

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
 Date & Time of Initial Visit: _____

Name (<i>Last, First, M.I.</i>):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Social Security Number:			
Address:			
Email address:			
Home Phone:		Cell Phone:	
Preferred method of contact: home phone / cell phone / other:			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor:		Date of last physical exam:	
How did you hear about us: Referred by: Dr. Alice Harper Website/ Phone book / Newspaper Ad / Brochure in community / Wellbeing Center Website / Saw Signs / Insurance Website / Other			

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio			
Immunizations and dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza		<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed and approximate date of diagnosis (Past Medical History)

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Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please continue to next page

Physician's Initials _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of the Drug	Dosage	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise (Outside of work)	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?		What kind? (Diet, regular, drip, espresso)		
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			

Please continue on next page

Physician's Initials _____

Drugs	Do you currently use recreational or street drugs? (Please list)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please continue on next page

Physician's Initials _____

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation (this is the date you began your period):		
Period every ____ days and they last for ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____ Number of Abortions ____ Number of Miscarriages ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you breastfeed your children? If yes, for how many months? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had an abnormal pap?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you've had an abnormal pap, did you have HPV? _____ What was the treatment/outcome?		
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Please continue on next page

Physician's Initials _____

Alice C. Harper, ND

Naturopathic Physician

INSURANCE INFORMATION

____ I do not have insurance or my insurance will not cover Naturopathic services and I am paying cash. (Please skip to next page)

____ Please bill my insurance and I will pay the remaining balance and copay.

My copay is: \$ _____

My insurance will cover _____ % of Naturopathic Services and I am responsible for the remaining.

Insurance Information

Insurance Carrier: _____

Patient Name: _____ DOB: _____

Patient's Address: _____ City: _____ State: _____ Zip: _____

Patient's Phone #: _____ Cell Phone: _____

Subscriber ID: _____ Group #: _____

Subscriber: _____ Subscriber SS#: _____ DOB: _____

Relationship to Patient: _____

Insurance Billing Address: _____

Insurance Phone #: _____

I, _____, certify that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Alice C. Harper, ND

Naturopathic Physician

SIGNATURE PAGE

FINANCIAL POLICY

PATIENT AUTHORIZATION AND UNDERSTANDING

I have read and understand the financial policies of Alice C. Harper, ND. I agree to abide by the terms of the financial policy. I request that payment of benefits be made to Alice C. Harper, ND, and hereby authorize the release of any information necessary to determine the liability of payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing and there has been a termination of services with Alice C. Harper, ND.

PATIENT'S PRINTED NAME: _____ DATE OF BIRTH: _____

Patient's or Legal Guardian's Signature: _____ Date: _____

Name of person completing form if other than patient: _____

Relationship to patient: _____

CONSENT FOR TREATMENT

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Alice C. Harper, ND. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or a representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

Guardian/personal Representative's Name (Print)

Patient's Name (Print)

Guardian/personal Representative's Signature

Patient's Signature

Relationship/Representative's Authority

Date

HIPAA

I hereby certify that I have received the *Notice of Privacy Practices* for **Alice C. Harper, ND**. I understand that if I have objections or concerns with this policy, I must notify **Alice C. Harper, ND** per the instructions in the *Notice of Privacy Practices*.

Name (printed)

Signature

Date

Alice C. Harper, ND

Financial Policy

Thank you for choosing Alice C. Harper, ND, for your Naturopathic care. We know you have many choices in providers and we appreciate your business. We look forward to a relationship with mutual trust and an opportunity to help you obtain optimal health. As you know, payment for services is part of your care and part of our professional relationship. We have developed a financial policy to make these obligations clear from the beginning.

CASH PAYMENTS

Payment is due at time of service. Dr. Harper accepts cash and checks.

INSURANCE COVERAGE AND PAYMENTS

We will gladly bill your insurance if you have a PPO or out-of-network coverage. It is your responsibility to obtain and verify this information prior to your scheduled appointment.

If you have a copay, this will be due at the time of service. If your insurance covers only a portion, it is your responsibility to pay the remaining balance that will be billed to you by the clinic after the 60-day grace period allotted to insurance companies by the state. If you have a deductible, this will be billed to you after receiving notification of payment from your insurance company.

In the event that your insurance coverage has changed, you will be responsible for the full cost of the office visit that is not covered by your insurance company. At that time, you may personally submit the bill to your insurance company for reimbursement.

THIRD PARTY PAYORS

PIHWC will submit to third party payors such as PIP. There will be a \$25 deposit due at the time of service, which will be reimbursed to you when payment is received. Please note that issues or conditions that are outside the parameters of your PIP coverage will need to be scheduled for a different visit on a different day.

PHONE CONSULTATIONS

Phone visits can be scheduled and will be charged a flat rate of \$50 for each 1-15 minutes on the phone. The fee will be waived if it is determined that an in person office visit is required or if you are referred for emergency services. The fee will also be waived if it is a question limited to a current and documented treatment plan.

EMAIL CORRESPONDENCE

Due to liability, email consultations are not permitted. If there is an extenuating circumstance, we may make exceptions.

MISSED OR LATE CANCELLED APPOINTMENTS

It is a professional courtesy to provide 24 hours notice if you cannot keep an appointment. ***There will be a \$35 charge for all appointments cancelled less than 24 hours in advance.***

If you are late to an appointment, please understand that you have a scheduled time and this may result in your appointment being cut short to remain within the parameters of your scheduled appointment time.

RETURNED CHECKS

There will be a \$35 fee for returned checks. Please note that you will still be responsible for charges and asked to pay with a different form (cash or money order).

Thank you for your understanding and cooperation in our financial policies. As stated before, payment for services is part of your treatment and part of our professional relationship. This creates mutual respect and trust between physician and patient. We appreciated your support in helping us to continue to serve you and others.

Alice C. Harper, ND

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact your practitioner:

Alice C. Harper, ND
211 West Hill Street
Monroe, WA 98272
Phone: (360) 863-2407
Email: dr_alice_harper@yahoo.com

We respect your privacy and understand that your medical information is personal and sensitive. Moreover, we are required by law to make sure that medical information that identifies you is kept private. This *Notice of Privacy Practices* describes how we may use or disclose your protected health information at our clinic. We are required to give you this notice of our legal duties and abide by the terms of this notice; however, we may change our notice at any time. **Please note that any new notice adopted will be effective for all protected health information maintained at the time of change.** You will not be notified individually if a change is made to our notice, however, upon request, we will provide you with a copy of our current notice. You may always obtain a copy of our current notice by any of the following means:

1. Contacting our office by mail, phone, or e-mail at the above address, phone number, and e-mail address
2. Asking for a copy at the time of your next visit

SECTION 1: We use and disclose your protected health information to carry out your treatment, obtain payment, and conduct health care operations.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosures to other third parties that are involved in your health care elsewhere. Specifically, we would disclose your protected health information to other physicians who may be treating you when we have the necessary permission from you to do so. For example, your protected health information may be provided to a physician to whom you have been referred in order to ensure that the physician has the necessary information to diagnose and/or treat you. In addition, we may occasionally disclose your protected health information to another physician or health care provider, such as a medical specialist or laboratory, who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for coverage of future treatment with some medical modalities may require that your relevant medical information be disclosed to the health plan in order to obtain approval for future scheduling. Similarly, insurance companies may require that copies of your applicable medical records accompany any requests for payment of services already provided to you.

Healthcare Operations: We may use or disclose, as necessary, your protected health information in order to support various business activities of our clinic. These activities include, but are not limited to, quality assessment activities, employee reviews, licensing, marketing and fundraising activities, and conducting or arranging for similar business activities. For example, we may call you by name in the waiting room when ready to see you, and we may use or disclose your protected health information, as necessary, to contact you and remind you of your upcoming appointment(s). We will share your protected health information with third party business associates that perform various activities—such as billing, collections, or records management—for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our clinic and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities. If you do not wish to be contacted for these purposes, please call or write to our office at the address or phone number specified on page one.

SECTION 2: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

Per your Authorization: If you give us authorization to use or disclose your protected health information, you may revoke such authorizations at any time, in writing, except to the extent that our clinic has already taken action in reliance on the use or disclosure permitted in the authorization.

Legally Permitted/Opportunity to Object: We may use and disclose your protected health information in the following instances, but you will be given the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of such information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- 1. To Others Involved in Your Healthcare:** Unless you object, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person you identify, to the extent the information directly relates to that person's involvement in your health care. For example, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care or your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. In Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your physician or another physician in the practice must treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

3. With Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances and the use or disclosure is done in accordance with other applicable laws.

Legally Permitted/No Opportunity to Object: We may use and disclose your protected health information in the following situations without your consent or authorization:

1. When Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law(s) and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures only if required by law.

2. For Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

3. For Health Oversight/Compliance Monitoring: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

4. Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child or dependent adult abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect, or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

5. To the FDA: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

6. Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request, or other lawful process.

7. Law Enforcement: We may disclose your protected health information for law enforcement purposes, so long as applicable legal requirements are met. Such purposes generally include: 1) those required by law; 2) limited information requests for identification and location purposes; 3) those pertaining to victims of a crime; 4) suspicion that death has occurred as a result of criminal conduct; 5) those where a crime occurs on the premises of the practice; and 6) medical emergencies where it is likely that a crime has occurred.

8. Research: We may disclose your protected health information to researchers when an institutional review board has approved their research. The institutional review board will have reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

9. Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel to authorized authorities; such as for determinations of your eligibility for benefits. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President, foreign heads of state, or others legally authorized.

10. Worker's Compensation: We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

11. Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner, medical examiner, or funeral director, if necessary, for them to carry out their duties should you die.

12. Inmates: We may disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of a correctional facility or under the custody of a law enforcement official and your physician created or received your protected health information in the course of providing care to you. Such information may be released only for the following purposes: 1) to enable the correctional institution or law enforcement official to provide you with necessary healthcare services; 2) to protect your own health and safety or the safety of others; and 3) for the safety and security of the correctional institution.

SECTION 3: Specially-Protected Information

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is release.

SECTION 4: Your Rights

The following is a list of your rights with respect to your protected health information and a brief description of how you may exercise those rights. Should you have questions about this section or if you wish to exercise your rights, please contact the medical records office at the address listed on page one.

The right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of the protected health information we maintain about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the institution use for making decisions about you. We may deny you access to some records as state and federal laws permit, however, if you are denied access, you may request a review or designate a health care provider with equal qualifications to receive the information instead.

The right to request a restriction on the use or disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment of healthcare operations as described in Section 1 of this notice. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must be in writing and state the specific restriction requested and to whom or in what situation you want the restriction to apply. Please note that we are not required to agree to a restriction that you may request. If we believe it to be in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Dr. Rhian Young.

The right to request that you receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

The right to request an amendment/correction to your health record. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us, and the statement of disagreement you provide will be released along with the information challenged whenever it is released. We may also include a letter of rebuttal, which will also be released along with the challenged information. You are entitled to a copy of any letter of rebuttal we may place in your record.

The right to receive and accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this *Notice of Privacy Practices*. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after October 1, 2004. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

The right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

SECTION 5: Complaints, Comments, and Inquiries

If you believe your privacy rights have been violated, you may report the suspected violation to us by contacting our clinic at (360) 794-6620 or by contacting the Secretary of Health and Human Services. We will take no punitive action against you for filing a complaint.

This notice becomes effective on October 1, 2004.

CONSENT FOR TREATMENT

I hereby authorize Dr. Harper to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine labwork, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals, and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)

Pharmaceutical Prescriptions (prescribing of various pharmaceutical drugs within the scope of practice for Naturopathic Physicians which includes all Legend Drugs and specific Schedule III, IIIN, 4, & 5 per the WAC.)

Dietary Advice and Therapeutic Nutrition (use of foods, diet plans, or nutritional supplements for treatment—may include intramuscular vitamin injections.)

Soft Tissue and Osseous Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.)

Electromagnetic and Thermal Therapies (includes the use of therapeutic ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and hydrotherapies.)

Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used.