KINGWOOD WELLNESS CLINIC®
REGISTRATION FORM

(Please Print Clearly)

Today's date:			PCP:			
PATIENT INFORMATION	We verify your identity with your Drivers License					
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		DL #		Cell:		
P.O. box: EMAIL:	City:	State:	ZIP Code:			
Occupation:	Employer:	Pharmacy:				
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr. ❑ Business Card	❑ Billboard	❑ Google		
❑ Family	❑ Friend	❑ Newspaper	❑ Internet Search	Billboard location:		
Other family members seen here:						

Advance Beneficiary Notice of Non-coverage

I hereby certify that the above information is true and correct to the best of my knowledge. I hereby authorize Kingwood Wellness clinic to release any of my patient information required for continued care to other Providers that I may utilize for my care. I understand and agree, that I am financially responsible for any balance owed for my care This is a fee for service clinic. Payment due on day of service. _____**Initial**

We will not authorize lab slips or lab testing and that the lab testing must be done outside of any insurance plan Dealing with insurance companies and HRT has been difficult and insurmountable. We, therefore, wish to advise you that your HRT treatment will not involve any use of insurance or completing insurance forms or statement of medical necessity." _____ Initial**

Your telephone number is collected to send appointment reminders as well as clinic specials. You may "opt out" of receiving texts at any time. Please sign below to indicate that you understand and consent to treatment and agree to receive our text reminders._____**Initial**

We strive to achieve optimal health & wellness through nutrition, exercise, hormone balance and optimization. Our programs, protocols and philosophy are designed to maximize your QUALITY of life. If your hormone levels are in a "normal" range but are low and you have symptoms we may start therapy to alleviate symptoms. ._____**Initial**

Patient signature (SIGN HERE) *Date*

REASON FOR VISIT TODAY

Please check the reason you are coming in today; if it is not listed please write in the reason, if doing lab-work what is the reason:

_____
_____
_____
_____

- □ New weight patient
- □ New Hormone
- □ B-complex Injection
- □ Thyroid Evaluation
- □ Botox Injections
- □ Laser Evaluation
- □ Juverderm/Fillers
- □ Fatigue

- □ Hormone Imbalance
- □ Loss of sexual desire
- □ Low Testosterone Symptoms

(Patient MUST read and sign in order to be seen)

KINGWOOD WELLNESS CLINIC®

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Current or referring doctor:		**Date of last physical exam:**	
PERSONAL HEALTH HISTORY			
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	

List or circle any medical problems that other doctors have diagnosed

☐ Low thyroid ☐ high thyroid	☐ Cancer	☐Elevated PSA
☐ High blood pressure	☐ Depression	☐ Constipation
☐ High Cholesterol	☐ Bipolar	☐ Snoring or sleep apnea
☐ Diabetes (insulin or no-insulin)	☐ Reflux	☐ Waking at night to urinate

Surgeries ☐ **No Surgeries Please list or circle if listed**

Year	Surgery	Thyroidectomy ☐R ☐Left ☐Total
	☐ C-section How many?_____	Gastric ☐ Staple or ☐ Banding
	☐ Hysterectomy ☐ Tubal Ligation	Heart Surgery
	☐ Gallbladder removed (cholecystectomy)	Other:
	☐ Appendectomy	Other:
	☐ Tonsillectomy	Other:
	ANYTHING ELSE:	

Other hospitalizations

Year	Reason	Age if you do not remember year

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins ,inhalers and including birth control

Name the Drug	Strength	Frequency Taken

Allergies to medications ☐ **No Known Drug Allergies**

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

PLEASE ANSWER ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting ?			☐ Yes	☐ No
	Have you taken appetite suppressants in the past?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind? ☐ Beer ☐ Wine ☐ Liquor ☐Tequila ☐Vodka				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	

	☐ # of years	☐ Or year quit ☐ Do you desire to quit?_____	
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you get dizzy on standing?	☐ Yes	☐ No
Quality of Life	HOW WOULD YOU RATE YOUR HEALTH AND WELL-BEING		
	Poor Fair Good Very Good Excellent		
	** This helps us evaluate our treatments, please compare o the best you ever felt health-wise		

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father (F)			**Children** (M)male (F)female	☐ M ☐ F	
Mother (M)				☐ M ☐ F	
Diabetes	☐ M ☐ F			☐ M ☐ F	
Heart Disease	☐ M ☐ F			☐ M ☐ F	
Hypertension	☐ M ☐ F		**Grandmother** *Maternal*		
Thyroid	☐ M ☐ F		**Grandfather** *Maternal*		
Kidney	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have problems with weight gain or losing weight?	☐ Yes	☐ No
Do you occasionally feel depressed or have depressed moods?	☐ Yes	☐ No
Is your concentration decreased?	☐ Yes	☐ No
Do you have problems with occasional constipation?	☐ Yes	☐ No
How often are bowel movements?		
Do you get cold easily or have cold hands or feet?	☐ Yes	☐ No
Have you noticed excessive hair loss?	☐ Yes	☐ No
Is your skin dry?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Poor energy or fatigue?	☐ Yes	☐ No
Bone / Joint Pain	☐ Yes	☐ No

WOMEN ONLY

DO NOT WRITE N/A, EVERYTHING IS APPLICABLE

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days Length of periods_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____ Miscarriage_____Abortions_____		
Are you pregnant or breastfeeding?	☐ **Yes**	☐ **No**
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ **Yes**	☐ **No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Date of last pap and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)		

Date of last mammogram?_____Results: ☐ Normal ☐ Abnormal (Please list any findings)

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)	☐ Yes	☐ No

OTHER PROBLEMS

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Hormonal symptoms

I hereby certify that the above information is true and correct to the best of my knowledge._____

Notice of Privacy Practices Acknowledgment

KINGWOOD WELLNESS
2316 TIMBER SHADOWS DRIVE, #100
KINGWOOD, TX 77339
PHONE: 281-852-1800

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (**"HIPPA"**), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to so as documented below:

Date: Initials: Reason:

THYROID CONSENT

Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffer symptoms of hypothyroidism or an underactive thyroid. We are/may be prescribing these medications off label. They are being used in a manner or reason that they may not be necessarily marketed for. **Your blood levels may be in the normal range but are on the low side and not optimal to maintain your health. We are prescribing you thyroid medication to alleviate SYMPTOMS.** Although weight gain may be a result of low thyroid, increasing your thyroid level will not guarantee weight loss. **We are NOT giving thyroid for weight loss.**

Statement of Patient: I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications most commonly seen are **palpitations, headaches, anxious, irritability or insomnia** have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages. I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a KHWC Provider.

TSH SUPPRESSION: Will probably occur with treatment, It is not the same as the autoimmune disease known as hyperthyroid (Grave's Disease). As recommended by the manufacture, we follow the T4 and T3 levels, not the TSH.

Secondary or Tertiary Hypothyroidism
Start SYNTHROID at the full replacement dose in otherwise healthy, non-elderly individuals. Start with a lower dose in elderly patients, patients with underlying cardiovascular disease or patients with severe longstanding hypothyroidism as described above. Serum TSH is not a reliable measure of SYNTHROID dose adequacy in patients with secondary or tertiary hypothyroidism and should not be used to monitor therapy. Use the serum free-T4 level to monitor adequacy of therapy in this patient population. Titrate SYNTHROID dosing per above instructions until the patient is clinically euthyroid and the serum free-T4 level is restored to the upper half of the normal range.

I agree to immediately report to my Provider any adverse reaction or problem that might be related to my therapy. Risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of thyroid hormone treatments, and have had all my questions answered.

I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with thyroid hormone replacement therapy. I acknowledge that I am NOT being given thyroid for weight loss.

Name (PRINT) _____

Signature of Patient _____ Date_____

Statement of Provider: I have explained the risks and benefits of the therapy as detailed above. The patient has verbalized to me his/her understanding of those risks and benefits and gives verbal consent to initiate this therapy. I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed the patient has no further questions and wishes to initiate thyroid hormone replacement therapy.

Signature of PROVIDER Explaining Procedures: _____

Kingwood Wellness

1543 Green Oak Place, Suite 200

Kingwood, Texas 77339

(281)852-1800

Informed Consent for Off-Label Medication

The off-label use of a medication is defined as the use of a medication that is currently approved for use by the FDA in a manner that is different than its approved use. An example of this would be quinine, a medication to treat malaria, for leg cramps. This is a very effective medication for this condition and is safe. Although the FDA has not approved this use, it is very common for doctors to prescribe this medication for this reason. Many medications are commonly used off-label. Sometimes, the off-label use of a medication will lead to further studies being done and for the FDA additional indications and uses for the medication. An example of this is topamax, a medication that was originally approved to treat seizures. It was later used to treat bipolar disorder. It wasn't a very effective medication for these conditions. It was commonly used off-label to treat migraines. It now has FDA approval for this and is also approved for weight loss. Off-label use of medication is a common, almost daily practice for physicians. Prescribing medications in forms other than what was FDA approved such as a tablet versus a capsule, cream, troche is considered off-label. Slow releasing phentermine to control hunger longer is another example of off-label use.

The American Medical Association and the Texas Medical Board have put forth guidelines for the off-label use of medications. It is the policy of this clinic to follow those guidelines.

Because off-label use of medication usually begins with individual ideas or experiences of individual physicians/providers, often there are other physicians who are not familiar with certain off-label uses of medications. This can be confusing to the patient and can affect treatment with these medications. You are being prescribed medication for off-label use. In addition to this general information on off-label prescribing, you will receive specific instructions about the medication you will be receiving. You may talk with other physicians about this medication before beginning treatment. If you receive any conflicting information about this treatment, you are free to discontinue the treatment or have further discussions about it. We would also be willing to provide your other physicians with additional information regarding your treatment if needed.

Name_____ Date_____

I have received and understand the above information. I consent to off-label treatment.

Signature_____

TESTOSTERONE CONSENT AND INFORMATION FORM

I have been advised of the risks and benefits of testosterone as well as the following: Testosterone is FDA approved to treat symptoms of andropause and until recently there were no restrictions for prescribing testosterone. Testosterone administration was based on treatment of symptoms and signs of andropause and not by a laboratory test value. Under new restrictive FDA guidelines however, testosterone is indicated only if a TT level is < 300ng /dl. Based on these guidelines that are intended to restrict the use of testosterone, the FDA states that the patient does not qualify for testosterone treatment if lab tests are normal. Are we now supposed to ignore the patient and not treat their symptoms based on a new restrictive guideline? We don't believe so. The FDA should not dictate how physicians practice medicine and Congress has reaffirmed that.

However, because the patient has symptoms of andropause (but normal lab values) and is requesting treatment for these symptoms, and testosterone is indicated for treating symptoms that the patient has, I have prescribed testosterone to help improve these symptoms, quality of life, health and wellness. Even though the patient does not qualify based on new strict guidelines of having very low levels, I have prescribed testosterone "off label" in order to help improve symptoms. The medical literature adequately supports the use of testosterone for off label use to treat symptoms in men with normal testosterone levels despite not having low levels of <300ng /dl. The patient knows and understands the risks vs. benefits that we have discussed and printed information has been given to the patient that further reviews and discusses these issues.

The patient is also advised that testosterone can cause testicular atrophy (shrinkage in size) and infertility, although that is usually reversible upon discontinuation of testosterone. However, infertility may be permanent, although this is very rare. We advise men to consider postponing treatment with testosterone if he desires to maintain fertility and to resume testosterone at a later time when fathering children is no longer anticipated.

Transdermal testosterone cream can transmit to the spouse and children and we have advised the patient of the harm of transference to others and how to avoid transference to others. Testosterone can increase hemoglobin and red blood cells which some term thick blood or polycythemia. This increase in red blood cells, however, is not the blood disorder polycythemia but is rather termed erythrocytosis. However, family doctors may think that it is polycythemia, a blood disorder that is harmful. Over 50 years of studies do not show any harm of testosterone induced erythrocytosis. Testosterone does not cause blood clots as does the blood disorder called polycythemia. The FDA has advised that testosterone may cause blood clots due to this increase in red blood cells although there is no study that shows harm or increase in blood clots in the heart, brain, or legs (DVT). If this or any other side effect occurs, or the PMD does not understand any of the above, then the patient is advised to contact us so that we can help better explain the safety of testosterone based on medical studies. In spite of the FDA precautions that testosterone may cause an increased risk of blood clots, there is no RCT (randomized controlled trial) or study that demonstrates this in hundreds of studies over 50 years of use. There have been individual case reports to the FDA of blood clots and therefore the FDA is obliged to list this risk on the package insert. The patient is advised of the FDA warnings and precautions, although there is little evidentiary support of any harm for this warning in any medical study.

We prescribe testosterone and other hormones for their health benefits and improvement in quality of life and improvement of symptoms. Hundreds of studies show that low levels of

testosterone (and other hormones) put men at risk of heart disease, cancer, and increased mortality. These same studies demonstrate benefit to optimizing testosterone levels to protect against cardiovascular disease. Based on the medical literature we do not find any significant risk or harm of HRT other than infertility. The patient is advised that their PMD (primary medical doctor) may not understand optimization of hormones or the medical literature and the patient is advised to contact us if the PMD, or the patient, has any concerns.

By signing, I acknowledge that I understand the potential risks of testosterone replacement.

_____
Patient Name

_____
Patient Signature

_____
Witness

Date_____

Authored by Neal Rouzier, M.D.

FOR MEN ONLY: ADAM Questionnaire plus additional questions

Name _____ Age _____ Date _____

Circle your answers and follow the directions below to learn your score.

1. **Do you have less libido (sex drive)?**	**Yes**	**No**
2. **Do you have low energy?**	**Yes**	**No**
3. **Have you lost weight?**	**Yes**	**No**
4. **Have you noticed a decreased "enjoyment in life"?**	**Yes**	**No**
5. **Are you sad and/or grumpy?**	**Yes**	**No**
6. **Have you lost height?**	**Yes**	**No**
7. **Are your erections not as strong?**	**Yes**	**No**
8. **Have you noticed a recent deterioration in your ability to play sports?**	**Yes**	**No**
9. **Are you falling asleep after dinner?**	**Yes**	**No**
10. **Has there been a recent deterioration in your work performance**	**Yes**	**No**

If you answer "yes" to questions 1 or 7 or any 3 other questions, you may have low T.

Adapted from Morley JE, et al. Validation of a screening questionnaire for androgen deficiency in aging males. *Metabolism.* 2000;49(9):1239-1242.

"It is now well established that testosterone levels decline with age. What has not been established is whether the decline in testosterone is associated with a symptom complex. This study examined whether certain symptoms are more commonly present in males with low bioavailable testosterone (BT) levels. These were used to evaluate a questionnaire for androgen deficiency in aging males (ADAM). The validity of the ADAM questionnaire to screen for low BT was tested in 316 Canadian physicians aged 40 to 62 years. Low BT levels were present in 25% of this population. None had elevated luteinizing hormone (LH) levels. The ADAM questionnaire had 88% sensitivity and 60% specificity. When the questionnaire was administered twice 2 to 4 weeks apart to 10 men, it was determined that the coefficient of variation was 11.5%. In a second study of 34 ADAM-positive patients, 37% of those with clearly normal BT levels demonstrated some evidence of dysphoria. Finally, in 21 patients who were treated with testosterone, improvement on the ADAM questionnaire was demonstrated in 18 ($P = .002$). These data support the concept of a symptom complex associated with low BT levels in aging males. In addition, the ADAM questionnaire appears to be a reasonable screening questionnaire to detect androgen deficiency in males over 40 years of age."

Check the questions below that pertain to you.

- € Have you been diagnosed with osteoporosis?
- € Do you have chronically dry skin?
- € Are you losing body hair, especially on the legs?
- € Are you balding?
- € Do you experience an unexplainable unhappiness?
- € Have you become more irritable?
- € Do you have less ability to cope with stress?
- € Are you more emotional?
- € Does your body temperature fluctuate easily?
- € Do experience hot flushes?
- € Do you have chronic pain?
- € Have you gained weight gradually without an obvious cause?
- € Are you experiencing difficulty losing weight?
- € Are you retaining fat in your abdomen (increased belly fat)?
- € Do you produce less semen so your ejaculation quantity is reduced?
- € Have you been diagnosed with insulin resistance, diabetes, or metabolic syndrome?

Kingwood Wellness Clinic

Fertility Discussion Consent

I had an extensive discussion regarding the effects of testosterone replacement on infertility/testicular shrinkage/atrophy. The patient was informed of the possibility that testosterone replacement can have a negative impact or eliminate fertility entirely. There are no guarantees that it will return after stopping therapy, and the patient may have to go to a specialty clinic, and possibly have further testing and/or the addition of other/new medications in attempt to return some sort of fertility. The only way to ensure the ability to reproduce after starting testosterone therapy is to *freeze* sperm with a specialty center prior to starting therapy. Patient was advised to follow up with urologist/fertility specialist for sperm conservation and other fertility concerns. There is potential that after starting therapy, the only means for fertility on his part could be regulated to artificial insemination. He wishes to go forward with the treatment, understanding the risks to future fertility. The patient is in good understanding of this aspect of therapy, and accepts the risks associated with it. He wishes to move forward with testosterone therapy, despite these risks.

Print name: _____

Signature: _____ Date: _____

Provider signature: _____ Date: _____

PATIENTS BEHAVIOR TOWARDS STAFF MEMBERS

Dear Patient,
Your treatment at Kingwood Wellness is founded on our set of core values and principles which we hold paramount. Our staff works diligently to maintain and adhere closely to these values throughout your health journey with us.

OUR CORE VALUES AND PRINCIPLES

-We love our patients and building trusting relationships

-We are humble, life-long learners pursing optimal wellness.

-We prioritize productivity and work-life balance and boundaries.

-We provide personalized, hands-on care for patients.

-We empower our patients and cultivate an authentic community.

In our best effort to uphold these values as top priority, our staff have been throughly trained to provide our patients with the utmost care and respect.

Likewise, we expect patients behave appropriately and respectfully towards our staff. Verbal disrespect, abuse, or mistreatment of any kind will not be tolerated.

A patient's first offense will result in a warning letter, stating the incident and requesting appropriate and respectful behavior going forward. The second offense will result in complete dismissal from our practice. However, the severity of the first offense may require immediate dismissal from the practice. Examples of offenses that may result in immediate termination include but are not limited to name-calling, yelling/screaming, swearing/cursing, or threatening.

Please contact our office if you have any concern about the behavior of a staff member, and we will connect you to the appropriate supervisor related to your concern.

We are so grateful to be a part of your healthcare team and look forward to working with you on your wellness journey.

Kindest regards,

The Team at Kingwood Wellness

Signature _____ **Date** _____