The Center for Advanced Medicine & Clinical Research
Dr. Rashid A. Buttar
19620 West Catawba Ave., Suite 100
Cornelius, NC 28031
704-895-9355  Fax 704-895-9357

Dear Patient:

Thank you for choosing The Center for Advanced Medicine & Clinical Research as your health care provider. Due to our success in effectively treating medical conditions resulting from toxicity, a demand has been placed on our clinical services. Therefore, it is required that all paperwork be completed prior to confirming your initial appointment.

Enclosed you will find the paperwork that must be completed prior to scheduling your initial appointment. Please review all forms in their entirety. It is important that you fill in all of the paperwork so that your provider gets the best information possible and so you will get the maximum benefit from your office visit. Please make sure the following is completed when sending in your paperwork:

1. Fill out the entire Patient Information and Registration Form. Make sure you let us know how you heard about us.
2. Read, sign and date the Consent for Treatment, Financial Policy, as well as the Permission and Release for Filming.
3. Thoroughly read through the Consent for Various Therapies and initial each section. In addition, you must sign the consent at the bottom of the page.
4. Read, sign and date the HIPPA Notice of Privacy Practices.
5. Use the Release of Medical Record form if you feel we may need information from any of your previous providers.

After your appointment is confirmed you will receive two informational DVDs from the Know Your Options™ The Medical Series, created by Dr. Rashid A. Buttar. Watch these DVDs **before** your initial consultation so that you get the most benefit from your visit.

In the meantime, you will find a list of additional resources and learning tools that our past and present patients have found invaluable. This information is outlines on the last page of this packet.

Welcome to the team! We look forward to working with you and providing your medical care. Together we will *Make the Change the World is waiting for*!

Sincerely,

The Center for Advanced Medicine and Clinical Research Staff

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# Patient Information and Registration

Patient Name: _____ Date: _____
Last First Middle

Sex: □M □F Date of Birth: _____ Marital Status: □S □M □D □W

Patient Social Security #: _____

Primary Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email Address: _____
*used for important administrative & clinical purposes - please list email address you will check often

Names of Parents: _____ Date of Birth: _____
(if patient is minor)
_____ Date of Birth: _____

To Be Filled Out by Financially Responsible Party:

Name of Responsible Party: _____

Driver License #: _____ Social Security #: _____

Employer: _____ Work Phone: _____
Address: _____
Street City State Zip

Health Insurance: _____ Phone: _____
Address: _____

ID #: _____ Group #:_____

Relative Not Living with You: _____ Phone #: _____
Address: _____ Relationship: _____

Family Doctor: _____Phone #:_____
Address: _____Fax #: _____

**How did you hear about us?** _____

_____

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# Consent for Treatment

I authorize the Medical and Nursing Staff of The Center for Advanced Medicine & Clinical Research to perform any diagnostic tests and/or administer treatment plans for allergy, immune and nutritional disorders, as well as cancer, autism or any other chronic medical conditions. I fully recognize and understand that the advanced medical treatments I will receive may include nutrient, herbal, oxidative, functional, integrative, alternative, preventative, traditional, pharmaceutical, dermaceutical, nutraceutical, and/or conventional therapies. I also understand and fully acknowledge that:

1. Almost all the patients coming to The Center for Advanced Medicine & Clinical Research have previously been evaluated and treated with limited or no success prior to coming to our practice.
2. The safety and efficacy of many such therapies has not been established with controlled studies (the prevailing, but inadequate methods, of evaluating effective treatments).
3. Specifically, no claim to "cure" cancer or "cure" any other medical condition with these therapies has been made to me.
4. Our medical staff will NOT be providing hospitalized care or emergency care for me from this clinic.
5. The therapies I receive will compliment the care I receive from my primary care physician, and will not replace them.

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature  Date

_____ _____
Representative of The Center for Advanced Medicine  Date

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# Financial/Appointment Policy

We ask that all patients read and sign our Financial/Appointment Policy prior to scheduling their initial appointment. You will be given your choice in seeing Dr. Buttar or Jane Garcia, ANP, both of whom review all charts.

We require pre-payment of all initial appointments. Thereafter, payment is due at the time services are rendered. We require a 72 hour cancellation notice for initial appointments. If you must reschedule you may apply the entire payment to a future visit as long as we receive a 72 hour notice. After you have had your initial appointment, we only require a 24 hour cancellation notice. You may be charged for appointments cancelled without the required notice.

Please note that we do not participate with or accept assignment from any insurance companies. Although most treatments are not reimbursable, as a courtesy we will print HFCA claim forms (except for Medicare patients) for you to file on your own behalf. Treatments that are reimbursable will vary based on your policy. Because we are not contracted with your insurance company, any reimbursements issued to our office will be returned with a letter stating that all payments should be issued directly to you.

1. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you, NOT your insurance company. All charges are ultimately your responsibility whether your insurance company chooses to pay on your claims or not.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In most cases, the majority of alternative and preventative medical treatments are not covered by insurance. We are able to bill some lab work to Medicare if that is an option for you.
3. Returned checks will be subject to an additional collection fee and will not be reprocessed.

Thank you for choosing us as your health care provider. Our main goal is to provide you the treatment needed to restore and maintain your health. We sincerely appreciate your trust in us. The opportunity to care for our patients is something we take very seriously.

**I have read the above policy and accept full financial responsibility for my medical treatments. I recognize that many of the services rendered to me may not be covered by my insurance company.**

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature  Date

_____ _____
Representative of The Center for Advanced Medicine & Clinical Research  Date

Original Date: July 17, 1997 | Last Revised: October 28, 2010

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# Permission and Release for Filming

In signing this form, I provide all rights to the use of my image, likeness and voice for the filming, editing and duplication of footage by Dr. Rashid A. Buttar, The Center for Advanced Medicine & Clinical Research, Adelphia, Dolphin Entertainment Company or associated companies and any media outlet authorized by The Center for Advanced Medicine & Clinical Research.

I understand that I may be asked questions regarding my health and medical condition. I give my permission for release of this information and understand that it will be videotaped, but may be used in other forms of media, including but not limited to CD-ROM, audio, new publications, broadcasts or internet. I fully understand that I will receive no compensation or royalties for participation. This release is for all purposes including educational and marketing and is all inclusive of the filming done on all occasions in or around the clinic located at 19620 West Catawba Ave., Suite 100, Cornelius, NC 28031.

_____
Patient's Name (print)

_____ _____
Patient/Guardian's Signature Date

_____ _____
Representative of The Center for Advanced Medicine Date

**Please print the following:**

Address: _____

_____

Phone: _____

Email: _____

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# HIPAA Notice of Privacy Practices

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an office procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the visit.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation:
Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

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**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main number.

**Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.**

Patient's Name (print): _____

Patient/Guardian's Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Original Date: July 17, 1997 | Last Revised: October 28, 2010

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# Request for Release of Medical Records

Date: _____

Patient Name: _____ Date of Birth: _____

To (Institution or Physician): _____

Physician's Phone or Fax #: _____

The above named patient has requested to have a copy of their medical records sent to our clinic. Please fax or mail the following records to us as soon as possible:

_____ The last 2 (most recent) EKG's

_____ All recent (last 3 months) lab work

_____ Reports of Vascular Studies if applicable

_____ Stress test / Echocardiogram reports if applicable

_____ Most recent doctor's notes / history and physical if available

_____ _____

_____ _____

Please fax or mail this information to the above address. We greatly appreciate your help and thank you in advance for your prompt attention to this matter.

Patient Request and Consent for Release of Medical Records

I, _____hereby authorize the release of any medical records, diagnostic tests or treatment history requested by The Center for Advanced Medicine & Clinical Research. Please send this information to their office as soon as possible. Thank you.

Signature of Patient: _____ Date: _____

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# Learning Tools

The following **FREE** resources may be helpful to you:

**FACTS ON TOXICITY VIDEO SERIES** - The Free FACTS ON TOXICITY Video Series is a complete collection of short videos of riveting medical information, which provides the basis of ALL chronic disease. This vital information is crucial for the world to know and has already impacted literally thousands of people around the globe. Please visit www.FactsOnToxicity.com and watch these FREE videos. If you find them to be of immense value has hundreds of people before you have, we only ask you to "Pay it Forward" in return by telling your loved ones about this site.

**MEDICAL SECRETS AUDIO SERIES** - The Free Medical Secrets Audio Series is a complete collection of over 15 hours of riveting medical information that has been kept secret from the population, primarily presented by one of the top 50 doctors in the USA. along with a few lectures presented from other highly respected physicians or researchers. To sign up for the Medical Secrets Audio Series, visit www.DrButtar.com/audio.php or visit www.FactsOnToxicity.com.

**WEEKLY H.O.W. REPORT** - Is our weekly Health Optimization and Wellness email newsletter. This newsletter feeds into our blog so you can comment and interact with other intelligent, like-minded people. To subscribe to our newsletter visit: www.drbuttar.com/newsletter_reg.php

**DR. BUTTAR TRUTH SITE** - Another website you may wish to review, in case you have an interest or questions surrounding the controversy regarding the false accusations against Dr. Buttar from the North Carolina Medical Board, feel free to visit www.DrButtarTruth.org. The truth and supporting evidence are all provided so that you can determine for yourself the true agenda of the North Carolina Medical Board and why we are a threat to them and the standard medical paradigm.

Our office contact information is as follows:

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19620 West Catawba Ave., Suite 100 | Cornelius, NC 28031
**(704) 895-WELL (9355)** | www.DrButtar.com
Fax (704) 895-9357

To send an **email** to the clinic, simply send it to: Info@DrButtar.com