Congratulations on your new journey to wellness…

Dr. Nicole Lean Lyons is a Licensed California Naturopathic Doctor, graduating with honors from Southwest College of Naturopathic Medicine in Tempe, AZ. Her passion for medicine began in her high school biology classes, where she decided to pursue a degree in Biology from Binghamton University in Vestal, NY. During her time at Binghamton, she took classes and found a great interest in nutrition and natural wellness, which lead her to finding out about Naturopathic Medicine. This journey has been very fulfilling for Dr. Nicole and she is excited to welcome you to Lean Into Naturopathic Health.

Dr. Nicole is dedicated to optimizing health by treating each patient as a whole, unique person deserving individualized care and support. Dr. Nicole’s focus is in family practice, utilizing a multitude of modalities including botanical medicine, clinical nutrition, homeopathy and various other healing therapies to support her patients reach optimal vitality. Her focuses range from your every day coughs and colds to thyroid dysfunction and chronic diseases like diabetes, autoimmune conditions and lyme disease. She also has a deep passion for women’s health, specifically pre/postnatal care. She finds it very important to educate her patients in the importance of cleansing before conception and prepping the body for pregnancy. She also offers supportive care during pregnancy and post-natal care. A women’s body is a sacred temple that needs to be cared for at all stages of life, from puberty to menopause.

“A woman's body is a sacred temple. A work of art, and a life-giving vessel. And once she becomes a mother, her body serves as a medicine cabinet for her infant. From her milk she can nourish and heal her own child from a variety of ailments. And though women come in a wide assortment as vast as the many different types of flowers and birds, she is to reflect divinity in her essence, care and wisdom.” - Suzy Kassem
Dr. Nicole also loves to start with looking at her patient's gastrointestinal health and how it’s functioning as she wholly believes you are what you eat! She believes the function of your gut is of utmost importance because it is where a lot of disease begins. Making sure you are eating right for your body and healing your gut is always at the top of Dr. Nicole's to do list.

Please see the attached forms, which should be completed and submitted ONE WEEK before your initial appointment with Dr. Nicole. During your initial appointment, please bring any supplements you are currently taking. Please send or bring copies of any recent laboratory test results you’ve had done within the last year. If you do not have copies, we will have you sign a records release form so that we can obtain these for you. These will allow Dr. Nicole to see what types of tests and labs you’ve already performed and give a more in depth look into your medical history.

Your initial appointment with Dr. Nicole includes a 60-minute consultation including a physical. At this time, she is not performing women’s wellness exams. Follow up appointments typically last 30 minutes.
PRACTICE INFORMATION

Please read the following information carefully and please ask us if you need clarification on any of the following topics.

Website:
Dr. Nicole’s Website is www.leanintohealth.org
Advanced Wellness Center’s website is www.advancedwellness.org

Phone Calls, Messages, Faxes & Email
My office hours are Thursdays & Fridays from 9-5pm and Second Saturdays from 9-12pm.
*Alternate hours may be available throughout the week, please inquire with Dr. Lean

All Scheduling Inquiries: 714-709-8030
Dr. Nicole’s Private Line: 818-850-5326

Fax number is 888-558-1604

Dr. Nicole’s email is drnicole@leanintohealth.com

Due to the volume of emails received a response may take several days. If you need a more timely answer please call Dr. Nicole.

DISCLAIMER FOR EMAILS: Emails are NOT to be used in replacement for a medical visit or urgent medical questions. Please limit your emails to follow up questions from your previous appointment, for new matters we ask that you make an appointment. For after hours non-urgent questions please call the above number, leave a message and we will get back to during the next business day.

If you have a medical emergency, call 911 or go directly to the nearest emergency room.

When leaving a message, please be brief and include the following information:
Full name, Reason for call, Best time to be called back and if it is okay to leave a detailed message, Phone number(s).

Prescription refills can be requested by contacting your pharmacy first and then they will fax over the request to my office. Please allow 2 business days for refills to be completed.

Office Location and Information
Advanced Wellness Center
14340 Bolsa Chica Rd, Suite G
Westminster, CA 92683
IMPORTANT PATIENT INFORMATION

Patient awareness and responsibility:
- Any therapy, no matter how well appointed, may fail to resolve your symptoms and improve your health.
- Dr. Nicole will inform you of the therapies most relevant to your condition both conventional and alternative.
- You have the choice to accept, refuse or terminate these therapies at any time.
- By agreeing to make every effort to implement an agreed upon program, you will receive the full benefit of your visits with Dr. Nicole.
- You are responsible for seeking professional medical attention from Dr. Nicole or another facility for a worsening of your condition.
- You are aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- You are aware that you may be referred to another physician for treatment when needed.

Evening and Weekend Calls:
- Dr. Nicole does not maintain regular call on the evenings and weekends.
- If you have a non-urgent question please call during clinic hours or feel free to email Dr. Nicole directly or call and leave a message at the office and she will respond to your question during the work week.

Medical Records
Medical Records can only be released with your authorization. A medical records release form is enclosed for your use. You may directly obtain previous medical records from other physicians or health care providers. Please contact your physician or other health care provider to obtain these records. You can also have the release faxed from our office. Your records should be mailed or faxed to Dr. Nicole at 14340 Bolsa Chica Rd, Westminster CA 92683 or FAX 888-558-1604.

PATIENTS INITIALS: __________
IMPORTANT PATIENT INFORMATION

Supplements

Dr. Nicole will be supplying a majority of supplements at her office. For all other supplements that are not supplied at the office, they may be available through her online portal with the company Natural Partners or Emerson Ecologics (Wellevate). Please note that patients are not obligated to purchase supplements through this portal or through the office.

After your appointment, Dr. Nicole may want to have you purchase certain supplements to take, with that, please see below for how to manage the Natural Partners Website/Emerson Ecologics which will be providing your individualized supplements:

1. You will either receive an email from info@naturalpartners.com or support@wellevate.me (make sure to check junk mail)

2. Click on link that the email provides and LOGIN using the given CODE and EMAIL address that they have highlighted.

3. Once you are on the homepage they will direct you on how to set up an account. Please call them if you have any issues.

4. Once your account is completed, you will be directed to my main page: Lean Into Naturopathic Health

5. Choose the supplements that Dr Nicole has prescribed and complete your order!

Lab Testing/Lab Kits

Dr. Nicole does not provide phlebotomy services at Lean Into Naturopathic Health. Any blood draws will be performed at an outside lab facility. Typically, after your initial or follow up appointments, Dr. Nicole may want to run lab tests and/or diagnostic tests may be ordered. Testing recommendations and cost(s) per test will be reviewed. Fees for such tests are billed directly by the lab to the patient. In many cases, the lab will work directly with the patient’s insurance care provider. Patient’s are responsible to check with their insurance company for coverage on each and every lab. Due to the ever changing requirements for each insurance plan, Dr. Nicole cannot be responsible for any extra payments patients may owe. It is the patient’s responsibility to check with their insurance concerning coverage of each and every lab ran through Dr. Nicole. Some lab tests can take up to 4 weeks to be finalized and sent to the office, Dr. Nicole cannot guarantee turn-around time on laboratory testing. You will receive a copy of your labs at your appointment.

PATIENTS INITIALS: __________
IMPORTANT PATIENT INFORMATION

Payment Policy:
Payment must be given at time of appointment. We except cash, credit or check.

ADULT INITIAL APPOINTMENT 60 MINUTES $300
ADULT FOLLOW UP APPOINTMENT 30 MINUTES $150
*Follow up appointments OVER 45 minutes will be charged $50 per 15 minutes*

CHILD (12 YEARS AND UNDER)
CHILD INITIAL APPOINTMENT 60 MINUTES $200
CHILD FOLLOW UP APPOINTMENT 30 MINUTES $100
*Follow up appointments OVER 45 minutes will be charged $50 per 15 minutes*

Cancellation Policy:
We have a 24-hour cancellation/rescheduling policy. If you do not call Advanced Wellness Center within 24 hours prior to your scheduled appointment to either cancel or reschedule, you will be charged a $50.00 fee for the appointment. In the event of a cancellation in order to make the appointment available to another patient, we have our 24-hour policy so that we can make this valuable time available for other patients.

Emergencies:
In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

INSURANCE
Naturopathic Medicine is currently not accepted by most insurance carriers, as Naturopathic Doctors are not directly contracted with insurance companies in the state of California. Many insurance PPO plans will cover partial lab costs. Call your carrier prior to visiting to learn if they cover, Naturopathic Doctors as providers, Out-of-Network labs and Labs/Imaging ordered by a Naturopathic Doctor. You will be given a Superbill at time of service to self submit to your insurance provider. The California Naturopathic Doctor's Association is consistently making efforts to expand our scope of practice here in the state of California. This includes working towards having Naturopathic Doctors covered under insurance companies, please keep an eye out for the latest legislative actions in regards to these efforts: http://www.calnd.org/legislative

By signing below, I understand and agree to the above policies. I guarantee payment of all charges incurred as a patient of Dr. Nicole Lean Lyons, ND.

PATIENT SIGNATURE__________________________________________________

(OR PATIENT GUARDIAN/REPRESENTATIVE)

DATE____________________________________________________
Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

• For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.

• To protect the public’s health, such as reporting when the flu is in your area.

• To make required reports to the police, such as gunshot wounds.

• Obtain payment from third party payers.

Email Communication: Dr. Nicole often utilizes email to correspond with her clients and other physicians regarding her clients. However, such email correspondences are not secure. They could theoretically be intercepted, read and information could be misused. I understand that such communications are not secure and hereby release Dr. Nicole from any responsibility or liability in connection with using unsecured email for communication. I understand that I can choose not to provide an email address or to request, in writing, that my email be removed from my file and Dr. Nicole will no longer use email correspondence with me. Regardless, if at any time I email a question to Dr. Nicole, I hereby authorize a reply via unsecured email and agree not to hold Dr. Nicole responsible for any interception or misuse of such information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice is available upon request. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Advanced Wellness Center 14340 Bolsa Chica Road, Westminster CA 92683. P:714-709-8030 F:888-558-1604 Email: dnicole@leanintohealth.com

PATIENT INITIAL __________
PRIVACY NOTICE CONT.

Right to Revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact above. Please understand that revocation of this consent will not affect action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I _______________________________ have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out our treatment, payment and healthcare operations.

______________________________________________________ Patient Signature

_____ / ____ / _____ Date
LEANG INTO NATUROPATHIC HEALTH

DR. NICOLE LEAN LYONS, ND

Informed Consent And Request For Naturopathic Medical Care

I, _______________________________ (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care from Dr. Nicole Lean Lyons, a California licensed naturopathic doctor. This extends to any other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES, which discusses my rights under the Health Insurance Portability and Accountability Act of 1996.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act, which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections and IV therapy (with proper training).

I have had the opportunity to discuss with the Naturopathic Doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomach ache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat the medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any even, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 911.

I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME, (PRINTED)____________________________________________________________
PATIENT SIGNATURE____________________________________________________________
(OR PATIENT REPRESENTATIVE)

You are entitled to a copy of this consent after you sign it. Please ask Dr. Nicole for a copy if you want a copy.
IMPORTANT PATIENT INFORMATION

Please INITIAL the following:

_______ I understand that Dr. Nicole Lean Lyons, ND, is licensed to prescribe supplements and natural/synthetic hormones.

_______ I understand that Dr. Nicole Lean Lyons, ND, will make appropriate referrals in order to manage prescriptive medications.

_______ I understand that Dr. Nicole Lean Lyons, ND, is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Nicole Lean Lyons, ND and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Nicole explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

I have read and understand my heath information privacy rights as described herein.

__________________________________________________________________
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)
Lean Into Naturopathic Health

General Information

Name:____________________________________________(First, Middle, Last)

Date of Birth: ____ / ____ / ____ SSN: ____ - ____ - ______

Gender:  Male  Female (please circle)

____________________________________________________

Genetic Background:  (Please Circle All That Apply)

African  Ashkenazi  Asian  European
Mediterranean  Middle Eastern  Native American  Other

____________________________________________________

Education Level:

[  ] High School,  [  ] Some College,  [  ] Graduate,  [  ] Post-Graduate

____________________________________________________

Job Title: __________________________________________

____________________________________________________

Nature of Business: ___________________________________

____________________________________________________

Address: ___________________________________________  Phone: (____)____-______

Fax: (____)____-______

____________________________________________________

Email: _____________________________________________

____________________________________________________

Emergency Contact: _________________________________(Name & Phone)

____________________________________________________

Referral By:

[  ] Book,  [  ] Website,  [  ] Media,  [  ] Friend/Family,  [  ] Other
Pediatric Intake Form

Date:

Patient Name: ___________________________ DOB: ___________

Age: ___________

Street Address:
________________________________________________________________________________________

City: ___________________ State: _______ Zip Code: _________ Phone: ________________

Sex (m/f): _____ Grade of School: ________

Mother’s Name and Occupation: ____________________________________________________________

Father’s Name and Occupation: ____________________________________________________________

Parents are (circle): Married Separated Divorced Living Together Other: ________________________________

Relationship: _______________ Employer: _______________________________

Reason for Office Visit: ____________________________________________________________

Has child been seen by any other doctor(s) for this complaint? Yes No Past

Regular Pediatrician name and city located in: __________________________________________________

Last time you had blood work done and with what physician: __________________________________________

List All Surgeries & Hospitalizations, including date occurred:

1) ___________________________________________ 4) ___________________________________________

2) ___________________________________________ 5) ___________________________________________

3) ___________________________________________ 6) ___________________________________________

8) ___________________________________________ 9) ___________________________________________
List All medicines (from drugstore or prescription) child is on now:
1) ________________________________ 4) ________________________________
2) ________________________________ 5) ________________________________
3) ________________________________ 6) ________________________________

List all supplements child is taking:
1) ________________________________ 4) ________________________________
2) ________________________________ 5) ________________________________
3) ________________________________ 6) ________________________________

Any known Allergies to food, drugs, environment, animals: ________________________________

__________________________________________________________________________________________

**Previous Medical History**

YES (Y) indicates the child gets the problem **regularly**; NO (N) indicates the child **never** had the problem; PAST (P) indicates the child had the problem in the **past, but not recently**. Please circle the correct one for your child.

**Ear Infections:** Y N P  If has had, how many total: __________

**Colds:** Y N P  If has had, how many total: __________

**Strep Throat:** Y N P  If has had, how many total: __________

How many times has the child taken antibiotics: ________

**What other medicines has the child taken and how often:**

1) ________________________________ 3) ________________________________
2) ________________________________ 4) ________________________________

**Hearing Tests Normal:**  Yes  No  Not Tested

**Vision Tests Normal:**  Yes  No  Not Tested

**Speech Impediments:**  Yes  No  Past

**Learning Impediments:**  Yes  No  Past
**Vaccination History**

YES, has had; NO, has not; SOME, did not finish all shots:

**MMR:** Yes  No  Some  
**DPT:** Yes  No  Some  
**Hep B:** Yes  No  Some  
**Hib:** Yes  No  Some  
**Chicken Pox:** Yes  No  Some  
**Polio:** Yes  No  Some  
**Other:** ____________________________

Any reactions to vaccinations? If so, please explain: ____________________________

**Family History**

**Allergies:** Y  N  P  
**Obesity:** Y  N  P  
**Tuberculosis:** Y  N  P  
**Mental Illness:** Y  N  P  
**Diabetes mellitus:** Y  N  P  

**Mother’s Pregnancy History**

**Age at conception:** ________  
Did she have other children already?  
Yes  No

**Health During Pregnancy**

**Smoking:** Y  N  
**Diabetes:** Y  N  
**Coffee:** Y  N  
**Nausea/Vomiting:** Y  N  
**Recreational Drugs:** Y  N  
**Emotional Stress:** Y  N  
**Preeclampsia:** Y  N  
**Length of Labor:** ________  
**Vaginal Birth:** Y  N  
**Traumatic Birth:** Y  N  
If the birth was difficult, please explain: ____________________________

Health of baby at birth: ____________________________

**Health History of Child**

**Child Breastfed:** Y  N  
For how long: ________  
When put on formula: ________

What Formula was used: ________  
When was child put on solid food: ________

When did child walk: ________  
Talk: ________  
Develop Teeth: ________
<table>
<thead>
<tr>
<th>Jaundice as baby:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cradle Cap:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Eczema or Psoriasis:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diarrhea:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Constipation:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Finicky Eating:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Poor Teeth:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Chronic Sniffles:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bad Foot Odor:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Very Sweaty Baby/Child:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Hyperactivity:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Growing Pains:</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colic:</th>
<th>Y</th>
<th>N</th>
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<tbody>
<tr>
<td>Anemia:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Asthma:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Warts:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Nightmares:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bed-wetting:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Tantrums:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Disobedient:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Fears/Phobia:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diaper Rash:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Early Puberty:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Stomach Aches:</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Any Particular household stressors child has witnessed or gone through:
1) ___________________________________________  2) ___________________________________________
3) ___________________________________________  4) ___________________________________________

**Toxin Exposure**

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ___________________________________________

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all? ___________________________________________

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? ____________________

Do you spray pesticides, herbicides or other chemicals around your home? ____________________
Typical Day’s Diet

Breakfast: ________________________________________________________________

Lunch: __________________________________________________________________

Dinner: __________________________________________________________________

Snacks: __________________________________________________________________
REQUEST FOR MEDICAL RECORDS

THIS DOCUMENT PROVIDES YOUR AUTHORIZATION FOR PRIOR DOCTORS
AND AGENCIES TO RELEASE YOUR PREVIOUS MEDICAL RECORDS TO DR LEAN

PATIENT INFORMATION
NAME:________________________________________
DATE OF BIRTH:_______________________________
ADDRESS:____________________________________
PHONE NUMBER:_______________________________

I hereby authorize the release of the following patient medical records:
_____ All Medical Records
_____ Other_____________________________

Time period of records to be released from:
FROM____________________ TO_______________________

INFORMATION TO BE RELEASED:
PLEASE SIGN NEXT TO YES OR NO FOR FOLLOWING PROTECTED INFORMATION TO BE
RELEASED:
Drug/Alcohol Information:    Mental Health Information:
    Yes_________  No_________    Yes_________  No_________
AIDS/HIV Testing & Results     Sexually Transmitted Diseases Testing/Results
    Yes_________  No_________    Yes_________  No_________
Communicable Diseases
    Yes_________  No_________    Yes_________  No_________

TO BE RELEASE FROM:
DOCTOR OR AGENCY___________________________
ADDRESS_____________________________________
PHONE_______________________________________
FAX_________________________________________

TO BE RELEASED TO:
Nicole Lean, ND
14340 Bolsa Chica Rd, Westminster CA 92683
Phone: 818-850-5326    Fax: 1-888-558-1604

I understand I have the right to revoke this authorization at any time. I understand if I revoke this
authorization I must do so in writing. I understand the revocation will not apply to information that has
already been released in response to this authorization. Unless otherwise specified, this authorization will
automatically expire in 90 days. I understand that authorizing the disclosure of this health information
is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I
understand I may inspect or receive copies of the information to be used or disclosed. I understand any
disclosure of information carries with it the potential for an unauthorized re-disclosure and the
information may not be protected by federal confidentiality rules. A copy of this authorization shall be as
valid as the original.

My signature below indicates I give my authorization to release my medical information as indicated.
PRINT PATIENT’S NAME:_____________________________________________________________
PATIENTS SIGNATURE OR LEGAL GUARDIAN:_________________________________________
DATE:____________________________________
EMAIL CONSENT

As a supplement to your in-office appointments, I am inviting you to use email to communicate with my practice. Set forth below are policies outlining when and how email should be utilized to maintain your privacy and to enhance communication as well as a place for you to acknowledge your consent to its use. Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time. Email will be accessed by Dr. Nicole Lean Lyons You may expect any required response 1-3 business days.

When may I use email to communicate with Dr. Nicole?

Email may be used for:
- Prescription refill requests
- Appointment requests
- Simple follow up questions to previous treatment plan
- Other matters not requiring an immediate response

When should I NOT use email to communicate with Dr. Nicole?

Email should never be used (list unacceptable uses)
Example:
- New symptoms that have arose since your last appointment
- Emails (more than 3 sentences) regarding your treatment, that would require you to come in or have a phone appointment so that Dr. Nicole can ensure the best care for you.
- In an emergency
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- If you need an immediate response

When does Dr. Nicole use email for?
Email may be used for:
- Letting patients know that lab results have been received and that they can make an appointment to review everything
- Checking in as a follow up to previous appointments or if doctor hasn’t heard from patient in a while (usually followed up with phone call)
- Follow up emails with Treatment Plans that patient and doctor weren’t able to review at their appointment (For example if doctor had to do more research or patient had to get previous medical records to doctor)
- Sending lab slips to patients
- Let patients know a supplement that was ordered for them is in
What are the advantages to using email?

- Unlike trading voicemail messages, email allows you to see exactly the question the doctor is responding to and to have a written record of that exchange for future reference.
- Email allows for the rapid transmission of forms or other paperwork such as information regarding your medications/condition.

What are the risks of using email?

Risks of communicating via email include but are not limited to:

- Email may be seen by unintended viewers if addressed incorrectly.
- Email may be intercepted by hackers and redistributed.
- Someone posing as you could access your information.
- Email can be used to spread computer viruses.
- There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters.
- Emails are discoverable in litigation and may be used as evidence in court.
- Emails can be circulated and stored by unintended recipients.
- Statements made via email may be misunderstood thus creating miscommunication and/or negatively affecting treatment.
- There may be an unanticipated time delay between messages being sent and received.

What happens to my messages?

- Emails will be printed out and maintained as a permanent part of your medical record.
- As part of your permanent record, they will be released along with the rest of the record upon your authorization or when the doctor is otherwise legally required to do so.

What are my obligations?

- I must let Dr. Nicole know immediately if my email address changes.
- If I do not receive a response from Dr. Nicole in the time frame indicated, I will contact him/her by telephone if a response is needed.
- I will use email communication only for the purposes stated above.
- I will advise Dr. Nicole in writing should I decide that I would prefer not to continue communicating via email.
- I understand that email may only be used to supplement my appointments with Dr. Nicole and not as a substitute for them.
- To avoid possible confusion, I will not use internet slang or short-hand when communicating via email.

What steps has Dr. Nicole taken to protect the privacy of my email communications?

Dr. Nicole Lean Lyons, ND:

- Set up a password protected screen-saver on his computer.
- Does not access patient email from public Wi-Fi hotspots.
- Does not allow family members access to his personal work computer.
- Will not transmit highly sensitive information via email.
- Will not forward patient email to third-parties without your express consent.
- Will verify email addresses before sending messages.
What steps can I take to protect my privacy?

• Do not use your work computer to communicate with Dr. Nicole as your employer has a right to inspect emails sent through the company’s system.
• Do not use a shared email account to transmit messages.
• Log out of your email account if you will be away from your computer.
• Carefully check the address before hitting “send” to ensure that you are sending your message to the intended receiver.
• Avoid writing or reading emails on a mobile device in a public place.
• Avoid accessing email on a public Wi-Fi hotspot.
• Make certain that your email is signed with your first and last name and include your telephone number and date of birth to avoid possible mix up with patients with same or similar names.

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself/___________ (your name) and Dr. Nicole Lean Lyons. I recognize that there are risks to its use, and despite Dr. Nicole’s best efforts, he/she cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in the form. I further agree to follow these policies and agree that should I fail do so, Dr. Nicole may cease to allow me to use email to communicate with him/her. I also understand that I may withdraw my consent to communicate via email at any time by notifying Dr. Nicole in writing.

____________________________________                     __________________________
Print Name of Patient/Guardian                           Date

____________________________________                     __________________________
Signature of Patient/Guardian                            Email Address