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 treatments 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 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.

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, DABHM

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 and follow-up appts. not included)

Adults: 425^{00} **Children** (below 7 years old): 385^{00}

Follow-up visits (30 mins.- in person or telephone): 130^{00} (additional fee might apply for extra time)

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

Initial bioidentical hormone evaluation: $328
(labs are not included)
Combined homeopathic/BHRT consultation: $495

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.** And finally, if a written report is submitted by a prospective new patient and reviewed by Dr. Guess prior to scheduling, **there will be a $50 fee charged if the prospective patient does not complete appointment scheduling or contact the office within one month of having been notified by email or telephone that said report review has been completed**.

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, $110 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 $35 surcharge.

Emails: Lengthy emails, especially those resulting in a homeopathic prescription, will be also be billed based on time involved.

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: _____
ADDRESS: _____
PHONE: _____

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

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

PERSON RESPONSIBLE FOR PAYMENT (if other than the above): _____
ADDRESS:_____ PHONE: _____
_____ SOCIAL SECURITY #: _____
EMPLOYER/ADDRESS/PHONE: _____
_____
_____

INSURANCE COMPANY: _____ POLICY (GROUP) #:_____

NAME OF INSURED (PRINCIPLE): _____ INSURANCE CO. PHONE #: _____

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 Delinquent Accounts

We will make every effort to meet you half-way if you are having trouble paying your bill; so please call us if you require special consideration. Accounts 90 days past due, with no payment activity registered during that time, will be turned over to collections. Once turned over to the collection agency, the amount due will be doubled to cover the cost of collection.
Please initial below, signifying that you understand this collection policy. _____ (your initials)

Important symptom report: please be sure to complete this symptom report and return to Dr. Guess before scheduling your appointment. Your report will be reviewed and the best case analysis strategy will be selected for your particular health situation. Once received you'll be contacted to schedule your appointment(s). You'll be scheduled for either one longer initial consultation or, if appropriate, one of two shorter appointments – total approximates the same amount of time usually. (Cost is the same). Thank you.

And, Should it be impossible for you to provide such a written narrative, just let Joanne know and we'll go ahead and schedule you. Depending on the time involved in taking your case, there might be a small extra fee if it takes much longer than 90 minutes to obtain all the information required.

Directions: Please respond to the following **on separate pages of paper/a separate .doc or .docx file**; **don't simply circle words or jot down notes on this questionnaire** – details are important. **Please condense your reporting such that you don't exceed approximately 5 pages (typed) total as exceptionally long written report will incur a time-based additional fee.** Brevity, though, will help focus your report on the essentials. [If the patient is a child less than 7 years old, please use the questionnaire for children, available on my website; in some cases, you might want to also refer to the adult questionnaire, especially if your child is especially mature. It is best if the parent prepares the report combining his/her observations with those of the child.]

1 Chief Complaint: Describe your chief complaint – your main reason for coming for the consultation – in full detail; ie, when and how it began, its diagnosis (if you have one), all signs (physical changes) and symptoms/sensations associated with it, and all influences that seem to either aggravate or relieve the complaint (termed 'modalities'), referring to the descriptive headings below (if a skin complaint, also refer to item 7 below):

a. Quality of pain/sensation (eg, dull, ache, pulsating/throbbing, burning, cutting, stitching, numbness, tingling, crawling, coldness, heat, etc.)
b. Location of pain/sensation.
c. Does the pain/sensation extend to another part of the body?
d. What makes the pain/sensation feel better or worse (homeopaths call these modalities)?
   Heat or cold (air temperature, room temperature, applications, baths)?
   Weather or weather changes?
   Time of day or night?
   Position (standing, sitting, lying – in what position, etc.)?
   Activity (walking, running, driving/riding, bending, rising, ascending or descending stairs, reaching, turning, lifting, sleeping, waking, jarring, etc)?
   Touch, rubbing, pressure (hard or light, clothing?
   Eating or drinking (if so, what in particular – hot/cold drinks, type of food)?
   Bodily functions (menstrual period, sweating, salivating, urination, defecation, coughing, sneezing, etc.)?
   Other exposures (light, sunlight, noise, odors, music, conversation)?
   Certain emotions?
e. And, finally, are there any associated symptoms/conditions that tend to occur with the complaint (homeopaths call these "concomitants")? Examples: abdominal bloating, salivation, chills, anxiety, irritability, sadness, etc.

Comment on the previous treatment this complaint (and others) has received and the result.

And, especially important, if it seemed that your overall health and/or your chief complaint seemed to follow some important event in your life, a particular illness, or a particular medical or surgical treatment, please make note of same here.

2 **Past Medical History**: Mention all previous illnesses. A complete history of your health is important, even of such things as skin diseases, children's diseases and their after-effects; tell of fevers, colds, flus, sores, ulcers, etc.; also injuries, if any. Tell their location and what treatment was used.

3 **Additional Complaints**: Describe all additional health complaints – you may reserve mental-emotional complaints for a later section or describe them here, and provide all relevant details ("modalities", etc. - see above under #1) of each as requested for the chief complaint. Also, describe how your sense of vitality, well-being is, your energy level and what affects it for the better or worse.

4 **Generalities**: "Generalities" is the term homeopaths apply to the 'modalities' of the whole person, as opposed to specific complaints; that is, what makes you feel better or worse overall, unrelated to your particular symptoms. Using all the modality descriptors listed in item 1, comment upon how you as a person, in general are affected by various influences, stimuli, and activities, if remarkable. For example, are you cold or warm 'blooded' (meaning more sensitive to cold or heat); affected by weather or storms (approaching or present), drafts, sunlight, clouds, humidity, wet weather; affected much by eating or drinking; by time of day or night; by perspiration; getting wet; your menstrual period; resting; activity; exercise; occupation; thinking/mental exertion; meditating; the ocean or mountains, nature, animals, music, sunrise/sunset. Do any of these or anything else make you feel significantly better or worse overall? (Note: sometimes one's 'Generalities' are exactly the opposite of the modalities of a local complaint.)

5 Food/Drink

Appetite: How strong or weak is your appetite? Do you get hungry at any specific or unusual time?
Thirst: How strong or weak is your thirst? Do you get thirsty at any specific or unusual time?

Tell what foods or condiments **strongly craved or disliked**, including such things as salt, sweets, fats, sour, spicy things, eggs, milk, cheese, ice cream, chocolate, meats, fish, chicken, fruits, vegetables, onions, garlic, soup, ice, cold things, warm things, bread, etc. Also, what drink is preferred? (Here I'm less concerned by the particulars of your diet; rather I'd like to know what foods you either really crave, would miss if you couldn't have them or still miss though you're avoiding them, or what foods you strongly dislike.)
Also, do any foods, condiments, drinks, etc., make you or a complaint better or worse?
Do you crave or have a problem with alcoholic drinks?

6 Mental-Emotional Characteristics

A. If mental-emotional distress troubles you, please provide as full a description as you can, mentioning 1)how you feel
2)how the problem seemed to begin and the apparent cause
3)what makes you feel better or worse (this could be any of the modalities mentioned in item 1 or it could consist of other influences; eg, consolation, company, being alone, anger, specific types of stress, overwork, humiliation, criticism, etc.)

B. Tell of any emotional shocks, frights, disappointments, etc. of the present or past.

C. Provide a thorough description of yourself – your character and personality, as best you can. (*In this section, the information sought relates to your personality, character, temperament, and 'idiosyncrasies.' In that there are many varieties of 'normal,' personality characteristics are very often helpful in narrowing down the homeopathic prescription. So please don't stint in your self description!*) For example, are you outgoing or introverted, a loner or quite sociable, shy, timid, confident, assertive, arrogant, calm, angry, aggressive, anxious, melancholy, moody, cheerful, humorous, serious, talkative, quiet, industrious, impatient, hurried, lazy, slow, content or discontent, easily offended and sensitive to criticism or impervious to same, engaged and curious, neat or sloppy, bored and indifferent—whatever you or your loved ones can think of. If you have trouble thinking of things to say, try to recall what friends and family have said about you, or even ask them to write-up their own description of you.

D. Have you any fears? For example, heights, claustrophobia, darkness, robbers, animals, insects, snakes, water, storms, airplanes, crowds, sight of blood, public speaking, death, disease, germs, being alone, performing/speaking in public, rejection, criticism, death of a loved one, horrible/violent sights (real or in the media), etc.
E. How is your mental functioning and memory?

F. How to do you feel about your work/career/school? What about it do you like or dislike? Are there any serious issues affecting you at work? How do you approach work; eg, with enthusiasm, dread, diligence, avoidance, anxiety, impatience, etc.?

G. How do you feel about your relationships/marriage/family? Any significant issues in relation to same?

H. What are your dissatisfactions in life, your goals, your joys?

I. What do you like least/most about yourself? What are your personal strengths and weaknesses?

J. What are your favorite hobbies or pastimes (eg, crafts, music, reading, travel, sports, etc)? What do you especially love to do? Where do you especially love to be; eg, in nature, specifically in the mountains, desert or at the sea? How do you feel about animals? Are there any you especially love or loathe?

7 **Skin**: In skin, scalp, or nail problems, tell the exact location, color, whether dry or moist, thick or thin, scaly, crippled, pimply, with or without matter, warts or growths, appearance of surrounding skin; whether itching, burning or having another sensation; worse or

better from scratching/rubbing, and what else makes it better, such as heat, the heat of the bed, cold, exercise, wool, water, etc. Tell of any enlarged veins, unusual bruising, etc.

8 **Discharges**: Describe discharges of any part, whether slight or heavy, the color, odor; if thick or thin, gluey or sticky; if causing redness or burning, rawness; color or stain; and what makes it better or worse and when.

9 **Urine**: Is there urinary tract pain before, during or after passing? Describe your urine: color, odor, appearance, quantity, sediment; if there's any frequency, urgency (if hurried), incontinence, bedwetting (especially in a child).

10 **Bowel condition/Elimination**: What is the stool's appearance: color, odor, consistency (hard, dry, large, pasty, bloody, frothy, slimy, thin, watery, slender, flat, etc.)? How often, at what times worse or better, or how affected by certain circumstances; whether difficult, incomplete, urging without result; if the stool slips back in, if prevented by spasm of the rectum; or anything else peculiar.

11 **Menstrual History**: Woman are to give age at first menstrual period, how far apart then and now; whether pain before, during, or after, then and now, and where; also where the pain may extend to, as to the back, sides, groins, thighs, etc. What kind of pain, what relieves or aggravates; how often the pains come. If you have experienced PMS (premenstrual syndrome), please describe all of the symptoms associated with it. Tell whether there have been miscarriages. Tell how you feel in general, before, during and after the periods. Please also describe how any past pregnancies affected you.
If comfortable doing so, please describe the following: strength of libido or if there's aversion to coition, frequency of masturbation (at your discretion, of course), whether intercourse is normal, unsatisfactory, or painful; if you experience any aggravation in general after coition.

12 **Males**: Men are to give particulars as to male organs (prostate, penis, testes, scrotum), if anything is not normal; whether there's been a history of any former disease; effect of intercourse; strength of sexual drive; frequency of masturbation (at your discretion, of course); whether night emissions, etc.

13 **Sleep**: Describe the details of your sleep. Do you sleep well or poorly? Do you have trouble falling asleep or staying asleep? Do you waken at a certain hour? In what manner; e.g., as from fright, from a dream, from a sensation of heat, from a physical pain or other sensation? In what position do you sleep? Do you stay covered or uncover? Do you uncover your feet at night? Are there any peculiarities associated with sleep, such as teeth grinding, perspiration, salivation (drooling), jerking, restlessness, talking or walking? Do you dream? Do you have any recurring dreams or dreams of a similar nature; i.e., similar theme, same object or person recurrently appears, etc.? Mention any other peculiarities of sleep. How do you feel on waking in the morning?

14 **Summary**: Lastly, but most importantly, if you are willing and haven't already covered it, using the guidelines given above, please write a narrative summarizing your principle complaints and the "reason" you think you became ill. Do you think your life situation at the time or now, any stress you may have been exposed to, any qualities in yourself might have contributed to your illness. Similarly, did any physical, chemical, or biologic trauma contribute? Describe the significance of your illness to you, what your emotional reaction to it is, what your worries in regard to it are.
Include a brief summary of your life history focusing upon the most important events in your life — major griefs and losses, disappointments, the worst thing(s) that has happened to you, your childhood —especially if they clearly impacted your health. There may be overlap with your answers to item 4 above, in which case there's no need to repeat yourself here. Discuss what is most important to you in life.

And that's all! Whew! I know what an effort it is to describe yourself and your symptoms in the details necessary for a homeopathic interview, and I appreciate your labors. This will greatly assure me that some important detail has not been left out. Again, if you prepare this narrative well in advance and mail/email (preferable) it to our office before scheduling your appointment. Thank you!

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_____
_____
_____

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., coccaine, 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