



PHANTOM MEDICAL, INC

Neal H. Patel, D.O.

1240 E. Chapman Ave, Orange, CA 92866

Tel: 714-771-2800 | Fax: 714-771-3200

www.PhantomMed.com

Dear Patient,

Welcome to our practice. I am delighted for you to join me and intend to provide you with the care that you expect and deserve. Achieving your best possible health requires teamwork between us. As part of this team, I ask you to help me in the following ways:

Schedule Visits for Routine Physical Exams and Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal/family history. I understand I may need to complete these recommended health screenings or any other testing. These screenings are routine tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exams and to discuss these health screenings.

Keep Follow-Up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after leaving the office. Returning to my doctor on regularly gives him a chance to check my condition and response to treatments. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medications, or even discover and treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat such serious health conditions. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs or Other Tests

I understand that my physician's goal is to review and report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within a specific timeframe, I will make the effort to call the office for my results.

Inform My Doctor if I Decide NOT to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he feels is best for my health. This might include prescribing medications, referring me to a specialist, ordering labs and tests, or asking me to return to the office within a certain period of time. I understand that NOT following my doctor's treatment plan can have serious adverse effects on my health. It is my responsibility to inform my doctor whenever I decide to NOT follow his recommendations so that he can inform me of any risks associated with my decision to delay or refuse treatment.

As my patient, you have the right to be informed about your health care. I invite you to ask questions, report symptoms, obtain more information about your health, or discuss any concerns you may have at any time. Thank you for being a part of this team, and I look forward to helping you achieve the highest physical, mental, emotional, and spiritual health.

Sincerely,
Dr. Patel

Patient Signature: _____

Date: _____

Print Name: _____



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PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

GENERAL

Name (Last, First, Middle): _____

Date of Birth (MM/DD/YYYY): _____ Social Security #: _____

Gender: _____ Driver's License #: _____ State: _____

Marital Status: Single Married Divorced Separated Partner Other: _____

CONTACT INFORMATION

Home Address:

Street _____ City _____ State _____ Zip _____

Home Phone #: _____ Fax #: _____ Cell Phone #: _____

Employer Name: _____ Occupation: _____

Work Address:

Street _____ City _____ State _____ Zip _____

Work Phone #: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

PRIMARY INSURANCE

Name of Primary Insurance Co: _____ Phone #: _____

ID / Policy #: _____ Group #: _____

Subscriber / Insured: _____ Relationship: _____ Gender: _____

Date of Birth (MM/DD/YYYY): _____ Social Security #: _____

Employer Name: _____ Employer Phone #: _____

SECONDARY INSURANCE

Name of Secondary Insurance Co: _____ Phone #: _____

ID / Policy #: _____ Group #: _____

Subscriber / Insured: _____ Relationship: _____ Gender: _____

Date of Birth (MM/DD/YYYY): _____ Social Security #: _____

Employer Name: _____ Employer Phone #: _____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, assign directly to Phantom Medical, Inc., all surgical and / or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not. I hereby authorize the Doctor to release all information necessary to secure payment of benefits.

Signature: _____ Date: _____

(If patient is a minor, Signature of parent or Guardian authorizing treatment)



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NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review this page carefully.

At our office, we have always and will continue to keep your health information secure and confidential. New laws require us to continue to maintain your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist physician whom we may involve in your care.

We may use or disclose your health information for our normal health care operations. For example, one of our staff members will enter your information into the computer and electronic medical records.

We may share your medical information with our business associates, such as a billing service. Note that we have written contracts with each business associate that requires them to also protect your privacy and medical information.

We may use your information to contact you. For example, we may send you newsletters or other updates.

We may also call and remind you about your appointments. If you are not at home, we may leave this information on your answering machine, voicemail, or with the person who answers the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information if required by law.

If this practice is sold to another physician, your information will become the property of the new physician.

Except as described as above, this practice will not use or disclose your health information without your prior written authorization.

You may request, in writing, that we do not use or disclose your health information as described above. We will let you know if we can fulfill your requests.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

We will need to contact you from time to time, and we will use whatever address or telephone number you prefer or is on file.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Please give us a written request regarding the information that you want to see. If you also want a copy of your records, we may charge you a fee for the copies.

You have the right to request an amendment or change to your health information. Please give us your request to make changes in writing and to include a statement in your file. We may or may not make the changes you request, but we will certainly include your statement in your file. If we agree to an amendment or changes, we will not remove or alter earlier documents, and will add the new information to your file.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing. Thank you.

ACKNOWLEDGEMENT

I have received a copy of Phantom Medical, Inc Notice of Privacy Practice.

Patient or Patient's Legal Guardian (PRINT)

Signature

Date



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HIPAA RELEASE FORM

Patient: _____ **DOB:** _____

I hereby authorize the release of information including the diagnosis, records, examination rendered to me, and the claims information. This information may be released to:

Spouse: _____

Children: _____

Other: _____

This information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

MESSAGES

Please call: home: _____ work: _____ mobile: _____

If you are unable to reach me:

Please leave me a detailed messaged.

Please leave me a message asking me to return your call.

The best time to reach me is: (day) _____ between (time) _____.

Patient or Patient's Legal Guardian (PRINT)

Signature

Date



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IMPORTANT INFORMATION ABOUT YOUR PHYSICAL/MEDICAL EXAM

Dear Patient: (Established and New Patients)

Please note that your physical exam consists to two parts:

This pertains to your MEDICAL exam and is billed under the 99205 (new patients) or 99215 (established patients) code.

This part consists of detailed history taking to address all your medical problems, medications, and a detailed review of all systems to diagnose and formulate an appropriate treatment plan. This often requires ordering appropriate blood tests and diagnostic procedures to determine how to treat you accordingly. This code and the tests ordered are often subjected to your MEDICAL DEDUCTIBLE which will be your responsibility along with checking with your insurance plan.

The second part consists of your Preventive exam which is often performed on a separate visit. This part is billed with either a 99395, 99396, or 99397 code depending on your age bracket for established patients or 99385, 99386, or 99387 for new patients depending on your age bracket. The diagnosis code used for this exam is V70.0 which stands for the preventive exam. This part purely addresses all the appropriate preventive measures and addresses your vaccine needs, preventative health screenings, evaluations of your social and mental health, fall prevention, dietary counseling, etc.

Please note that this part DOES NOT address the diagnosis and treatment of your ongoing medical conditions or any new medical complaints or problems. This is generally covered by most insurance plans once a year and is also covered by MEDICARE once every 13 months (again, please check your insurance plan about your coverage).

I hope you do understand that we, as Board certified physicians, aim to address & meet ALL of your medical needs for your continued physical, mental, emotional, and spiritual well being in the years to come.

Patient or Patient's Legal Guardian (PRINT)

Signature

Date



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INSURANCE WAIVER

I understand that it is my responsibility to supply Dr. Patel's office with any current insurance information. I also understand that at the time of my appointment, if my insurance cannot be verified or determined that I am not eligible for coverage, I will be responsible for the payment for all services provided.

Patient or Patient's Legal Guardian (PRINT)

Signature

Date

MEDICARE PATIENTS ONLY

This letter is to inform you that Medicare will or may not cover routine exams. You will be financially responsible for the cost.

Patient or Patient's Legal Guardian (PRINT)

Signature

Date



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ADVANCE BENEFICARY NOTICE (ABN)

Name: _____ DOB: _____ ID: _____

Medicare/PPO may not pay for the item(s) or service(s) that are described below. Medicare/PPO may not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare/PPO rules are met. The fact that Medicare/PPO may not pay for a particular item or service does not mean that you should not receive it, and there may be a good reason your doctor recommended it.

Items or Services:

Annual Physical Exam: 99215 = \$200.00

Preventive Medical Exam: 99395 or 99396 or 99397 = \$150.00

The purpose of this form is to help you make an informed decision about whether you want to receive these items or services, knowing that you may have to pay for them yourself. Before you decide, you should read this entire notice carefully.

- Ask us to explain if you do not understand why Medicare might not pay.
- Ask us how much these items or services will cost you (Estimated cost: \$150 / \$200) in case you do have to pay for them yourself or through another insurance.

Please choose from one of the options below.

Option 1: Yes. I want to receive these items or services.

I understand that Medicare/PPO will not decide whether to pay unless I receive these items or services first. Please submit my claim to Medicare/PPO. I understand that you may bill me for the items or services first, and that I may have to pay the bill while Medicare/PPO is making their decision. If Medicare/PPO does pay, I will be refunded to me any payments I made to you that are due to me. If Medicare/PPO denies payment, I agree to be personally and fully responsible for the entire payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I have the right to appeal Medicare/PPO's decision.

Option 2. No. I choose NOT to receive these items or services.

I will not receive these items or services, and I understand that you will not be able to submit a claim to Medicare/PPO. I understand I will not be able to appeal your opinion that Medicare/PPO will not pay.

Patient or Patient's Legal Guardian (PRINT)	Signature	Date
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Note: Your health information and any information that we collect on this form will be kept confidential in our office. If a claim is submitted to Medicare/PPO, your health information may be shared with them but will be kept confidentially by Medicare/PPO as well.



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CONSENT TO RELEASE MEDICAL INFORMATION

Patient: _____

DOB: _____

Physician releasing records:

Physician to receive results:

Name: _____

Neal H. Patel, D.O.

Address: _____

City: _____

Phone: _____

I hereby authorize the release of the following information:

All health information pertaining to my medical history, mental or physical conditions, and treatments received, OR:

Only the following records of types of health information (including any dates):

I specifically authorize the release of the following information (check as appropriate):

Mental Health treatment information _____ (initial)

HIV test results _____ (initial)

Alcohol/Drug treatment information _____ (initial)

I hereby authorize the medical information to be released as indicated above. I understand this release is effective until _____, but that I may revoke my consent at any time by providing written consent to the above-named party.

Patient or Patient's Legal Guardian (PRINT)

Signature

Date



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GENERALIZED ANXIETY DISORDER (GAD-7) SCREENING

Name: _____

DOB: _____ Date: _____

Sex: Male Female

1. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly everyday (3)
Feeling nervous, anxious, or on edge?				
Not being able to stop or control worrying?				
Worrying too much about different things?				
Trouble relaxing?				
Being so restless that it is hard to sit still?				
Becoming easily annoyed or irritable?				
Feeling afraid as if something awful might happen?				
TOTAL				

2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Total Score	Anxiety Severity
0 – 4	Minimal
5 – 9	Mild
10 – 14	Moderate
15 – 21	Severe

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9) SCREENING

Name: _____

DOB: _____ Date: _____

Sex: Male Female

1. Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly everyday (3)
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Feeling tired or having little energy?				
Poor appetite or overeating?				
Feeling bad about yourself - or that you are a failure, or have let yourself or your family down?				
Trouble concentrating on activities, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or off hurting yourself in some way?				
TOTAL				

2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Total Score	Depression Severity
0 - 4	None
5 - 9	Mild
10 - 14	Moderate
15 - 19	Moderate severe
20 - 27	Severe

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SLEEP QUESTIONNAIRE (EPWORTH SCALE)

Name: _____ DOB: _____ Age: _____

Date: _____ Height: _____ Weight: _____ Sex: Male Female

How likely are you to nod off or fall asleep in the following situations, compared to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number for each situation.

	0 = never nod off	1 = Slight chance of nodding off	2 = Moderate chance of nodding off	3 = High chance of nodding off
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (meetings, theater, or dinner event)				
As a passenger in a car for an hour or more without a break				
Lying down to rest when circumstances permit				
Sitting quietly and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Total Score: _____

A score of 10 or greater raises concerns that: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

Sleep Questionnaire:	Yes	No	Yes	No
Do you snore?			Do you wake up tired?	
Do you have trouble falling asleep?			Do you wake up choking/gasping for air?	
Do you have high blood pressure?			Are you depressed?	
Do you wake up with a headache?			Do you have night sweats?	
Are you tired throughout the day?			Do you have shortness of breath?	



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“STAYING HEALTHY” ASSESSMENT ADULTS (18 and older)

Name: _____

DOB: _____ Date: _____

Sex: Male Female

Please answer these questions as best as you can. You may circle or “skip” if you do not know the answer or wish to not answer. Your answers will be protected as part of your medical record. Please talk to your provider with any questions you may have.

Do You:	Yes	No	Skip
1. Receive health care from anyone besides a medical doctor (acupuncturist, herbalist, chiropractor, other)?			
2. See the dentist at least once a year?			
3. Brush and floss your teeth daily?			
4. Drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?			
5. Eat fruits and vegetables every day?			
6. Limit the amount of fried food or fast food that you eat?			
7. Easily able to get enough healthy food?			
8. Drink a soda, juice drink, sports or energy drink most days of the week?			
9. Often eat too much or too little food?			
10. Have difficulty chewing or swallowing?			
11. Have concerns about your weight?			
12. Exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?			
13. Feel safe where you live?			
14. Often have trouble keeping track of your medicines?			
15. Sometimes fall and hurt yourself, or is it hard to get up?			
16. Keep a gun in your house or place where you live?			
17. Often feel sad, hopeless, angry, or worried?			
18. Often have trouble sleeping?			
19. Think that you are having trouble remembering things?			
20. Smoke or chew tobacco?			
21. Use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?			

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"STAYING HEALTHY" ASSESSMENT ADULTS (18 and older)

Continued

Date of Birth

Name

Yes No Skip

22. Think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?			
23. Have someone to help you make decisions about your health and medical care?			
24. Need help bathing, eating, walking, dressing, or using the bathroom?			
25. Have someone to call when you need help in an emergency?			
26. Have you been hit, slapped, kicked, or physically hurt by someone in the past year?			
27. Are family members or friends worried about your driving?			
28. Have you had any car accidents lately?			
29. Do friends or family members smoke in your house or where you live?			
30. In the past year, have you had 4 or more alcohol drinks in one day?			
31. Have you or your partner(s) had sex with other people in the past year?			
32. Have you or your partner(s) had sex without a condom in the past year?			
33. Have you ever been forced or pressured to have sex?			

Do you have any other questions or concerns about your health?



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FALL PREVENTION, BALANCE, AND DIZZINESS SURVEY

Name: _____

DOB: _____ Date: _____

Age: _____

To help determine if you are at significant risk for a fall or have a balance disorder, please take the survey below. If you answer yes to one or more of these questions, you could be at risk. The best way to determine if you have a problem is to share with your doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he/she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer	Yes or Often	Sometimes	No or Never
Have you had a recent loss of or decrease in your vision or hearing?			
Have you fallen 2 or more times in the past year, fallen and had an injury, or fallen without an obvious reason?			
Do you fear falling?			
Does moving your head quickly make you dizzy or cause to you feel nauseous?			
Does dizziness or imbalance interfere with your job or your household responsibilities?			
Do you use a walker, cane, or any other form of assistance for your mobility?			
Are you ever dizzy or unsteady when you first get up in the morning?			
Do you ever fall or feel like you are about to fall for no apparent reason?			
Does walking down the aisle of a super market or stopping next to moving traffic make you dizzy?			
Do you feel dizzy while sitting down or rising from a seated or lying position?			
Do you feel unsteady when you are walking or climbing stairs?			
Do you ever lose your balance or feel dizzy or unsteady?			
Has your balance concerns caused problems in your social life?			
Have you continued to experience dizziness after an injury or accident?			
Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			

Patient Signature: _____

Phone: _____



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PERIPHERAL VASCULAR DISEASE (PVD) QUESTIONNAIRE

Name: _____

DOB: _____ Date: _____ Age: _____ Sex: Male Female

Answers to the following questions will help determine if you are at risk for PVD and if a vascular examination can help better assess your vascular health status.

	Yes	No
Do you experience any pain in your legs or feet while at rest?		
Have you ever had any testing done for your legs for poor circulation?		
Have you ever been told you have diabetes?		
Do you have high blood pressure or are you on blood pressure medication?		
Do you have high cholesterol or on a medication to lower your cholesterol?		
Do you smoke or have you ever smoked?		
Have you ever been told that you have had a heart attack or stroke?		
Has anyone ever told you that you have poor circulation in your legs, intermittent claudication, or peripheral arterial disease?		
Have you ever had an angioplasty or stent placed in your heart or leg?		
Do you have a history of carotid stenosis or aneurysm?		
Do you have any infections or sores that are not healing on your legs, feet, or toes?		
Has your walking pace slowed enough to significantly alter your daily activities?		
Do your legs ever feel tired or heavy causing you to stop and rest? Do they get better with rest?		
When you walk, do you ever have to stop because you have pain or cramping in your calves, thighs, or buttocks? Does the pain go away with rest?		
Do you ever experience cramping, tightness, "Charlie horses," or pain in the legs or feet when lying down that improves when you stand up?		
Have you given up activities you once enjoyed doing over the last year due to leg fatigue, weakness, or discomfort?		
Have you ever had trauma to either of your legs?		



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PREPARING FOR YOUR DOCTOR'S VISIT

Name: _____ DOB: _____ Date: _____

Fill out the information below to the best of your ability. Please share it with your doctor. Be open and honest in answering any questions your doctor may ask you about the changes you have been experiencing.

Has your health, memory, or mood changed?

How has it changed?

When did you first notice this change?

How often does it happen?

When does it happen? Is it during a certain time of the day?

What do you do when it happens?

Do you have problems with any of the following?

Remembering appointments, family occasions, holidays, or birthdays?

Never

Sometimes

Frequently

Does not apply

Name: _____ DOB: _____ Date: _____

Writing checks or paying bills?

Never Sometimes Frequently Does not apply

Shopping independently (ie. clothing, groceries)

Never Sometimes Frequently Does not apply

Taking medications according to the instructions?

Never Sometimes Frequently Does not apply

Getting lost while walking or driving to familiar places?

Never Sometimes Frequently Does not apply

Medications and Medical History

List your prescription medications (dosage, frequency) including over the counter medications.

List vitamins and herbal supplements.

List your current medical conditions.

List your past medical conditions.

Questions to ask the doctor:

- What tests do I need to take and how long will it take to get the results?
- Will you refer me to a specialist if needed?
- Could the medicines I am taking be causing my symptoms?
- Do I have any other conditions that could be causing my symptoms or making them worse?
- What should I expect if I am diagnosed with Alzheimer's Disease?
- What treatments are available for Alzheimer's Disease? What are the risks, benefits, and side effects?
- What about participating in a clinical trial? What are the risks and benefits?
- Is there anything else I should know regarding my health?
- When should I come back for another visit?



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COVID - 19 (CORONAVIRUS) TIPS

Per the World Health Organization (WHO), “COVID-19 is the disease caused by a new coronavirus called SARS-CoV-2. WHO first learned of this new virus on December 31st, 2019, following a report of a cluster of cases of ‘viral pneumonia’ in Wuhan, People’s Republic of China.” Since its discovery, it has spread throughout the world and is now considered a pandemic. Given this new virus and continuously emerging information, it is important to stay and aware and up to date of the current situation. Please consider the following tips and information to help you stay safe during this unprecedented time.

- Common symptoms include: fever, dry cough, shortness of breath, fatigue, loss of smell/taste, chills, or muscle aches, congestion, runny nose, etc
- RED flag symptoms include: blue lips/face, coughing up blood, confusion, non-blanching rash, severe chest pain, severe shortness of breath, or elevated heart rate.
- Symptoms typically appear within 5 days of exposure.
- **Please make sure to:**
 - Follow the recommendations put in place per the Centers for Disease Control and Prevention (CDC).
 - Stay home as much as possible.
 - Avoid crowds.
 - Maintain at least 6 feet of separation from others whenever possible, including within the household.
 - Wear a face mask that covers BOTH your nose and mouth, including when at home.
 - Wash your hands often with soap and water for at least 20 seconds OR rub hand sanitizer that contains at least 60% alcohol on your hands for at least 20 seconds.
 - Cover your cough or sneeze with a tissue, and then throw that tissue away in the trash.
 - Avoid touching your eyes, nose, or mouth.
 - Avoid contact with people who are sick.
 - Continue to rest, drink plenty of fluids, and watch for signs and symptoms of worsening infection.
 - Consider buying a pulse oximeter and thermometer to monitor your oxygen status and temperature, respectively.
- **Testing, Vaccination, and Treatment:**
 - Home Testing - rapid way to determine if exposed
 - PCR test - confirmatory test; a positive result is good at ruling IN a recent infection
 - Getting vaccinated with either Moderna, Johnson and Johnson, or Pfizer vaccines is recommended along with getting the booster if not already done so.
 - If exposed to COVID, please call immediately and determine if you are a candidate for Paxlovid treatment.



PHANTOM MEDICAL, INC

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FALL PREVENTION TIPS

Falls are the leading cause of injury and accidental death in adults over the age of 65. New or unfamiliar surroundings, improper footwear, cumbersome furniture arrangements, and distractions can all cause a person to accidentally stumble or fall. According to the World Health Organization, 28-35% of people over the age of 65 will fall each year. Grace L. Walker, PT, DPT, OTD, says: "If a patient is unable to stand on one leg for one minute without support, this may be a good candidate for our balance and fall prevention program." Please consider the following recommendations to lower your risk of falls.

- Be sure to have adequate lighting throughout the house (hallways, bathrooms, doorways, etc).
- Wear appropriate footwear. When walking long distances or in unfamiliar areas, wear flat, non-slip shoes that fit snug and are comfortable. Avoid high heels, loose-fitting shoes, or slip-on backless shoes.
- Install railings in hallways and grab bars in the bathrooms and showers to prevent slipping.
- Install nonslip strips or a rubber mat on the floor of the tub or shower, and consider using a shower seat.
- Arrange furniture so that it creates plenty of room to walk freely. If you are using a walking aid, ensure that doorways and hallways are large enough to get through with and without any devices you may use. Clear all hallways and doorways of items and clutter.
- Do not walk and talk at the same time. Concentrate on the task of walking and continue the conversation after you have reached a safe place.
- Remove throw rugs or secure them firmly to the floor.
- Know your limitations. If there is a task you cannot complete with these considerations, then do not risk a fall by trying to complete it.
- When getting up from bed, take a few minutes to orient yourself before getting out of bed.
- Use caution when carrying items while walking.
- Stay active and perform regular strengthening and balancing exercises.



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MAINTAINING A HEALTHY LIFESTYLE

Our focus for your health is to prevent disease. Please read the following advice to help you stay in the best possible physical, mental, emotional, and spiritual health.

1. Eat healthy foods. Increase fiber, hydration, and eat plenty of fruits and vegetables.
2. Exercise regularly. It is recommended to do at least 150 minutes of aerobic exercise per week (swimming, running, walking, cycling) and at least 2 days per week of muscle strengthening activities (squats, weights, yoga, resistance bands).
3. Always wear a seatbelt when in a car and always wear a helmet when riding a bicycle.
4. Use sunscreen when exposed to the sun with SPF 30 or higher and both UVA/UVB.
5. Consider intermittent fasting (16 hours per day) or prolonged fasting (24-72 hours) to help with losing weight and helping with many different medical ailments.
6. Immunize yourself with the Influenza (Flu) vaccine every year in the Fall and Tetanus Toxoid vaccine every 10 years. Obtain the Shingrix vaccine if you are 50 years or older.
7. Practice safe sex using condoms and get tested for sexually transmitted diseases (STDs) if concerned or with a new partner.
8. Consider a daily dose of Vitamin E (180 mg or 400 International Units) to help with memory and as an antioxidant.
9. To prevent osteoporosis and help overall bone health, consider daily calcium (1000 mg - 1200 mg) and daily Vitamin D3 (2000 - 4000 International Units).
10. Cigarette smoking and alcohol has been linked to many health diseases and it is important to quit or if concerned about your use. We encourage you to talk to Dr. Patel about ways to quit.
11. Avoid and try to quit illicit street drugs.
12. Practice mindful techniques (yoga, meditation, music, art, journaling, humor, deep breathing).
13. Be involved in your community and have a strong support system.