Dr. Michael Reed
4627 Fermi Place Suite 110 Davis, CA 95618
P: (530) 753-2787   E: contact@drmichaelreed.com

Dear Friend,

Welcome to the beginning of a fruitful and transformative partnership. I am committed to actively listening to your needs and leveraging my expertise to help you achieve your therapeutic objectives. Our success hinges on collaboration, as we must work together harmoniously. Just as you have expectations of me, I also have expectations of you.

I expect you to diligently complete the lab tests as prescribed, promptly attend follow-up appointments, and make every effort to keep the scheduled visits we have arranged. Furthermore, it is crucial that you adhere to the therapeutic regimen we have agreed upon, which includes medications, supplements, and lifestyle adjustments. If you have concerns about any aspect of your treatment, whether it's discomfort, adverse reactions, or reservations about a specific therapy, I urge you to inform me before taking any independent actions.

Your satisfaction is paramount, and if you feel that progress is not meeting your expectations, please communicate your concerns. By doing so, we can address the issue head-on and potentially chart a more gratifying path forward.

Thank you for entrusting me with your well-being, and I am eagerly anticipating the opportunity to work alongside you in accomplishing all your wellness goals.

Sincerely,

Michael Reed, MD

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Appointment Policies

No Shows, Cancellations/Reschedules

We understand that there are times when you must miss an appointment due to unavoidable circumstances, however, Dr. Reed sets aside a considerable amount of time for each of his appointments. No shows, last-minute cancellations and reschedules leave open appointments that could have been offered to others who also need treatment.

All patients will receive a courtesy appointment reminder text and/or phone call (depending on the contact information we have on file) one week as well as one day prior to their visit. We require 48 hours notice for all cancellations/reschedules.

***New patients** who fail to show up for their appointment or who do not provide adequate notice for a cancellation/reschedule will incur a charge to the credit card provided for the $100 deposit fee.

***Established patients** are given a grace of one no show or limited notice cacellation/reschedule per year. All subsequent instances will be subject to a $50 fee, which must be paid prior to being seen for your next visit.

Scheduled Appointments:

We understand that delays can happen, however we kindly ask that you notify the office if you are going to be running more than 10 minutes late for your appointment.We will always try to accommodate you, however when Dr. Reed's schedule is fully booked, you may receive a shorter visit or need to rescheduled.

Please be advised that there are NO EXCEPTIONS to this policy.

____ ____________________

Patient Signature **Date**

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Title Summary of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one time acknowledgement that you have received this summary. A copy of the full notice is available upon your request.

Use of Protected Health Information

You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information

We are permitted to use your protected health information for treatment purposes, to facilitate our being and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of the authorized communication routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentially of this information.

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Disclosures of Protected Health Information Requiring Your Authorization

For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health information Not Requiring Your Authorization

We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Communication To You Of Confidential By Alternative Means

If you make a written request, we will communicate confidential information to you by reasonable means, or to an alternative address.

Restrictions To Use and Disclose

You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Access To Protected Health Information

You may request access to or a copy of your medical record in writing. We will provide these within the time period specified unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments To Medical Records

You may request in writing that correction be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures Of Protected Health Information

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

Other Uses Of Your Health Information

Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How To Lodge Complaints Related To Perceived Violations Of Your Privacy Rights

You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.

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Acknowledgement of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgement this notice was received.

Therefore, I, ______________________________, (printed name of patient or personal representative), acknowledge that Dr. Michael Reed or his duly authorized representative has provided a written copy of his Notice Of Privacy Practices for Protected Health Information to (check one) _____ myself or _____ specify: ________________________

If you are signing as a personal representative, documentation of your legal right to do so must be provided.

____ ______________________
Signature of patient or personal representative Date

____ ______________________
Printed Name Relationship to Patient

This section is for the use of the office only

We made a good faith attempt to provide the above named patient with a copy of our Notice Of Privacy Practices for Protected Information, but we were not successful for the following reason:

____ ______________________
Signature of Representative **Date**

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Self Pay Contract

Dr. Michael Reed is not associated with any insurance networks including Medicare, which means that they are not obligated to pay for any services rendered here. Payment in full at the time of service is required but if you choose, we will provide you with a "Super Bill" (a receipt showing that you paid out of pocket) with all pertinent information required for submission to your insurer for possible, (partial), direct reimbursement as per your "Out Of Network" coverage benefit plan. We will not, however, communicate with your insurance company in any way. The form/receipt is your responsibility and serves as evidence of your treatment. We will not call, write, pre-certify or make any contact with your insurance company nor respond to any of their communications. If we receive a check from your insurance, we will return it to sender.

I hereby acknowledge and understand the above.

____ ________________________

Patient Signature **Date**

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Patient Registration

Patient Information:

Last name: ____

First name: ____

Address: ____

City: ______________________________ State: ____________________

Zip: ____

Phone #: ____

Work #: ____

Cell #: ____

Email: ____

Date Of Birth: ____

Preferred Pharmacy: ____

Marital Status: ____

Language: ____

Referral Source Name: ____

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Confidential Health Questionnaire

Patient name: ____
I heard about Dr. Michael Reed from: ____
My usual healthcare provider is: ____
My occupation is: ____
Are you presently married or partnered: ____
Name of partner: ____
Partner's occupation: ____

Health history

Have you had any previous health problems related to the following areas? Check all that apply.

___ Head, Eyes, Ears, Nose, Throat	___ Skin, Hair, Nails
___ Neck, Thyroid	___ Back, Spine, Muscles, Bones
___ Chest Respiratory	___ Nervous System
___ Heart, High Blood Pressure	___ Psychological, Psychiatric
___ Breasts	___ Weight Problems, Eating Disorder
___ Liver, Gallbladder, Hepatitis	___ Chemical or Alcohol Dependency
___ Kidneys, Bladder	___ Reactions from Medications
___ Stomach, Intestines (including constipation	___ Lymph Nodes / Anemia
or diarrhea)	___ Other Health Issues

If you've checked any of the above, please describe:

____
____
____
____
____

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Please list all medical procedures (including plastic and cosmetic), surgeries, hospitalizations, serious injuries or serious medical problems you have had? ______________________________
____
____

Please list all medications you presently take (including vitamins, herbs and supplements)?
____
____

Please list all medications (as above) you no longer take, but have taken in the past 5 years:
____
____

Please list any drug/medication allergies: ____
____

List any food/environmental allergies: ____
____

GYN SPECIFIC

How many children do you have? ______________________________ What are their ages? ______________________________	Do you have any grandchildren? __________________________ Do you lose urine when you don't want to (incontinence)? __________________________	Date of last period: ______________________ Date of last pap smear? ______________________

Have you had a miscarriage, and if so, how many? __________________________ Have you terminated a pregnancy, and if so, how many? __________________________	Is incontinence enough of a problem that you wish to do something about it? __________________________	Date of last mammogram: ______________________ Date of last annual exam: ______________________

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Have you taken hormones before? If yes, what kind and what was your experience? ________
____
____

Please describe any present or past problems with your periods? ___________________________
____
____

List all contraceptive methods and satisfaction (including surgeries such a tubal ligation and vasectomy): ____
____

Describe any present/past problems with your uterus, tubes, ovaries, vulva, vagina: ________
____
____

Any past history of STD, HIV, recurrent herpes? ____
____

Are you significantly affected by cyclic premenstrual symptoms? If yes, please describe:
____
____

Is your sexual life: Fine or good ___________ **Fair** ___________ **Unsatisfactory** ____________
Please comment: ____
____

Any problems with vaginal dryness, vulvar pain or irritation? _______________________________
____

Does your partner have sexual or erectile issues? If yes, please explain: ____________________
____

What is the present state of your marriage/partnership? __________________________________
____
____

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RISK ASSESSMENTS:

Weight: ______ Height: ______ Ever smoked cigarettes? ______ Smoke now? ______ How much? ______ If you quit smoking, when? After smoking for how many years? ______ ______	At what age did you have your first child? ______ Did you nurse your children? ______ ______

Previous problems with cholesterol? If yes, please describe: ______

Any family cardiac history? If yes, please explain: ______

Please describe exactly what type/how much exercise you get on a weekly basis: ______

Please list everything that you had to eat yesterday (breakfast, lunch, dinner, all snacks): ______

Any family members with breast, colon, ovarian cancer? If yes, who and at what age? ______

Have you ever been told you were at risk for any of these cancers? If yes, please describe: ______

Have you ever had a breast biopsy? How many/results? ______

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Any family history of osteoporosis? If yes, who? ____
____

Have you or any close family member ever been treated for depression? ________________

If yes, please describe:
____
____

Do you work outside your home? ____

If yes, please explain:
____
____

Have you had a problem with or been treated for fatigue?_______________________________

If yes, please explain:
____
____

Any present or past situations of verbal, physical or sexual abuse? _______________________

If yes, please describe:
____
____

Does your work or home life expose you to excessive stress?_____________________________

If yes, please explain:
____
____

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FSFI Questionnaire

(Over the last 4 weeks)

______________________________ **Patient Name**

________________ **Date**

How would you rate your level of sexual desire or interest?	No sexual activity 0	Very High 5	High 4	Moderate 3	Low 2	Very Low or none 1
How would you rate your level of sexual arousal during sexual activity or intercourse?	No sexual activity 0	Very High 5	High 4	Moderate 3	Low 2	Very Low or none 1
How often did you become lubricated ("wet") during sexual activity or intercourse?	No sexual activity 0	Very High 5	High 4	Moderate 3	Low 2	Very Low or none 1
When you had sexual stimulation or intercourse, how often did you reach orgasm?	No sexual activity 0	Very High 5	High 4	Moderate 3	Low 2	Very Low or none 1
How satisfied have you been with your overall sexual life?	No sexual activity 0	Very High 5	High 4	Moderate 3	Low 2	Very Low or none 1
How often did you experience discomfort or pain during vaginal penetration?	No sexual activity 0	Very High 5	High 4	Moderate 3	Low 2	Very Low or none 1

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Interested in Cosmetic Labial and/or Vaginal Surgery (Check all that apply)

- ☐ I want cosmetic vaginal surgery
- ☐ My labia are larger/looser than what I want
- ☐ I do not like the way my labia look
- ☐ My labia rub, tug, and pull on my clothing
- ☐ I am unable to wear the type of clothing I want
- ☐ I have had unflattering comments about my genital region
- ☐ I have had difficult childbirth(s)
- ☐ My vagina feels too loose inside
- ☐ I have decreased sensation
- ☐ I feel pelvic heaviness/pressure
- ☐ Sex is uncomfortable/unpleasurable
- ☐ I rely on my appearance at work
- ☐ I am interested in G-Spot treatments

Interested in Non-Surgical Treatments (Check all that apply)

- ☐ To tighten the labia majora
- ☐ To tighten the vagina
- ☐ To treat a leaky bladder
- ☐ To reduce urinary urgency and frequency
- ☐ To improve vulva and vaginal moisture
- ☐ To improve sensitivity of tissues
- ☐ To improve or achieve orgasms
- ☐ To reduce painful intercourse
- ☐ Intimate lightening
- ☐ Botox