BOTHELL NATURAL HEALTH ~ NEW PATIENT REGISTRATION FORM

All information on this form is confidential. If you are uncomfortable answering any questions, you may leave them blank and discuss them with Dr. Bowen.

PATIENT INFORMATION / PROFILE

Name:	Date of Birth:	Gender: M F Other
Address:	Single Partnered Married Divorced	
(zip)	Number of people in household:	children?
Occupation:	Employer / School:	
Education completed: ☐ High School ☐ Some College ☐ College ☐ Graduate Degree ☐ Other		
Travel Outside US? ☐ Yes ☐ No	Where / When?	

CONTACT INFORMATION E-MAIL:

Phone Numbers: ☐ Phone (work): ☐ Phone (home): ☐ Phone (cell / pager):
Check the box next to the number where we can leave a private message that may contain confidential health information
Name of Spouse or Partner:
Name(s) of Children:
Emergency Contact : home phone:
Relationship to patient: work phone:

REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care? ☐ No ☐ Yes For:
Please list other health care professionals from whom you receive care (name, specialty, contact # if possible):
How did you find Dr. Bowen? ☐ Insurance Referral: ☐ Physician Referral: ☐ Patient Referral: ☐ Other:
Referring Physician or Patient Name:
Who is your Primary Care Physician (PCP)?
Clinic Name, Address and phone:
Have you ever consulted with or been treated by a naturopathic physician, acupuncturist, chiropractor, nutritionist or massage therapist before? ☐ No ☐ Yes (circle those that apply) When? Who?

HEALTH CONCERNS (please list in order of importance to you)

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

Are you currently pregnant? ☐ No ☐ Yes Months?
Is your condition injury or accident related? ☐ No ☐ Yes, auto accident ☐ Yes, work related
What goals do you have from your visit today and overall?
What expectations do you have of your physician?

MEDICATIONS AND SUPPLEMENTS

Medications & dose:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc):	
1.	4.
2.	5.
3.	6.

HEALTH HISTORY / REVIEW OF SYSTEMS

Allergies or Reactions to:	☐ Iodine	☐ Penicillin / antibiotics	☐ Sulfa Drugs	☐ Local anesthetics
☐ Aspirin	☐ Nuts	☐ Scents	☐ Other:	
History of serious illness, accidents, hospitalization or operations (description, date):				
Childhood Illnesses:	☐ Chicken Pox	☐ Measles	☐ Mumps	☐ Rubella
☐ German measles	☐ Rheumatic Fever	☐ Strep Throat	☐ Other:	
Have you ever been touched in a way that made you uncomfortable without your permission?			☐ Yes	☐ No
Have you ever been physically or emotionally abused?			☐ Yes	☐ No
Do you have concerns with abuse / violence in your life now?			☐ Yes	☐ No

Please check if you have or have ever had:

Condition	Never	Past	Current	Physician's Notes
1. General				
Weight loss / gain	☐	☐	☐	Max weight: Min. wt: Current Wt:
Fever / Chills	☐	☐	☐	
Fatigue / Chronic Fatigue	☐	☐	☐	
Heat / Cold Intolerance	☐	☐	☐	
Cold Hands and Feet	☐	☐	☐	
Sweats / Night Sweats	☐	☐	☐	
Thirst	☐	☐	☐	
2. Skin				
Dryness	☐	☐	☐	
Eczema	☐	☐	☐	
Rashes / Itching	☐	☐	☐	
Sores	☐	☐	☐	
Moles	☐	☐	☐	
Hair or nail dryness / changes	☐	☐	☐	
Easy Bruising	☐	☐	☐	
Yellow / Jaundice	☐	☐	☐	
3. Head				
Headache	☐	☐	☐	
Trauma	☐	☐	☐	
4. Eyes				
Blurred Vision	☐	☐	☐	
Corrective Lenses / Contact Lenses	☐	☐	☐	
Double Vision	☐	☐	☐	
Dry Eyes	☐	☐	☐	
Eye Pain	☐	☐	☐	
Glaucoma	☐	☐	☐	
Floaters	☐	☐	☐	
Discharge	☐	☐	☐	
Poor night vision	☐	☐	☐	

5. Ears	Never	Past	Current	**Physician's Notes (Con't)**
Earaches	☐	☐	☐	
Ringing of Ears	☐	☐	☐	
Hearing Problems	☐	☐	☐	
6. Nose				
Sinus congestion or infection	☐	☐	☐	
Bleeding	☐	☐	☐	
Discharge	☐	☐	☐	
Post Nasal Drip	☐	☐	☐	
7. Mouth / Throat				
Sores	☐	☐	☐	
Bleeding gums	☐	☐	☐	
Cavities / Root canals / toothaches	☐	☐	☐	
Hoarseness	☐	☐	☐	
Sore Throat	☐	☐	☐	
Bitter or Metallic taste in mouth	☐	☐	☐	
8. Lungs				
Asthma	☐	☐	☐	
Difficulty Breathing / Shortness of Breath	☐	☐	☐	
Chest Pain / Tightness in chest	☐	☐	☐	
Cough: Persistent or Bloody	☐	☐	☐	
Wheezing	☐	☐	☐	
Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
Pneumonia	☐	☐	☐	
Tuberculosis	☐	☐	☐	
9. Cardiovascular				
Heart palpitations	☐	☐	☐	
Blood Clots in Legs or Lungs	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Low Blood Pressure	☐	☐	☐	
Swelling (Edema) of hands, feet, legs	☐	☐	☐	
Heart murmurs / Arrhythmias	☐	☐	☐	
Heart Disease	☐	☐	☐	
Heart Attack	☐	☐	☐	
Stroke	☐	☐	☐	
Circulatory Problems (raynauds, etc)	☐	☐	☐	
Varicose Veins	☐	☐	☐	
Pacemaker	☐	☐	☐	
10. Gastrointestinal				
Loss of / Excess Appetite	☐	☐	☐	
Nausea / Vomiting	☐	☐	☐	
Difficulty or pain with swallowing	☐	☐	☐	
Eating Disorders	☐	☐	☐	
Pain with Digestion	☐	☐	☐	
Indigestion / Reflux	☐	☐	☐	
Gas / Bloating	☐	☐	☐	
Constipation	☐	☐	☐	
Diarrhea (with or without blood?)	☐	☐	☐	
Colitis / Crohn's	☐	☐	☐	
Hernia	☐	☐	☐	
Hemorrhoids	☐	☐	☐	
Anal Discomfort	☐	☐	☐	
Blood or Mucus in Stool	☐	☐	☐	
Black tarry or "coffee ground" stools	☐	☐	☐	
Gallbladder Disease	☐	☐	☐	
Hepatitis (type _____)	☐	☐	☐	
High Cholesterol / Lipids	☐	☐	☐	
Liver Disease	☐	☐	☐	
Ulcer	☐	☐	☐	

11. Genitourinary	Never	Past	Current	
Pain with Urination	☐	☐	☐	
Urgency to Urinate	☐	☐	☐	
Frequent Urination	☐	☐	☐	
Wake to Urinate	☐	☐	☐	
Blood in Urine	☐	☐	☐	
Difficulty holding urine (sneeze / cough)	☐	☐	☐	
Kidney disease / Stones	☐	☐	☐	
12. Musculoskeletal				
Muscle pain / spasm / strain	☐	☐	☐	
Joint pain / sprain	☐	☐	☐	
Arthritis (type:)	☐	☐	☐	
Back Problems (type:)	☐	☐	☐	
Broken Bones	☐	☐	☐	
Osteoporosis	☐	☐	☐	
Weakness	☐	☐	☐	
Trauma / Swelling	☐	☐	☐	
13. Endocrine				
Diabetes	☐	☐	☐	
Thyroid disease	☐	☐	☐	
Goiter	☐	☐	☐	
Tremor	☐	☐	☐	
Hormone Therapy	☐	☐	☐	
14. Blood / Lymphatic				
Anemia	☐	☐	☐	
Bleeding tendencies	☐	☐	☐	
Blood Transfusions	☐	☐	☐	
Swollen Lymph nodes	☐	☐	☐	
Blood / Lymph disease or cancer	☐	☐	☐	
15. Allergic / Immune				
HIV / AIDS	☐	☐	☐	
Cancer / Chemotherapy	☐	☐	☐	
Autoimmune (scleroderma, hashimotos, lupus, etc)	☐	☐	☐	
Hay fever / Asthma / Eczema	☐	☐	☐	
Drug Allergies	☐	☐	☐	
Food Allergies	☐	☐	☐	
Environmental / Animal allergies	☐	☐	☐	
16. Neurologic				
Epilepsy / Seizures / Convulsions	☐	☐	☐	
Fainting	☐	☐	☐	
Dizziness / Vertigo	☐	☐	☐	
Problems with speech	☐	☐	☐	
Problems with walking / coordination	☐	☐	☐	
Paralysis / weakness	☐	☐	☐	
Numbness	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	
17. Psychologic				
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Chemical Dependency	☐	☐	☐	
Phobias	☐	☐	☐	
Memory Loss	☐	☐	☐	
Mood Changes	☐	☐	☐	
Psychiatric Care	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

Sexual Health Information

Are you currently sexually active?	☐ No	☐ Yes	With:	☐ Men	☐ Women	☐ Both	
Have you been sexually active with:	☐ Men	☐ Women	☐ Prostitute				
☐ Current ☐ Past	☐ Both	☐ Neither	☐ Bisexual	☐ IV drug user			
Are you satisfied with your sex life?	☐ No	☐ Yes	Do you practice safer sex?	☐ No	☐ Yes		
Do you have need for birth control?	☐ No	☐ Yes					
Method of birth control currently used			Number of sexual partners this year?				
STDs ☐ HIV ☐ Herpes	☐ HPV/ Warts	☐ Gonorrhea	☐ Chlamydia	☐ Syphilis	☐ Hepatitis		
Notes:							

Male Health Information

Condition	Never	Past	Current	Physician's Notes
Difficult Urination	☐	☐	☐	
Testicular Pain / Swelling	☐	☐	☐	
Impotence / Sexual difficulties	☐	☐	☐	
Prostate problems	☐	☐	☐	
Notes:				

Female Health Information

Menstrual History			**Obstetric History**		
Age at first period			Have you ever been pregnant	☐ No	☐ Yes
Date last menstrual period began			Age at first pregnancy		
Periods regular?	☐ No	☐ Yes	Number of pregnancies		
Days between periods			Number of living children		
Length of flow			Number of stillbirths		
Heaviness of flow			Number of miscarriages	When in pregnancy?	
Color of flow			Number of tubal pregnancies		
Clots (size? Sm, Med, Lg)	☐ No	☐ Yes	Number of abortions	When in pregnancy?	
Pain with ovulation?	☐ No	☐ Yes	Number of Cesarean sections		
Pain with Menses?	☐ No	☐ Yes	Date of last pregnancy		
Menopause?	☐ No	☐ Yes	Difficulty conceiving	☐ No	☐ Yes
			Difficulty with pregnancy	☐ No	☐ Yes
PMS Symptoms: ☐ None	☐ Bloating/swelling		Difficulty with labor or delivery	☐ No	☐ Yes
☐ Breast Tenderness ☐ Acne	☐ Mood Swings		Difficulty with breast feeding	☐ No	☐ Yes
☐ Digestive changes ☐ Fatigue	☐ Headache		Future OB plans	☐ No	☐ Yes
☐ Other					

Vaginitis Symptoms:	**Never**	**Past**	**Current**	**Risk Factors**		
Discharge	☐	☐	☐	History of Abnormal paps	☐ No	☐ Yes
Irritation	☐	☐	☐	Did your mother take DES?	☐ No	☐ Yes
Itching	☐	☐	☐	Did your mother ever miscarry?	☐ No	☐ Yes
Odor	☐	☐	☐	Do you do self breast exams?	☐ No	☐ Yes
Pain with sex	☐	☐	☐	Long term Hormone Replacement?	☐ No	☐ Yes
Trichomoniasis	☐	☐	☐			
Bacteria (BV)	☐	☐	☐			
Yeast	☐	☐	☐			

Notes:

Family History

Mother:	☐ Living	☐ Deceased	Cause	Age:
Father:	☐ Living	☐ Deceased	Cause	Age:
Siblings:	Number living:	Number deceased:	Causes / Ages:	
Children:	Number living:	Number deceased:	Causes / Ages:	

Has any family member had:	Yes	Which Relative(s) & Age of Onset	Physician's Notes
Diabetes	☐		
Severe allergies	☐		
Stroke	☐		
Heart Disease	☐		
Heart Attack	☐		
Blood clots in lungs or legs	☐		
High Blood Pressure	☐		
High Cholesterol	☐		
Kidney Disease	☐		
Osteoporosis	☐		
Hepatitis	☐		
Thyroid problems	☐		
Colitis / Crohn's	☐		
HIV / AIDS	☐		
Tuberculosis	☐		
Birth Defects	☐		
Drinking or Drug problems	☐		
Breast Cancer	☐		
Colon Cancer	☐		
Ovarian Cancer	☐		
Uterine Cancer	☐		
Other Cancer:	☐		
Mental Illness/Depression	☐		
Alzheimer's	☐		
Other:	☐		
	☐		

Social & Lifestyle

Habits	Yes	No	Details	Notes
Current Tobacco Use	☐	☐	Packs per day:	
Past Tobacco Use	☐	☐	Packs per day:	
Quit?	☐	☐	When?	
Alcohol consumption	☐	☐	Per day?	
Types:			Per week?	
Recreational Drug Use	☐	☐	Type:	
Ever been treated for drug or alcohol abuse	☐	☐	When?	
Seat Belt Use	☐	☐		
Caffeine Use (coffee, tea, cola)	☐	☐	Cups per day?	
			Type?	
Regular Exercise?	☐	☐	How much?	
Types:				
Health Hazards at home / work?	☐	☐		
Social				
Happy with relationship status?	☐	☐		
Do you have a good support network of family and friends?	☐	☐	Who?	
What is your predominant emotion?				
Lifestyle				
Do you enjoy your work?	☐	☐	Hours per week:	
Stress Level	☐ Low	☐ Medium	☐ High	
Stress source	☐ Money	☐ Job	☐ Family/ Relationship	
What do you do to relieve stress?				

Sleep	Yes	No	Details	
Problems falling asleep?	☐	☐		
Problems staying asleep?	☐	☐		
Do you wake during the night?	☐	☐		
Do you wake rested in the am?	☐	☐		
Usual bed time / rising time:		Hours of sleep daily:		
Dreams?				
Diet				
Do you follow a particular Diet?				
Known food allergies / intolerances?				
What is a typical breakfast for you?				
Typical Lunch?				
Typical Dinner?				
Snacks?		Dessert / Treats?		
How much water do you drink per day?				

EXAM AND IMAGING HISTORY (Indicate date, doctor's name or place of most recent)

Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Colonoscopy		STD screen	
Prostate check		Cholesterol screen	
TB test		Bone density check	

IMMUNIZATION HISTORY

Immunization	Date	Boosters
Tetanus – Diphtheria		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu shot		
Other:		

_____ _____

Patient Signature *Date*

_____ _____

Signature of Physician *Date reviewed with patient*

CONSENT FOR TREATMENT

GENERAL INFORMATION: Dr. Bowen incorporates a wide variety of clinical tools in her practice. Most patients will receive a combination of treatment methods drawing from her varied background in nutrition, counseling, herbal medicine and other naturopathic medicine approaches. Diagnosis and treatment may include methods from any or all of the following treatment approaches: Naturopathic Medicine, Physical Medicine, Homeopathy, Lifestyle and Nutritional Counseling as well as referrals to other skilled clinicians.

METHODS, PROCEDURES AND THERAPEUTIC APPROACHES: Dr. Bowen may perform any of the following procedures as necessary to give proper diagnosis, determine treatment approaches or otherwise address your health concerns:

- ***General Diagnostic Procedures***: including but not limited to: blood collection, imaging orders (ultrasound, x-ray, MRI, CT), lab analysis of blood, urine and stool, general physical exam, neurological and musculoskeletal assessments. Most of these procedures will be performed outside of the clinic.
- ***Counseling***: Compassionate and reflective listening, coaching in healthy lifestyle changes, nutrition and exercise.
- ***Topical Treatments and Prepping***: prepping skin for puncture with alcohol, iodine or other antiseptic agents.
- ***Herbs and Natural Medicines:*** prescription of vitamins, minerals, and dietary supplements to achieve therapeutic goals; prescription and / or application of herbs in capsules, powders, teas, tinctures, plasters, pastes, suppositories, creams, salves, etc.; as well as highly dilute homeopathic remedies, intramuscular vitamin injections.
- ***Soft Tissue Manipulation:*** use of massage, neuro-muscular techniques, muscle energy stretching and visceral manipulation.
- ***Thermal Therapies:*** includes the use of hydrotherapy and applications of heat and cold.
- ***Minor Office Procedures:*** such as laceration care and cerumen removal
- ***Contraception***: counseling and prescription
- ***Pharmaceutical prescriptions:*** of herbs, nutrients, hormones and antimicrobials when necessary

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. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a 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 Dr. Bowen, regarding cure or improvement of my condition. 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 my representative or me or otherwise permitted or required by law.

_____	_____	_____
Patient Name (PRINTED)	Patient Signature	Date

CLINIC POLICIES

FEES

- **Office Visits**: Fees for appointments are determined by many factors including time spent, procedures performed and complexity of your health care needs. We can give an estimate for each visit upon patient request. Late patients will be charged for the full price of the original appointment duration.
    - INSURANCE. We are out-of-network with all insurance companies. All visits must be paid for in full at the time you are seen. Some lab orders and prescriptions may be eligible for insurance coverage. Any non-covered services or any non-covered fees are the patient's responsibility. You may be eligible for out-of network reimbursement for visits or other services. Please request a "coded bill" at your visit to submit to your insurance company for possible patient reimbursement. Each person's insurance policy is different from the next; please check with your insurance company to ask about out-of-network reimbursement.

Laboratory Testing: All eligible laboratory tests will be billed to the patients' insurance company by the laboratory or billed to the patient if you do not carry insurance. Any remainder balance not covered by the insurance company is the sole responsibility of the patient. Some labs ordered may require patient payment and may not be eligible for insurance payment.

E-Mails: Fees may apply. The doctor is available by e-mail for simple clarification of the treatment plan or updates on health status. To ensure privacy and confidentiality laws, e-mail correspondence must be conducted through our Patient Portal. Please call to gain access to the patient portal. E-mail is not to be used for the purpose of case management. The doctor will not have your case information in front of her while replying to your e-mail so be sure to include all pertinent information in your e-mail correspondence. If your questions or health needs exceed a simple e-mail reply, we will ask you to make an appointment for an in office visit to address your healthcare needs. Please allow 24-48 hours (during business hours/days only) to receive your e-mail reply.

Phone Consultations: Phone consultations with the physician are available and will have a fee attached. This fee is not charged in the following cases: when you require clarification of your treatment plan and when the doctor has asked you to call. The office will respond to your inquiry within 24-48 business hours. If the office has not responded within 24 - 48 hours, please call the office again.

Copies/Administrative Fees: Copies of patient chart notes or any request that incurs an expense to the clinic will be charged to the client. Fees will be variable depending on the extent of the request. $25.00 minimum per request.

Appointment cancellations: Any no-show appointments or appointments cancelled **without 24 hours notice will be billed the full appointment fee**. These fees will be the patients' responsibility (not billable to insurance).
_____Initial

PAYMENT

Payment is due at the time of service for office visits and pharmacy products. Dr. Bowen accepts checks, cash, credit card (Visa, Mastercard and Discover) and money orders. Invoices and receipts are available by request.

Returned Check Fee: There is a $25 fee for each returned check.

Returned Prescriptions: You may return **unopened prescriptions purchased from Dr. Bowen, within thirty days of purchase** for a refund except for the following items: any acidophilus products, suppositories, compounded hormones and amino acids, and specially ordered or assembled items.

All fees are subject to change and patients will be kept abreast of these changes. If you have any questions regarding these guidelines please feel free to ask.

By signing below you are acknowledging agreement with the above clinic policies.

_____ _____
Signature Date

Notice of Privacy Practices ~ Acknowledgement of Receipt

Dr. Bowen is required to provide you with a copy of its "Notice of Privacy Practices" document, and to obtain written acknowledgement, if possible, that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information. It also describes your rights and explains how you may exercise those rights.

I understand that my protected health information can and will be used to:

- Provide and coordinate my treatment among health care providers
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I understand that my provider has the right to change the Notice of Privacy Practices and that I may request a current copy at any time.

My signature below acknowledges that I have: *(please check one box)*

☐ Been offered a copy of the "Notice of Privacy Practices" document and have accepted that copy.

☐ Been offered a copy of the "Notice of Privacy Practices" document and have declined to take a copy. I understand that I may request a copy at any time in the future, and will be granted a current copy upon request.

_____ _____
Patient Signature Date

_____ _____
Guardian / Representative's Signature Date

OFFICE USE ONLY:

I hereby affirm that Bothell Natural Health Center has made a good faith effort to provide a copy of the Notice of Privacy Practices document to the above named patient, and to obtain written acknowledgement of such.

Staff Initials_____

☐ Patient was offered form but refused to sign
☐ Patient was physically unable to sign acknowledgement
☐ Communication barriers
☐ Other _____

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 CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of you health information and how we may disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to an insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to reasonable requests on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a

requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosure of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies or procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer. For more information about HIPAA or to file a complaint or for written inquiries, send inquiries to address below:

"Attention Privacy Officer."
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington D.C. 20201

Or call:
Phone: (202) 619-0257 Toll Free: 1-877-696-6775