agency. Due to collection agency fees, the amount due will be doubled to cover that added cost. Please initial, confirming that you understand this policy:_____(your initials here)

IMPORTANT SYMPTOM REPORT: PLEASE BE SURE TO COMPLETE AND RETURN BEFORE YOUR APPOINTMENT IS SCHEDULED!

Questionnaire for Children under 7 years old

*Please use a **separate** sheet (document) to answer these questions or, if **ONLY** responding in an electronic document, insert answers immediately after each question (as a .doc, .docx, .pdf, or .txt file).*

Child's Name:
Age:
Birth weight, if recalled:
Percentiles of height and weight, if known:

1. What is the child's chief complaint?
2. When did this problem begin? What happened in the childs life around that time? What do you think caused it?
3. What aggravates the complaint (eg, foods, weather, movement, light, noise, heat/cold, position, rubbing, pressure, touch, being at the seashore or mountains, or anything else that you can think of)?
4. At what time of the day or night is the complaints worse? Specify an hour if you can.
5. What symptoms can you identify that accompany the complaint?
6. What was your predominant emotional state when pregnant with this child?
7. During the pregnancy, did you suffer any particular shocks or traumas or losses?
8. Did you take any drugs?
9. How did you food cravings and aversions change during pregnancy?
10. Were there any particular complications at birth?
11. At what age did the child reach these stages, if you recall?

weaning	closing of fontanels	first milk teeth
talking	toilet training	first permanent teeth
crawling	walking	

12. How did your child react to these situations? Please try to think of mental and emotional reactions as well as any physical symptoms that may have developed.

vaccinations	birth of younger sibling	starting daycare regularly
first day at school	spending the night with a friend	
traveling with the family	going away to camp, etc.without the family	

13. How many rounds of antibiotics has the child had and for what?
14. Any skin conditions treated with cortisone cream?
15. Did the child suffer from a childhood disease with very severe symptoms? (measles, mumps, chickenpox, German measles, coup, etc.)
16. When ill or upset, does the child tend to cling to you or want to be left alone?
17. What is the child's behavior in playing with other children? Does it make a difference if the other kids are older or younger?
18. What feedback do you get from your child's teacher about behavior in class?
19. What pet do you have, and what is your child's attitude toward them? To other animals in general?
20. a) What types of food does your child crave? Please be as specific as possible and list as many as you can.
    b) What types of food does s/he refuse to eat?
    c) What types of foods does your child react badly to, whether physically (bloating, diarrhea, etc.) or behaviorally, and what are the reactions?
21. Any fears that are unusual for a child of your child's age (of the dark, being alone, lightening, thunder, animals, insects, ghosts, heights, etc.)? Are there nightmares?
22. Is the child chilly or hot? Is there excessive perspiration on the head and/or feet? Perspiration at night in sleep? Teeth grinding in sleep? Does s/he adopt a peculiar position in sleep? Put his/her feet of of the covers at night?
23. Is the child very affectionate when not sick? How does s/he react to affection and attention when ill?
24. Is the child unusually sympathetic (showing concern for the suffering of other children, animals, etc.)?
25. Does the child like music? What kind? Like dancing? Do symptoms (like restlessness) improve with music?
26. Is the child obstinate? How is this expressed?
27. Is the child fastidious?
28. Is the child sensitive to criticism and reprimand? What is the reaction?
29. Can you think of any unusual or distinctive things about your child—behavior, fears, fantasies desires, attachments, preferences in clothing, etc.?
30. In addition to the above, please provide a detailed description of your child's temperament (basic, innate qualities) and personality (personal characteristics and behaviors developing over time, seemingly bred from the child's experiences in life). (EG; mild, angry, anxious, affectionate, reserved, detailed, sloppy, careless, reckless, careful, fearful, fearless, pleasant, surly, etc.)
31. Give a timeline for the child with all possible traumas, diseases, important events, deaths in the family, as they seem possibly related to the child's physical and/or emotional health. Describe the reaction of your child to these events.

Homeopathic Treatment Consent Form

I,_____, by signing this document, hereby authorize Dr. George Guess to treat me/my child (_____), using homeopathic medicines and according to the tenets of homeopathic practice. I understand and acknowledge that Dr. Guess will base his treatment decisions on the school of homeopathic practice, and if I desire to be treated according to the orthodox or allopathic school of medicine, I will seek any such treatment from another physician.

Dr. Guess has made no guarantees to me that his homeopathic treatment will cure me, and I acknowledge that he has explained to me the principles of homeopathy and treatment by homeopathic means.

_____

Signature of patient or parent/guardian

HEALTH HISTORY QUESTIONAIRE

NAME:_____ DATE: _____

FAMILY HISTORY

For each member of your family read down the list of diseases and put a check in the boxes which apply. Put one check for each relative having a certain disease; ie, put 3 checks in grandparents-stroke if 3 of your grandparents suffered strokes. Indicate age only if relative is deceased.

	father	mother	grandparents	brothers	sisters	children	spouse	aunts/uncles
Age (at death only)								
Cause of death								
Cancer								
Tuberculosis								
Diabetes								
Heart trouble								
High blood pressure								
Stroke								
Allergies or asthma								
Anemia/blood disease								
Mental illness								
Genetic disease								
alcoholism,drug abuse								
Kidney disease								
arthritis,autoimmune								
Venereal disease								
Malaria								

PERSONAL HISTORY

Put a check next to any of the following that you now have or have ever had:

___measles
___mumps
___chicken pox
___polio
___diphtheria
___small pox
___meningitis
___scarlet fever
___hernia
___genetic disease
___thyroid disease
___bronchitis
___pneumonia
___pancreatitis
___ulcers
___diverticulosis
___hemorrhoids
___arthritis
___cancer
____bone or joint disease
___serious injury
___jaundice
___malaria
___liver disease
___skin disorders
___kidney disease or stones
___venereal disease
___concussion or head injury
___tuberculosis
___sinusitis
___hay fever
___frequent colds
___neuritis
___sciatica
___back pain
___anemia/blood disease
___asthma
___diabetes
___headaches
___migraines
___anxiety
____depression
___serious infection
___alcoholism or drug abuse
___hyperactivity
___heart trouble
___stroke
___rheumatic fever
___hypertension
___rabies
___reactions to drugs,vaccines, transfusions to what?____
other_____
_____
_____

MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious illness or operation, write in your most recent hospitalizations below. Use reverse side if needed. (Do not include normal pregnancies.)

YEAR	OPERATION OR ILLNESS	PHYSICIAN'S NAME	CITY AND STATE

Please list the name and address of any other physicians who have treated you in the last five years and the problem you were treated for. (Do not include visits for colds, flus or other minor acutes.)		
PHYSICIAN'S NAME	ADDRESS	PROBLEM

MEDICATIONS

Indicate those medicines you are presently taking or which you have taken in the past; please give the name and dosage of all current medicines.

Present	Past		Present	Past	
_____	_____	Antibiotics _____	_____	_____	Diabetes medicine_____
_____	_____	Pain medicine_____	_____	_____	Arthritis medicine_____
_____	_____	Diuretics_____	_____	_____	Diet pills _____
_____	_____	Sedatives_____	_____	_____	Antacids/laxatives_____
_____	_____	Blood pressure medicine_____	_____	_____	Allergy/sinus medicine_____
_____	_____	_____	_____	_____	Birth Control Pills_____
_____	_____	Heart medicine _____	_____	_____	Hormones _____
_____	_____	_____	_____	_____	Antimalarials _____
_____	_____	Thyroid medicine _____		_____	Antituberculosis _____
_____	_____	Aspirin_____		_____	Allergic desensitization _____
_____	_____	Vitamin supplements_____		_____	Other_____

DRUG ALLERGIES

Please list any and all medicines you are allergic to; e.g., penicillin, sulfa drugs, other antibiotics, aspirin, codeine, etc.:

_____

_____

_____

TESTS AND IMMUNIZATIONS

Check those tests and immunizations you have had. Enter the year when you last were given the tests or shots.

_____Chest X-Ray	_____Sigmoidoscopy	_____DPT or DPaT
_____Kidney X-Ray	_____PAP smear	_____Tetanus
_____GI Series	_____Nutritional Analysis	_____Flu Shot
_____Colon X-Ray	_____Polio Series	_____Pneumonia Shot
_____Electrocardiogram	_____Measles,mumps,rubella	_____ Other
_____TB test	_____Hib Vaccine	
_____CT or MRI Scan	_____Ultrasound	

HEALTH FACTORS

Yes No

___ ___ Do you drink:
Coffee?___cups/day
Tea? ____cups/day
Sodas?_____12 oz. cans/day

___ ___ Do you drink:
Beer?____cans, bottles/day
Wine?_____glasses/day
Other alcohol?____drinks/day

___ ___ Do you use tobacco?
Cigarettes? ____packs/day
Cigars? ____cigars/day
Pipe? ____bowls/day

Yes No

_____Do you use an electric blanket

_____Do you have silver-mercury amalgam fillings in your mouth?

_____Do you exercise regularly?
How much? _____

_____Do you meditate regularly?

_____Do you use "recreational" drugs; e.g., cocaine, LSD, marijuana. etc.? How much; how often?

_____

___ ___Have you any known environmental sensitivities or past or present toxic chemical exposures?
Please describe: _____

From the office of Dr George Guess

Notice of Privacy Practices Policy

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
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.

Understanding your health record
A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment.

It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights
Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information (our practice may charge a fee for this), and to be given an account of certain non-routine disclosures (i.e. for non-treatment, non-payment or non-operations purposes). You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.
You are entitled to receive a paper copy of our notice of privacy practices.

Our responsibilities
This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. If applicable, this office will post changes on our web site that provides information about our customer service and/or benefits. Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem
For further explanation of this notice you may contact our Privacy Officer ,Joanne Showalter, at 434-823-1021. If you believe your privacy rights have been violated, you have the right to file a complaint with our medical office or with the Secretary of Health and Human Services with no fear of retaliation by this office.

Your health information will be used for treatment, payment, and health care operations.
Treatment – Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in your care, such as specialty physicians, lab technicians, or pharmacies. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children or parents.

Payment – Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used. We may disclose your health information to other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations – The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide. We may disclose your health information to other health care providers and entities to assist in their health care operations.

Optional items:
Our practice may use and disclose your health information to contact you and remind you of an appointment.

Understanding our office policy for specific disclosures

- Business Associates – Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- Communications with Family/Friends– Using best judgment, a family member, or close personal friend, identified by you, may be given information relevant to your care and/or recovery.
- Deceased Patients – Your health information may be disclosed to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs consistent with laws governing their services.
- Organ Procurement Organizations – Your health information may be disclosed consistent with laws governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.
- Marketing – This office reserves the right to contact you with information about treatment alternatives and other health-related benefits that may be appropriate to you.
- Fund Raising – This office reserves the right to contact you as part of general fund-raising efforts.
- Patient Directory (optional–typically applicable only to inpatient settings) –Unless you object, this facility will use your name, room number, general condition, and religious affiliation for directory purposes. This information will be made available to clergy, and others who ask for you by name.
- Research (optional) – Your information will be disclosed to researchers upon Institutional Review Board approval, and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.
- Food and Drug Administration (FDA) – This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- Worker's Compensation – This office will release information to the extent authorized by law in matters of worker's compensation.
- Public Health – This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, child abuse or neglect, injury, or disability.
- Serious Threats to Health or Safety – Our practice may use and disclose your 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.
- Military – Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- National Security – Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- Lawsuits and Similar Proceedings – Our practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your health information in 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.
- Correctional Facilities – This office will release medical information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.
- Disclosures Required By Law – Our practice will use and disclose your health information when we are required to do so by federal, state or local law.
- Law Enforcement – Your health information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena.
- Health Oversight Activities – Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posted where registration occurs. All individuals receiving care will be given a hard copy.

Receipt of Notice of Privacy Policies

WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of George A Guess, MD's, Notice of Privacy Practices.

_____ _____

Signature of Patient / Representative Date

_____ _____

Patient Name Name / Relationship to Patient if Representative