WELCOME TO INNOVATIVE HEALTH

M. Jackie Williams, MSN-NP-C

We are very pleased that you have selected Innovative Health for your medical care and wish to welcome you, INNOVATIVE FEMALE to our practice.

Your appointment is scheduled for _____ at _____.

Our office is located at: The Colonnades at Baptist Hospital (map and directions on back)
6th Floor
501 Marshall Street, Suite 605
Jackson, MS 39202
PH: 601-968-1690 FX: 601-968-1693

Enclosed are forms for you to fill out to assist us in making sure that we have all the information necessary to provide you with quality care and treatment. **Since the enclosed forms may take quite a while to fill out, we ask that you fill them out prior to your appointment.** If you have any questions or problems filling out the forms, do not hesitate to call so that we may assist you.

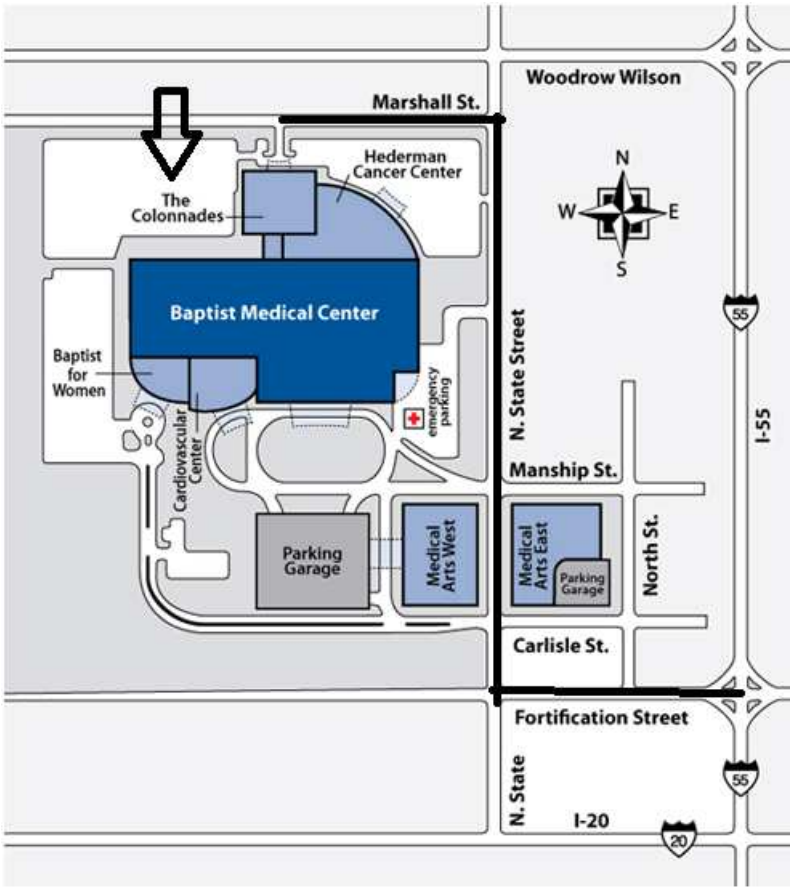
For your initial visit, we ask that you arrive 15 minutes. early. This will allow our staff ample time to verify your insurance, enter your history into the computer and setup your chart. You will need to bring:

1. Completed forms (enclosed)
2. Insurance cards (primary and secondary if applicable)
3. Photo ID
4. List of medications/supplement with dosage.
5. Pertinent past medical records and labs reports with the last 12 months if available.

There is plenty of parking available; however, at peak times there can be delays**. The building does provide complimentary valet parking for those that may need assistance. Please allow additional time as there can be additional delays when utilizing this service.**

Should you need to reschedule your appointment, please call us at 601-968-1690. Appointments not cancelled or rescheduled at least 24 hours in advance will be charged $25.

Once again, we welcome you to our practice. We look forward to providing you with quality care.



NOTE: MAP NOT TO SCALE

DIRECTIONS FROM NORTH VIA WOODROW WILSON:
From I-55, take Woodrow Wilson Exit. Continue to North State Street. Turn Left. Continue approximately 1 mile to Marshal Street. Turn Right. Entrance to The Colonnades will be on the left.

DIRECTIONS FROM SOUTH VIA FORTIFICATION STREET:
From I-55 take Exit 96C, Fortification Street. Continue to North State Street. Turn Right onto North State Street. Continue past Baptist Medical Center to the 2nd stop light, Marshall Street. Turn left. Entrance to The Colonnades will be on the left.

Patient Information Form

Demographic Information

Patient's Name: _____

Patient Address: _____

_____

Email Address:_____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

DOB: _____ SSN: _____ DL #: _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed Race: _____

Employer: _____ ____Full-time ____ Part-time

Occupation: _____Unemployed _____

Insurance and Billing Information

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Group #: _____ Effective Date: _____ Group #: _____ Effective Date: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's SSN: _____

Policy Holder's DOB: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Relationship: _____ Relationship: _____

Patient's Authorization

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above to furnish any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of this original.

Patient/Authorized Representative Signature: _____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIANS: I hereby assign to the above all insurance including Medicare and Medicaid payments otherwise payable to me for service(s) rendered, but not to exceed my indebtedness to the above. It is understood that any money received from the insurance company(s) over and above my indebtedness to the above will be refunded to the appropriate party (me or insurance carrier) when my bill is paid in full.

Patient/Authorized Representative Signature: _____ Date: _____

INNOVATIVE HEALTH, LLC
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Innovative Health, LLP (PRACTICE) to use and disclose protected health information (PHI) about me to carry out the treatment, payment and health care operations. (The Notice of Privacy Practices provided by PRACTICE describes such uses and disclosures more completely and is available with this acknowledgement. You may request an additional copy if desired.).

I have the right to review the Notice of Privacy Practices prior to signing this consent. PRACTICE reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rita Carter at the PRACTICE.

With this consent, PRACTICE may call my home or other alternative location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory test results, among others.

With this consent, PRACTICE may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders cards and patient statements.

With this consent, PRACTICE may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow PRACTICE to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Innovative Health, LLP may decline treatment to me.

I _____ authorize M. Jackie Williams, NP-C to discuss my medical care with my family member, _____ on this day ____/_____/_____.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian Date Relationship to Patient

_____ _____

Print Patient's Name Print Name of Legal Guardian, if applicable

Innovative Health

Nurse Practitioner Disclosure Statement

M. Jackie Williams, RN, MSN, NP-C, is a Family Nurse Practitioner. Jackie earned her Bachelor of Science degree in nursing at the University of South Florida in Tampa, Florida and her Master of Science degree in nursing at the University of Mississippi in Jackson, Mississippi. Mrs. William's postgraduate training is in Functional and Nutritional Medicine. She is a Healthcare Diplomat in Anti-Aging and is Board Certified in Anti-aging, Regenerative, and Functional Medicine. She has Fellowship status in Metabolic and Nutritional Medicine from the Metabolic Medicine Institute. She has 15 years of experience as a Family Nurse Practitioner, with an area of interest in Women's Health and Wellness, and is currently enrolled in the University of South Florida's: Morsani School of Medicine pursuing a second master's degree in Metabolic and Nutritional Medicine.

She has received postgraduate education in hormone balancing, including *Bioidentical Hormone Replacement* and *Hormone Pellet Therapy*. She has expertise in the management of interstitial cystitis, and is trained in the clinical management of pelvic floor disorders and pelvic prolapse. Mrs. Williams' areas of knowledge include the diagnosis and treatment of urinary and fecal incontinence, including urodynamic testing, biofeedback, electrical stimulation and pessary placement, and the management of specialty disorders including interstitial cystitis, sexual dysfunction, chronic vaginitis, vaginismus, and vulvodynia.

Mrs. Williams is an active member of the American Academy of Anti-Aging and Regenerative Medicine, the Metabolic Medicine Institute, the Interstitial Cystitis Association, the North American Menopause Society, the American Academy of Nurse Practitioners, the Mississippi Nurses Association, and other associations. She has served on many national speakers bureaus including Pfizer, and Ortho McNeil, and currently speaks in areas of her expertise on the local and regional level. She was awarded the Elizabeth Ann Coleman Award for Clinical Excellence by the University of Mississippi, and the Mississippi Nurse Practitioners Advocate Award by the American Academy of Nurse Practitioners.

Marie J. Williams, MSN, NP-C

I have read the above and acknowledge the credentials and expertise of **Marie J. Williams, NP** .

Signed_____Date: _____/_____/_____