Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Dear Very Important Patient,

Thank you for your interest in our cardiovascular disease prevention program. Attention to your vascular health at this time in your life will have many lasting benefits. As you probably know, heart attacks are the number one killer in this country and about 60% of those who suffer a heart attack had no idea they had a problem. Strokes are the third largest killer and the biggest cause of disability; and again, often strike without warning. In addition, the prevalence of diabetes, this country's most expensive disease, continues to rise. The debilitating effect of heart attacks, strokes, and diabetes, not to mention the socioeconomic impact on our society, touches all of our lives.

It is important to identify who is at risk as proven therapies are now available which can alter the natural progression of arterial disease. In many cases these therapies can prevent or delay the onset of disease. At this clinic, I specialize in identifying those at risk and developing an individualized treatment plan including proper lifestyles advice and/or medications. With a comprehensive aggressive approach, regression of disease can occur making this approach an asset to those with current disease, as well as those who do not have known disease but are at risk from these silent killers.

It is important to note that this is a specialty clinic devoted strictly to the prevention of heart attacks, strokes, and diabetes. I am not a replacement for your current health care provider, but a valuable asset to prevention. My goal is to perform a comprehensive individual assessment looking at all aspects of your health profile as it relates to your vascular health. A treatment plan is formulated incorporating the Bale/Doneen Method along with a specific in-depth educational approach.

I look forward to working with you to assure that you receive the necessary screening and treatment required to meet your healthcare goals and achieve optimum vascular health.

Sincerely,

Jason B. Wischmeyer, M.D, PhD, FACC, PA

4004 82nd St • Lubbock, TX 79423 • 806.535.1388 • www.optimalhearthealth.com

Appointment information:

Before the First Office Visit: Before your first appointment it is essential that all of your medical records be sent to our office. To do this, please complete the attached Medical Records Release / Consent form. Make enough copies to give one to each of your medical providers requesting that they send copies of your records to:

Jason B. Wischmeyer, M.D, PhD, FACC, PA
4004 82nd Street
Lubbock, TX 79423
FAX: 806-722-3145

Please stress that your records must arrive in Dr. Wischmeyer's office at least one week (5 working days) prior to your scheduled first visit. It is important that ALL of the forms you received in your initial packet from our office also must be completed and returned to our office one week prior to your first visit with Dr. Wischmeyer.

Dr. Wischmeyer carefully studies your medical history and incorporates it into his assessment of your risk for heart attack, strokes or diabetes. By obtaining your medical records, this office can also avoid the unnecessary duplication of tests, which will save you money and time.

First Office Visit: The first office visit is primarily an educational process. Please allow approximately 1-2 hours for this appointment. You will learn what happens inside your heart and cardiovascular system when cardiovascular disease is present. You will also learn how to avoid cardiovascular disease, arrest or stop the disease and actually reverse the disease. During this appointment you will become familiar with terms such as insulin resistance, genotyping, CIMT and advanced lipid testing. The educational portion of this visit may be presented in a variety of formats including power-point presentation, DVD, written materials (which you will be able to take home) and one-on-one conversation. You are welcome to bring a spouse or friend (only one please) to this session.

Toward the end of this office visit you will receive a cardiovascular physical examination. You also will receive information on how and where to have your blood drawn (fasting) for a special panel of tests. Several tests on this panel are ordered from a lab in California and Cleveland. Tests take approximately two weeks to be processed. *Labs may be drawn Monday through Friday at Grace Clinic.* You will also be asked to undergo a simple non-invasive CIMT test. It is important that the test results from the blood drawn and CIMT are available to Dr. Wischmeyer prior to your second office visit.

Second Office Visit: The second office visit starts with a one-one-one review of all your test results. Dr. Wischmeyer will formulate a treatment plan specifically for you and explain it to you in detail.

You will also receive an appointment for a half-hour telephone consultation with a highly trained specialist from Quest's 4 My Heart who will share lifestyle advice with you (diet, menus, and exercise goals) based on your Quest 4 My Heart Panel blood draw and personal Apo—E —Genotype.

A detailed letter will be composed by Dr. Wischmeyer that includes a treatment plan for the coming year as well as your tests results.

Annual Concierge Practice Option: After the completion of your Second Office Visit, you are welcome to discuss the option of continuing your cardiovascular prevention care with Dr. Wischmeyer. Please feel free to ask questions of either Dr. Wischmeyer or his staff.

Office Policy on Payment

Insurance Policy:

We do not contract with any insurance companies. It is the patient's full responsibility to submit his/her claims to their insurance carrier. At the time of service, this office will provide the patient with two copies of the billing statement including appropriate service and diagnostic codes. Upon request, this office will provide each patient with a copy of his/her medical record for insurance purposes. It is the responsibility of the patient to submit these records/statements to their insurance carrier(s).

Authorization for Release of Medical Records:

I authorize Dr. Jason Wischmeyer to release my medical information including but not limited to billing, diagnosis, x-ray, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for the following purposes: diagnostic, insurance, legal and when my physician deems it necessary in order to ensure the best medical care on my behalf. Continuation of care is included in the justification for this release of information to other care providers. I further understand that any person(s) or organization(s) that receive my medical records will not release any of the information obtained by this authorization to any other person(s) or organization(s) without further authorization signed by me for release of the information. In addition, I authorize the release of any medical information necessary to process my insurance claims. I understand I can revoke this authorization at any time.

In addition, I understand that while Dr. Jason Wischmeyer's treatment / methods strive to prevent diabetes, stroke and heart attacks, Dr. Wischmeyer and I understand there is no infallible method of prevention.

Medicare Patients: I further understand and agree that I will not submit any of Dr. Wischmeyer's concierge fees or fee for services provided by his clinic to Medicare or any Medicare supplemental insurance company. No legal action on my part is to be taken regarding Medicare or any Medicare Supplemental insurance company's exclusion of concierge fees or services provided by non-Medicare contracted providers for consideration or denial of coverage.

Signed_____Date_____

Call 806.535.1388 for scheduling and refills

Cardiovascular Disease Prevention

Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Demographics Form

Please Print

Name:_____ ☐ Male ☐ Female
First Middle Last

Address:_____ City:_____ State:_____ Zip:_____

D.O.B:___/___/_____ Age:_____ Social Security#:_____-_____-_____ Marital Status: S M D W
circle

Home Phone: (____)_____ Email Address:_____

Cell Phone: (____)_____ Other Phone: (____)_____

Employer_____ Work Phone: (____)_____

Emergency Contact (Friend / Relative):_____Phone: (____)_____

Parent / Spouse Name:_____
First Middle Last

Insurance Co.: _____ ID#:_____ Group#:_____

Subscriber's Name:_____ Subscriber's Date of Birth:____/___/_____

Person responsible for the bill?: ☐ Self ☐ Spouse ☐ Other_____

Name (if different from above):_____

How did you hear about our center? _____

_____

_____

_____

_____

Patient's Signature:_____ Date:_____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, intend to comply, now and in the future, with all requirements set forth in the Standards for Privacy of Individually Identifiable Health Information (known as the Privacy Rule) which implements the privacy requirements of the Health Insurance Portability and Accountability Act of 1996, commonly known as "HIPAA," so that the information described below will be freely available to those described below. All provisions hereof shall be construed in accordance with that intent.

I hereby authorize each Covered Entity identified below to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

My Additional Identification Information:

Name: _____
Date of Birth: _____
Social Security Number: _____

1. **Identity of Person or Class of Persons Authorized to Make Disclosure.** I hereby authorize all covered entities as defined in HIPAA, and all other health care providers, health plans, and health care clearinghouses, including but not limited to each and every doctor, psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other medical provider or agent thereof having protected health information (as that term is defined in HIPAA), each being referred to herein as a "Covered Entity."

2. **Description of information to Be Disclosed.** To disclose the following information: All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this Authorization.

3. **Person or Class of Persons to Whom the Covered Entity May Disclose the Above Described Protected Health Information.** The above described information shall be disclosed **to FIRST AGENT, SECOND AGENT, THIRD AGENT, FOURTH AGENT**, herein each known as an "Authorized Person."

4. **Purpose of Disclosure.** At my request.

5. **Termination.** This Authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the Covered Entity. Proof of receipt of my written revocation may be either by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the Covered Entity. Such revocation shall be effective upon the actual receipt of the notice by the Covered Entity except to the extent that the covered entity has taken action in reliance on this Authorization.

6. **Re-Disclosure.** By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Authorized Person and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

7. **Acknowledgment of Right to Treatment.** I understand and hereby acknowledge that the Covered Entities may not condition my receipt of health care upon my execution of this Authorization, and I may refuse to sign this Authorization if I wish to do so.

8. **Instructions to My Authorized Persons.** My Authorized Person shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, my Authorized Person is authorized to sign any documents that the authorized person deems appropriate to obtain the protected medical information.

9. **Revocation.** This Authorization may be revoked in writing by me at any time.

10. **Valid Document.** A copy or facsimile of this original Authorization shall be accepted as though it was an original document,

11. **My Waiver and Release.** I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my Authorized Person. I also specifically prohibit my Authorized Person, or any other person designated as my agent in any capacity from filing a complaint of any kind against any Covered Entity that complies with the directions of my Authorized Person hereunder to the extent that such a complaint purports to charge said Covered Entity with any violation of the Privacy Rules or other Federal or State laws related to disclosure of medical records as a result of their compliance with said directions.

Dated _____

_____
PRINT NAME

_____
SIGNATURE

Authorization to Disclose Information

I hereby authorize the use of information from the medical record of:

Name: _____ Date: _____

Date of Birth: _____ Social Security: _____

I authorize the following individual or organization to disclose the above named individual health information:

Name: _____ Address: _____

This Information may be disclosed to and used by the following individual or organization:

Jason Wischmeyer, MD PhD FACC PA

Grace Clinic – 4004 82nd Street - Lubbock, TX 79423 – FAX: 806-722-3145

For the purpose of: Medical Treatment

Please release the following:

Problem List	List Allergies	x-ray/imaging reports
Progress Notes	x-ray films	Genetic Testing Information
History and Physical Exam	Laboratory results	Other Diagnosis reports
Medication List	EKG reports	Other

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behaviors or mental services, and treatments for alcohol and drug abuse.

[ ] YES, I consent to the release of this information. [ ] NO, I do not consent to the release of this information.

I understand that I have the right to revoke this authorization anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing this disclosure or this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosures the information may not be protected by the federal confidentiality rules.

_____

Signature of Patient or Legal Representative Date

_____

Relation to Patient (If Legal Representative) Date

Complete only if information is to be released directly to patient	
Signature of Patient or Legal Representative	Date
Relation to Patient (if Legal Representative)	Witness

Doctor's Information Form

Your Name: _____ D.O.B:_____

1. Primary Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

2. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

3. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

4. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

5. Doctor's Name:_____
   Type of Doctor:_____
   Address:_____
   _____
   Telephone: _____
   Fax: _____

Please make sure to provide all information needed. If you have more Physicians, please finish on the back side of this sheet. You only need to list Physicians you have seen within the last 3-5 years.

EPWORTH SLEEPINESS SCALE

The following questionnaire will help you measure your general level daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they would have affected you.

Name: _____ Date of Birth: _____ Today's Date:_____

Instructions: Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

It is important that you circle a number (0 to 3) on each of the questions

Situation	Chance of dozing (0-3)
Sitting and Reading	0 1 2 3
Watching Television	0 1 2 3
Sitting inactive in a public place-for example, a theater or meeting.	0 1 2 3
As a passenger in a car for an hour without break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your Symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

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Jason Wischmeyer M.D., Ph.D., F.A.C.C.

Depression Self-Rating Test

Nearly 20 million Americans experience depression, but many will never seek treatment. The Depression Self-Rating Test is a simple l6-question quiz that can help identify common symptoms of depression and their severity. Remember-depression is more than just feeling down-it is a real medical condition that can be effectively treated.

Please complete the following questionnaire and return it to your healthcare provider.

Name: _____ Date of Birth: _____ Today's Date: _____

Instructions: Please circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:
- **0** I never take longer than 30 minutes to fall asleep.
- **I** take at least 30 minutes to fall asleep, less than half the time.
- **2** I take at least 30 minutes to fall asleep, more than half the time.
- **3** I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep during the night:
- **0** I do not wake up at night.
- **1** I have a restless, light sleep with a few brief awakenings each night.
- **2** I wake up at least once a night, but I go back to sleep easily
- **3** I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking up too early:
- **0** Most of the time, I awaken no more than 30 minutes before I need to get up.
- **1** More than half the time, I awaken more than 30 minutes before I need to get up.
- **2** I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually
- **3** I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping too much:
- **0** I sleep no longer than 7-8 hours/night, without napping during the day.
- **1** I sleep no longer than 10 hours in a 24-hour period including naps.
- **2** I sleep no longer than 12 hours in a 24-hour period including naps.
- **3** I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:
- **0** I do not feel sad.
- **1** I feel sad less than half the time.
- **2** I feel sad more than half the time.
- **3** I feel sad nearly all of the time.

6. Decreased appetite:
- **0** There is no change in my usual appetite.
- **1** I eat somewhat less often or lesser amounts of food than usual.
- **2** I eat much less than usual and only with personal effort
- **3** I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat

7. Increased appetite:
- **0** There is no change from my usual appetite.
- **1** I feel a need to eat more frequently than usual.
- **2** I regularly eat more often and/or greater amounts of food than usual.
- **3** I feel driven to overeat both at mealtime and between meals.

8. Decreased weight (within the last two weeks):
- **0** I have not had a change in my weight.
- **1** I feel as if I've had a slight weight loss.
- **2** I have lost 2 pounds or more.
- **3** I have lost 5 pounds or more.

9. Increased weight (within the last two weeks):
- **0** I have not had a change in my weight
- **1** feel as if I've had a slight weight gain.
- **2** I have gained 2 pounds or more.
- **3** I have gained 5 pounds or more.

10. Concentration/Decision making:

0 There is no change in my usual capacity to concentrate or make decisions.
1 I occasionally feel indecisive or find that my. attention wanders.
2 Most of the time, I struggle to focus my attention or to make decisions.
3 I cannot concentrate well enough to read or cannot make even minor decisions

11. View of myself:

0 I see myself as equally worthwhile and deserving as other people
1 I am more self-blaming than usual.
2 I largely believe that I cause problems for others
3 I think almost constantly about major and minor defects in myself

12. Thoughts of death or suicide:

0 I do not think of suicide or death,
1 I feel that life is empty or wonder if it's worth living.
2 I think of suicide or death several times a week for several minutes.
3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life

13. General interest:

0 There is no change from usual in how interested I am in other people or activities.
1 notice that I am less interested in people or activities.
2 I find I have interest in only one or two of my formerly pursued activities.
3 I have virtually no interest in formerly pursued activities

14. Energy level:

0 There is no change in my usual level of energy.
1 I get tired more easily than usual.
2 I have to make a big effort to start or finish my usual daily activities (for example: shopping homework, cooking, or going to work).
3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

0 I think, speak, and move at my usual rate of speed
1 I find that my thinking is slowed down or my voice sounds dull or flat
2 It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

0 I do not feel restless.
1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
2 I have impulses to move about and am quite restless.
3 At times, I am unable to stay seated and need to pace around.

This section is to be completed by your doctor.

To Score:

Enter the highest score on any I of the 4 sleep items (1—4) _____
Item 5 _____
Enter the highest score on any I appetite/weight item (6—9) _____
Item 10 _____
Item 11 _____
Item 12 _____
Item 13 _____
Item 14 _____
Enter the highest score on either of the 2 psychomotor items (I5 and 16) _____
TOTAL SCORE (Range 0—27) _____

Scoring Criteria: Normal 0-5 Mild 6-10 Moderate 11-I5 Severe 16-20 Very Severe 21+

NOTE: The above cutoff points are based largely on clinical judgment rather than on empirical data. Reference: 1. National Institute of Mental Health website. Depression research at the National Institute of Mental Health Fact Sheet. Available at http://www.nimb.nih.gov/publical/depresfact.cfm. Accessed November 28, 2002.