Gary E. Foresman, MD

Welcome to Middle Path Medicine! We would like to introduce you to Gary E. Foresman, MD, Founder and President of Middle Path Medicine. Dr. Foresman and our staff are dedicated to assisting you on your journey to health and healing.

Here is just a sampling of the information and health assistance Middle Path Medicine offers:

- **Gary E. Foresman, MD** – Fellowship Trained & Board-Certified Internal Medicine Specialist, Fellowship Trained & Board Certified in Functional, Anti-Aging and Regenerative Medicine, and an Integrative Oncology Fellow.
- **Medical Assisting Staff** – Our Medical Assistants go above and beyond every day to ensure that all your health & wellness questions are resolved in a timely and accurate manner. The MAs at Middle Path Medicine are your best resources for helping you achieve optimal health.
- **Intravenous Nutrition Therapy** – Administered under the direction of Dr. Foresman by our Registered Nursing staff. IV Therapy can be used to support your immune system, as an adjunct to chemotherapy, for surgery and travel preparation, and to address many other specific needs.
- **Phlebotomy** – Our certified phlebotomist is here to draw blood in our office to ensure the lab test the doctor orders are drawn correctly without the long wait of an outside draw site.
- **Supplement Shop** – Offering the finest herbal and vitamin nutritional support available anywhere. Each supplement is hand selected by Dr. Foresman. Our Supplement Shop offers a ***10% discount*** for our 55 and over shoppers every day, and everyone can take advantage of ***10% off*** most items every Friday and Saturday! Many of our favorite supplements are available for ***Buy One, Get One Half Off!*** Our shop is open to the community, not just our patients!
- **www.MiddlePathMedicine.com** – We have our bestselling supplements available to purchase via our website. While visiting, sign up for our **E-Mail Newsletters** for the latest articles from Dr. Foresman and our entire staff, as well as sale announcements and any upcoming events.

What to Expect

When you become a patient, you will see Dr. Foresman for an hour and one half. This provides time to establish your chart, obtain information regarding *you*, order an initial comprehensive set of blood tests, and make preliminary medical recommendations. Follow-up visits are approximately 60 minutes long.

In order to make the most of your visit, please follow these suggestions:

1. Write down questions you have and have pen and paper ready to take notes.
2. Provide a comprehensive list supplements, vitamins, and medicines you are taking so we can review them.
3. A copy of your specific recommendations will be provided for your reference.
4. The Middle Path Medicine Supplement Shop is here to serve you should the doctor prescribe any supplements. We are happy to help you in our shop immediately following your visits. Getting the exact prescription given to you by our providers is the only way to ensure our ability to help you on your journey to health and healing.

Our staff is here to make your visit a comfortable and positive experience. Every effort is made to confirm and keep your appointment time. Please take the time to review our cancellation policy. We request that you check in with our front desk 15 minutes prior to your scheduled appointment. This allows time to confirm insurance information, update any personal information and take payment. You are welcome to call MPM if you have any questions!

Once again, welcome to Middle Path Medicine; we look forward to supporting you on your journey to health and healing!

Gary E. Foresman, MD
Founder & President
Internal & Integrative Medicine

Miranda F.
Creative Director

Veronica S.
Office Manager

Patti B., RN
Registered Nurse

Maileen A.
Receptionist

Joy R.
Medical Assistant

Celena W.
Medical Assistant

Olivia C.
Certified Phlebotomist

Noel L.
Supplement Shop

Joy G.
Supplement Shop

Shonda A.
Supplement Shop

MPM MIDDLE PATH MEDICINE

MEDICAL HISTORY (1)

(PAGE 1 OF 4) PLEASE COMPLETE ALL 4 PAGES. Today's Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____ **Sex:** M/F

Marital Status (circle one): single married life partner divorced widowed

Do you have children? If yes, please list names and ages: _____

_____

*If you need additional space for any of the following questions, **please** attach an extra page.*

PRESENT HEALTH CONCERNS:

What are your most important health concerns listed in order of importance?
Describe in detail the history of these symptoms and the effect they have on your life.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICINES:

Please list all of the **prescription** and **over-the-counter medications** you are currently taking *including dosage and frequency*:

_____

_____

_____

SUPPLEMENTS:

Please list all of the **nutritional** and **herbal supplements** you are taking including *brand name, dosage and frequency*:

_____

_____

_____

ALLERGIES:

Please list all known **allergies** (drug, food, chemical and environmental):

_____

_____

MEDICAL HISTORY:

Please list all hospitalizations and treatments you have used for various ailments, both conventional and alternative.
Indicate the effectiveness of each treatment. _____

_____

_____

_____

SURGICAL HISTORY:

Please list any **surgeries** and dates: _____

_____

_____

ACCIDENTS:

Please describe all serious **accidents**, severe injuries, head injuries and broken bones and dates: _____

_____

_____

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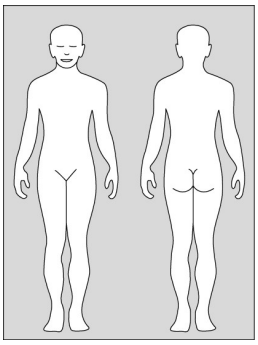
MEDICAL HISTORY (2)

(PAGE 2 OF 4) PLEASE COMPLETE ALL 4 PAGES.



On the picture, mark and "X" on the picture where you continue to have pain, numbness and/or tingling.
Please rate the severity of pain on a scale of 1-10 (1=least pain): _____
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Activities that are painful: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down

Have you ever had the following (circle "Y" for yes and "N" for no)?

Alcoholism	Y	N	Anemia	Y	N	Anorexia/Bulimia	Y	N
Arthritis	Y	N	Asthma	Y	N	Back Trouble	Y	N
Bleeding/Bruising	Y	N	Blood Transfusion	Y	N	Breast Lump	Y	N
Bronchitis (chronic)	Y	N	Cancer	Y	N	Cataracts	Y	N
Diabetes	Y	N	Drug Dependency	Y	N	Emphysema	Y	N
Epilepsy	Y	N	Glaucoma	Y	N	Gout	Y	N
Heart Disease	Y	N	Hemorrhoids	Y	N	Hernia	Y	N
High Blood Pressure	Y	N	High Cholesterol	Y	N	Hives/Eczema	Y	N
Kidney Disease	Y	N	Liver Disease	Y	N	Low Blood Pressure	Y	N
Migraines	Y	N	Mitral Valve Prolapse	Y	N	Multiple Sclerosis	Y	N
Pacemaker	Y	N	Prostate Problems	Y	N	Psychiatric Care	Y	N
Stroke	Y	N	Thyroid Disease	Y	N	Ulcers	Y	N
Varicose Veins	Y	N	Other _____					

Have you ever had any of the following infections (please circle any infection you have ever had)?

AIDS/HIV	Bladder Infections	Bronchitis	Chicken Pox	Diptheria
Hepatitis	Herpes	Measles	Mono	Mumps
Pneumonia	Polio	Rheumatic Fever	Rubella	Scarlet Fever
Sexually Transmitted	Shingles	Sinusitis	Tonsillitis	Tuberculosis
Typhoid Fever	Vaginal Infections	Whooping Cough		

FOR WOMEN

Age at 1st period: _____
Period frequency (i.e. 28 days) _____
Days of flow? _____
Any problems with PMS? _____
Any irregularities with periods? _____
Last menstrual period? _____
Extreme menstrual pain? _____
Are you satisfied with sex life? _____
Any history of infertility? _____

Last Pap: _____
Ever had an abnormal Pap? Yes No
If "yes" describe: _____
_____
Do you do self breast exam? Yes No
Last mammogram? _____
History of breast lump? Yes No
If "yes", describe: _____
Any hot flashes or night sweats? Yes No

List each pregnancy including abortions, miscarriages and births (including *birth date*). If complications with pregnancy or delivery (including C-section), please describe: _____

_____

_____

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MEDICAL HISTORY (3)

(PAGE 3 OF 4) PLEASE COMPLETE ALL 4 PAGES.

FOR MEN

Last prostate exam? _____ Last PSA? _____
How many times do you get up at night to urinate? _____
Are you satisfied with your erections? Y N Are you satisfied with your sex life? Y N

MEDICAL SERVICES

Please indicate the date you last received the following or put N/A for services that do not apply to you:

Tetanus shot _____ Flu shot _____ Pneumonia shot _____
Blood tests _____ EKG _____ Chest X-Ray _____
Colonoscopy _____ Eye Exam _____ Dental Exam _____
Bone Density _____ Coronary calcium score _____

LIFESTYLE

List other physicians/healers you are seeing (name/phone): _____

_____

_____

DIET

Do you have any dietary restrictions? _____
Do you have any cravings for any particular type of food (be specific)? _____

Are you satisfied with your diet? Yes No
If "no" to the above, why? _____
How much water do you drink daily? _____ Other liquids? _____

What did you eat and drink yesterday or a typical day (please be specific)?
Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____
Snack: _____

Smoking (type and amount per day) _____
If you are a former smoker, what was your quit date? _____
Do you drink alcohol? (type and amount per week) _____
If you used to drink alcohol, when did you quit? _____
Do you drink caffeine? (type and amount per week) _____
Do you use recreational drugs? (type and amount per week) _____
Usual weight? _____ Are you happy with your weight? _____
How much sleep do you get? _____ Do you feel rested enough? _____

EXERCISE:

Please describe the exercise you do each week (include minutes per session and days per week):

_____

_____

Do you enjoy exercise? Yes No

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MEDICAL HISTORY (4)

(PAGE 4 OF 4) PLEASE COMPLETE ALL 4 PAGES.

STRESS LEVEL AND STRESS REDUCTION

Describe your stress level (circle one): none mild moderate severe
Describe any stress reduction you practice including minutes per session and frequency: _____

_____

_____

Do you enjoy your work/what you do during the day? _____
Do you enjoy the people/pets in your life? _____
Do you live near an agricultural/industrial area? _____
Do you use paint, chemicals or solvents at home, for hobbies, or during work? _____
Have you moved to a new home recently? _____
Have you done any remodeling recently? _____
Do you have any mold in your home or work area? _____
Do you suffer from allergies? _____
How many times have you used antibiotics in the past two years? _____
List dental history (procedures): _____

_____

List any cosmetic surgery or procedures: _____
List travel history and vaccinations: _____

FAMILY HISTORY

(please include any family member who has had the following illnesses):

			Relationship				**Relationship**
Allergies/Asthma	N	Y	_____	Anemia	N	Y	_____
Arthritis	N	Y	_____	Bleeding	N	Y	_____
Cancer	N	Y	_____	Depression	N	Y	_____
Diabetes	N	Y	_____	Drugs/Alcohol	N	Y	_____
Gout	N	Y	_____	Heart Disease	N	Y	_____
High Blood Press.	N	Y	_____	High Cholesterol	N	Y	_____
Kidney Disease	N	Y	_____	Mental Illness	N	Y	_____
Migraines	N	Y	_____	Obesity	N	Y	_____
Stroke	N	Y	_____	Thyroid Disease	N	Y	_____

Other: _____

_____

	Present Age	**Age at Death**	**If living, current health (good, fair, poor)** **If Deceased, Cause of Death**
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Father			
Mother			
Siblings			
Spouse			
Children			

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MPM MIDDLE PATH MEDICINE

INTAKE FORM

TODAY'S DATE _____

PATIENT INFORMATION

Patient Name: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____ Fax _____

Date of Birth: _____ Sex: ☐ M ☐ F Age: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Employee Address: _____ Employee Phone: _____

(required) E-mail Address: _____

Would you like to receive our e-mail newsletter? ☐ Y ☐ N

EMERGENCY INFORMATION

In Case of Emergency, Who Should We Contact?

Name: _____ Phone #: _____ Work #: _____

Relationship to Patient: _____ Cell Phone or Pager #: _____

INSURANCE INFORMATION

Although Middle Path Medicine does not bill your insurance company out of our office, we do need to keep current insurance information on hand in case of a referral or prior-authorization.

Insurance Carrier: _____ ID#: _____

Group (if applicable): _____ Name on Card: _____ DOB: _____

HOW DID YOU HEAR ABOUT US?

- ☐ An existing patient, please give us their name so that we may thank them: _____
- ☐ Newspaper
- ☐ Online
- ☐ Radio
- ☐ Word of mouth
- ☐ Other, please specify: _____

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MPM MIDDLE PATH MEDICINE

OFFICE PAYMENT POLICY

We are very glad you chose us to assist you in achieving better health and vibrancy. Your health is our primary concern, and we will strive to provide you consistently excellent healthcare. In order to make the handling of your financial obligations as smooth as possible, please read and sign the following office policy. If you have questions, our staff will be glad to assist you.

CASH PRACTICE

Middle Path Medicine (MPM) does not bill to any insurance companies, when you come in for your visit you will be responsible for paying at the time of service either by cash, check or credit card. We will provide you a copy of your superbill, which you can submit to your insurance company. Your insurance company will then be responsible for reimbursing you directly for your visit with MPM. You will be seeing providers at MPM as an out-of-network provider and you should contact your insurance company to see how your insurance will reimburse you and if there is any additional paperwork they require from you.

PHONE APPOINTMENTS

If you schedule a phone appointment with Dr. Foresman, it will be at the same rate for the designated time of the appointment as if you were to come in. When scheduling the appointment you will be asked for a credit card to hold the appointment. This credit card will be charged for the price of the appointment before you speak with Dr. Foresman. If we are unable to reach you at the time of the appointment at the designated phone number given to us, your credit card will be charged a missed appointment fee of 50% the amount of the appointment scheduled.

CANCELLATION POLICY

We value your time, and appreciate you showing value for ours as well. We realize that sometimes emergencies arise, and canceling an appointment might be necessary. We do, however, require a 24-hour notice for cancellations. If you miss an appointment, or cancel with less than the 24-hour notice required, you will be invoiced for half (50%) of the amount of the scheduled visit. Each second and subsequent missed visits will be charged full (100%) of the amount of the scheduled visit. When invoiced for these charges you will have **30 days** to pay or the balance will be sent to the Credit Bureau of San Luis Obispo County.

REESTABLISHING POLICY

After two years of not seeing one of our healthcare providers you will need to reestablish as a new patient. This entails new patient paperwork, the Wellness Evaluation and 1 hour consultation. We will give you a courtesy call prior to the 2 years as we hope to provide you with continuous care.

I have read and understand my responsibility to pay for my care for services in this office.

_____ _____

Printed Patient Name Date

_____

Patient Signature

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MEDICARE PATIENTS: PRIVATE CONTRACT AGREEING TO NOT BILL

• This agreement is between Dr. Gary E. Foresman ("Physician"), whose principal place of business is Middle Path Medicine, and patient_____("Patient"), who resides at: _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on January 1, 2011 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

• Physician agrees to provide the following medical services to Patient (the "Services"):

Complex New Patient Office Visit; Comprehensive New Patient Office Visit; Intermediate Est. Patient Office Visit; Complex Est. Patient Office Visit; Comprehensive Est. Patient Office Visit; EKG; Trigger Point Injection; Glucose Check; Lipid; Urinalysis; Ear Lavage; B-12 Injections; Lab Handling Fee; Administration Fee; Intravenous Therapies and Infusions

•In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Office Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.
- Patient acknowledges that a copy of this contract has been made available to him/her.

Executed on _____ by

Name:_____ Signature _____

and Gary E. Foresman, MD _____

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Middle Path Medicine

HIPAA Notice of Privacy Practices
Effective date: September 23, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. As you pay for care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Obtaining approval for a medical procedure may require the disclosure of PHIin order to establish medical necessity.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

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With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Office Manager. If you have questions and would like additional information, you may contact us at 805-481-3442.

Print Name	Signature	Date

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MIDDLE PATH MEDICINE

THE OFFICE OF
GARY E. FORESMAN, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

As deemed under the HIPPA (Health Insurance Portability and Accountability Act of 1996) Compliance Privacy Standard code 164.508(b)(6).

I, _____, [Date of Birth:] the undersigned do hereby authorize:

_____
(Physician, Hospital, Clinic)

_____ _____
(Address) (Phone Number)

_____ _____
(City, State, Zip Code) (Fax Number)

To release information to:

Middle Path Medicine
180 West Le Point St. Suite A
Arroyo Grande, CA 93420
Telephone: (805) 481-3442
Fax Number: (805) 481-3443

Any information which said person/company may request concerning my present illness/injury while I was treated by the person/persons named above.

_____ _____
Date Patient'

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