PATIENT PROFIILE

Section I: Patient Information

Today's Date: _____

Last Name: _____ First Name:_____ Birth Date: _____

Sex: M / F / Non-Binary ☐ Transgender

Nick Name (goes by): _____Marital Status: ____ Single ____ Married ____Divorced

Address: _____

City / State: _____ Zip: _____

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

Preferred E-Mail: _____ Permission to call/text/e-mail: Y / N

Employer Name and Address: _____

Occupation: _____

Name of Spouse/Partner: _____

Emergency Contact: _____ Phone:(_____)_____-_____

How did you hear about Dr. Taylor-White? _____

Health Insurance Billing Information: Name of insurance: _____

Subscriber Name: _____ Birth Date: _____

Relationship to patient: _____

ID Number: _____ Group Number: _____

Section II: Current Health Concerns

PRESENT HEALTH CONCERNS: Please begin with the most important to deal with today.

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____
5. _____ For how long? _____

Olympic Naturopathic Wellness Center
Stephanie Taylor-White, ND
17528 W. Main St.
Monroe, WA 98272
Phone: (360) 794-8183 Fax: (360) 794-0305

Name: _____ DOB: _____

Section III: General Health Information

1. Are you currently seeing any health care professional (e.g., Naturopath, Medical Doctor, Chiropractor, Acupuncturist, Therapist, etc.)? Y / N

2. Please list the five most significant/ stressful events in your life, beginning with the most recent (e.g., Marriage or divorce, birth of child, career changes, moving, losses, financial, etc.)

    1. _____
    2. _____
    3. _____
    4. _____
    5. _____

Do you like your work/occupation? _____

Section IV: Personal Health Habits

Smoker: No / Yes now / Yes in the past Smoked for _____ years Amount per day _____
Year stopped _____

Alcohol: No / Yes Type: _____ Frequency: _____

Recreational Drugs: No / Yes Type: _____ Frequency: _____

Coffee: No / Yes Cups per day: _____ Black Tea: N / Y Describe: _____

Sodas: No / Yes Type: _____ Cans per day: _____

Sleep: Is your sleep restful? No / Yes Hours per night: _____

Regular Exercise: No / Yes Describe: _____

Name: _____ DOB: _____

Section V: Your Medical History

Please check if you have any of the following or have had in the past.

- ☐ AIDS/HIV+
- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Back pain
- ☐ Bladder/urinary problems
- ☐ Cancer
- ☐ Chest pain
- ☐ Colitis/Irritable bowel syndrome
- ☐ Frequent colds/flu's/sore throat
- ☐ Diabetes
- ☐ Digestive disturbances
- ☐ Ear or hearing problems
- ☐ Edema/water weight
- ☐ Epilepsy
- ☐ Eye problems/cataract/glaucoma
- ☐ Fatigue, chronic
- ☐ Female gynecological problems
- ☐ Frequent antibiotic use
- ☐ Gall blader/liver problems
- ☐ Gum/teeth problems
- ☐ Hair falling out
- ☐ Hay fever
- ☐ Headaches
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Impotence/sexual problems
- ☐ Jaundice
- ☐ Kidney/urinary problems
- ☐ Panic attacks
- ☐ Parasites
- ☐ Prostate problems
- ☐ Psychological difficulties/depression/suicide
- ☐ Sexual abuse
- ☐ Sinusitis/sinus congestion
- ☐ Skin problems/rashes
- ☐ Stroke
- ☐ Thyroid problems

Infectious Diseases

- ☐ Hepatitis
- ☐ Mono/Epstein bar
- ☐ Rheumatic fever
- ☐ Sexually transmitted diseases (herpes, gonorrhea, chlamydia)
- ☐ TB

Immunizations

- ☐ MMR
- ☐ DPT
- ☐ HEP B
- ☐ Polio
- ☐ Other _____

Section VI: Family Medical History

Please list any illnesses in your family:

Father: _____

Mother: _____

Siblings: _____

Children:

_____

_____

Please mention any significant illnesses/diseases of your grandparents, aunts, uncles, etc.:

_____

_____

Name: _____ DOB: _____

Section VII: Medications/Hospitalizations

Please list all your ***prescription medications*** (including sleeping pills, birth control pills, etc.), ***non-prescription medications*** (such as aspirin, Tylenol, antacids, laxatives, antihistamines, etc.) , ***Vitamins, herbs***, etc., that you take on a regular basis.

_____

_____

_____

Please list any known ***allergies*** you have to drugs, food, or other substances such as pollen, mold, chemicals, etc.

_____

_____

_____

Please list any ***hospitalizations, surgeries, serious illnesses*** you have had and the year occurred.

_____

_____

_____

Is there anything else you would like the doctor to know?

_____

_____

_____

_____

_____

Identi-T™ Stress Assessment

Name _____ **Age** _____ **Sex** _____ **Date** _____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I...

Section A:

1.	Get wound up when I get tired and have trouble calming down	0	1	2	3
2.	Feel driven, appear energetic but feel "burned out" and exhausted	0	1	2	3
3.	Feel restless, agitated, anxious, and uneasy	0	1	2	3
4.	Feel easily overwhelmed by emotion	0	1	2	3
5.	Feel emotional — cry easily or laugh inappropriately	0	1	2	3
6.	Experience heart palpitations or a pounding in my chest	0	1	2	3
7.	Am short of breath	0	1	2	3
8.	Am constipated	0	1	2	3
9.	Feel warm, over-heated, and dry all over	0	1	2	3
10.	Get mouth sores or sore tongue	0	1	2	3
11.	Get hot flashes	0	1	2	3
12.	Sleep less than seven hours a night	0	1	2	3
13.	Have trouble falling asleep and staying asleep	0	1	2	3
14.	Worry about high blood pressure, cholesterol, and triglycerides	0	1	2	3
15.	Forget to eat and feel little hunger	0	1	2	3

Total points: _____

Section B:

1.	Find myself worrying about things big and small	0	1	2	3
2.	Feel like I can't stop worrying, even though I want to	0	1	2	3
3.	Feel impulsive, pent up, and ready to explode	0	1	2	3
4.	Get muscle spasms	0	1	2	3
5.	Feel aggressive, unyielding, or inflexible when pressed for time	0	1	2	3
6.	See, hear, and smell things that others do not	0	1	2	3
7.	Stay awake replaying the events of the day or planning for tomorrow	0	1	2	3
8.	Have upsetting thoughts or images enter my mind again and again	0	1	2	3
9.	Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over	0	1	2	3
10.	Worry a lot about terrible things that could happen if I'm not careful	0	1	2	3

Total points: _____

Section C:

1.	Have muscle and joint pains	0	1	2	3
2.	Have muscle weakness	0	1	2	3
3.	Crave salt or salty things	0	1	2	3
4.	Have multiple points on my body that when touched are tender or painful	0	1	2	3
5.	Have dark circles under my eyes	0	1	2	3
6.	Feel a sudden sense of anxiety when I get hungry	0	1	2	3
7.	Use medications to manage pain	0	1	2	3
8.	Get dizzy when rising or standing up from a kneeling or sitting position	0	1	2	3
9.	Have diarrhea or bouts of nausea with or without vomiting for no apparent reason	0	1	2	3
10.	Have headaches	0	1	2	3

Total points: _____

Metagenics
Genetic Potential Through Nutrition

Section D:

1.	Have trouble organizing my thoughts	0	1	2	3
2.	Get easily distracted and lose focus	0	1	2	3
3.	Have difficulty making decisions and mistrust my judgment	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6.	Am forgetful	0	1	2	3
7.	Feel unsettled, restless, and anxious	0	1	2	3
8.	Wake up tired and unrefreshed	0	1	2	3
9.	Experience heartburn and indigestion	0	1	2	3
10.	Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1.	Feel tired for no apparent reason	0	1	2	3
2.	Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3.	Find it difficult to concentrate and complete tasks	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6.	Have little or no interest in sex	0	1	2	3
7.	Sweat spontaneously during the day	0	1	2	3
8.	Feel puffy and retain fluids	0	1	2	3
9.	Sleep more than nine hours a night	0	1	2	3
10.	Have poor muscle tone	0	1	2	3
11.	Have trouble losing weight	0	1	2	3
12.	Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13.	Have no energy and feel physically weak	0	1	2	3
14.	Am susceptible to colds and the flu	0	1	2	3
15.	Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B & C:** _____
Add points from sections C, D & E	**Total for C, D & E:** _____

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   _____
3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

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These certifications for Good Manufacturing Practices demonstrate the Metagenics commitment to purity and quality.

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☒ Past month ☐ Past week ☐ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

For Practitioner Use Only:

OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)

XTT SCORE _____ (High >10; moderate 5-9: Low <4)

50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom Specific Support

Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

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Dr. Douglas K. White and Dr. Stephanie Taylor-White
Naturopathic Physicians

PATIENT RESPONSIBILITY AND INSURANCE DISCLOSURE

Olympic Naturopathic Wellness Center understands how difficult it can be to determine the costs your insurance plan may or may not cover for alternative health care services. This questionaire is designed to assist you with your personal insurance account information. Please use the following questions to help you understand and verify your insurance benefits when you call the toll free number on your insurance card.
We DO NOT verify benefits for you.

You should know the following:

- Does the plan cover Naturopathic Doctors?
- Do you need a referral to see a Naturopathic Doctor?
- Is there a limit on the number of visits per year?
- Is there a maximum dollar limit per family member on coverage annually?
- Is there a maximum percentage per family member on coverage annually?
  - Insurance rarely covers the entire office visit
  - You will receive a bill for the portion your insurance deems your responsibility
- Is there a maximum dollar limit for specialists?
  - i.e.; massage, physical therapy, acupuncture, or any other specialist
- Does the insurance plan cover lab test/results?
- What is your deductible?
- Do you have a co-payment?
  - These are due at time of office visit

By signing below, I agree to be personally and financially responsible for services not covered by my insurance plan or for any services not covered as outlined above.

Patient Signature:_____ Date:_____

Patient Name Printed:_____

Parent or Responsible Party Signature (if a minor):_____

OR

I have **NO health insurance/or coverage under my current insurance plan**, therefore, I agree to be personally and financially responsible for services rendered and I will pay for the office charges at the time of service.
Patient Signature:_____ Date:_____

Patient Name Printed:_____

Please note Medicare does NOT pay for Naturopathic services.

Olympic Naturopathic Wellness Center
Douglas K. White, ND & Stephanie Taylor-White, ND

17528 W. Main St., Monroe, WA 98272 Phone: (360) 794-8183 Fax: (360) 794-0305

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on January 1, 2010 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Notice of Privacy Practices at any time.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when required to do so by law (court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION Cont'd

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. We are happy to give patients a copy of their lab tests when they come in. Requests beyond this may be charged as much as $2.00 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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Douglas K. White, ND ~ Stephanie Taylor-White, ND
17528 W. Main St., Monroe, WA 98272 Phone: (360) 794-8183 Fax: (360) 794-0305

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to offer you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____
_____
_____

_____ _____
Employee signature *Date*

Olympic Naturopathic Wellness Center
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17528 W. Main St., Monroe, WA 98272 Phone: (360) 794-8183 Fax: (360) 794-0305

CONSENT TO LEAVE MESSAGES & EMAIL / SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I have received or been offered a copy of Notice of Privacy Practices. I further understand that, in order for us to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission for us to do so.

Consent for Leaving Messages

I understand that when I give my consent, information regarding my or my child's (under the age of 18) lab test results or detailed appointment reminders/instructions may be left on my voice mail or answering machine. I understand that "sensitive" information as noted below will be excluded. (note: We do not sell/share your information to any third party. We will respond to your emails and send only occasional newsletters from our office.)

I give my permission for messages to be left on my phone number(s) below. Also, please circle the number which you prefer to receive your messages on.

☐ Cell #_____ ☐ Home #_____ ☐ Work #_____

☐ I prefer not to have voice mail messages from the clinic.

Consent for Email Communication

I understand that email communication is not strictly protected. We do not share/sell your email address to any third party. Also, our outgoing email is limited to responses to your emails or requests.

☐ I consent to email communication and my preferred email address is: _____

☐ I prefer not to be contacted via email.

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

The name(s) listed below are family members or friends to whom I grant permission for my health care providers and their representatives at our clinic to verbally discuss my care using their best judgment, and grant them permission to disclose health information that is relevant to my care or relevant for payment.

I understand that I must check the specific boxes in order for my provider or his/her designee to release any information considered as "sensitive".

☐ Mental Health/Psychiatric disorders (including depression)
☐ Chemical Dependency (drug and or alcohol abuse/treatment)
☐ Pregnancy information
☐ HIV/AIDS Virus
☐ Sexually Transmitted Diseases

	NAME	RELATIONSHIP	PHONE NUMBER
1.			
2.			
3.			

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

Printed Name (Patient/Parent) _____ Signature (Patient/Parent) _____ Date