PATIENT INTAKE FORM

PATIENT INFORMATION

Name:	DOB: / /	Gender: M F X T
Single Married Partnered Divorced Widowed Other		# of people in household: # of children:
Occupation:		Employer/School:
Travel outside the U.S? y n		Where/When:
Why are you coming in today?		

CONTACT INFORMATION

Home Address: City, State, Zip Code:			
Phone numbers:	home _____	cell _____	work _____
Please circle the numbers at which we may call you regarding confidential information.			
E-mail address:			
Spouse or Partner's Name, if any:			
Emergency Contact:	home phone #:		
Relationship to patient:	work phone #:		
May we send confidential information (e.g., lab results) to your home address?		y	n
To your email address?		y	n

REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care / seeing a physician? y n For?			
Do you currently have a primary care physician? y n If so, please provide us with your PCP's contact information (name, clinic name, address, and telephone number)			
Please list any additional health care providers from whom you receive care (name, specialty, and contact information if possible:			
How did you hear about Dr. Fasig?	Insurance referral:	Physician referral:	
Name of reference:	Patient referral:	Other:	

INSURANCE INFORMATION

Dr. Fasig is contracted with the following insurers and networks: Premera, Lifewise, Regence and the First Choice Health PPO network. Other insurers may cover Dr. Fasig at an out-of-network level (often 50% or more--please check with your insurer). NOTE: You are responsible for checking your specific insurance plan to determine if Dr. Fasig is listed as a PPO and/or if it has Naturopathic medical coverage. If you have coverage under one of these insurers, please present your insurance card and photo ID on arrival. Co-payments are due at time of service. If you are not covered by one of these insurers, payment is due at the time of visit. On request we will provide a billing statement you can submit to your insurer in the event that your insurer may reimburse you

for the visit. Cancellation of, or a failure to show for, an appointment without 24 hour notice (by e-mail or voicemail message) will result in a minimum $50.00 fee.

I do not bill PIP or L & I claims (these would be out of pocket).

I do not charge for brief telephone conversations in which we discuss ongoing treatment or administrative matters. However, although diagnosis generally requires an office visit, and I do not consult with new patients by telephone, a telephone consultation may be appropriate if you are an established patient. The minimum charge for such consultations is $50 (per 5-10 minutes). Even if I am contracted with your insurance, it does not cover these consultations, and you will be subsequently billed. I do not offer video consultations. Medical forms are $40 per 5 pages (although some will require an office visit).

I, the undersigned, certify that I have, or my dependent has, insurance coverage with _____ and assign directly to Dr. Fasig all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including those paid by Dr. Fasig on my behalf, whether or not paid by my insurer. I hereby authorize Dr. Fasig to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible party signature Date

Primary coverage

Person responsible for account:	
Relationship to patient:	Occupation:
Employer:	Birthdate:
Social Security Number:	Phone:
Address:	
Insurance company:	Contract #
Group#	Subscriber #
Names of any dependents covered under this plan: _____ _____	

Are you covered by any additional insurance? y n

Person responsible for account:	
Relationship to patient:	Occupation:
Employer:	Birthdate:
Social Security Number:	Phone:
Address:	
Insurance company:	Contract #
Group#	Subscriber #
Names of any dependents covered under this plan: _____ _____ _____	

HEALTH CONCERNS/SYMPTOMS

HEALTH CONCERNS

(Please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant?	y n # of months:
Is your condition related to	work-related injury auto accident
What are your goals for today's visit and for your long-term health?	
What do you expect of your physician?	

SYMPTOMS (Circle any symptoms you have or have had in the last twelve months)

General

Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness
Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

Arms Back
Legs Feet
Hips Hands
Neck Shoulders

Genito-Urinary

Blood in urine
Frequent urination
Lack of bladder control
Painful urination

Gastrointestinal

Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

Cardiovascular

Chest pain
High blood pressure
Irregular heartbeat
Low blood pressure
Poor circulation
Rapid heartbeat
Swelling of ankles
Varicose veins

Eyes, Ears, Nose, Throat

Bleeding gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hayfever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems
Sore throat

Skin-related

Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sores that won't heal
Eczema/psoriasis

HEALTH HISTORY

CHEMICAL EXPOSURE

Please indicate any known chemical exposure, past or present, to any of the following toxic substances?		
Mercury	Lead	Arsenic
Herbicides/Pesticides	Formaldehyde	Other:

MEDICATIONS & SUPPLEMENTS

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

CURRENT/PREVIOUS CONDITIONS

Please indicate any condition(s) you have been diagnosed as having:

ADD/ADHD	German Measles	Mumps
Alcoholism	Glaucoma	Pacemaker
Anemia	Goiter	Pneumonia
Anorexia	Gonorrhea	Polio
Anxiety	Gout	Prostate Problem
Appendicitis	Heart disease	Psychiatric Care
Arthritis	Hepatitis	Rheumatic Fever
Asthma	Hernia	Rubella
Back/Neck Pain	Herpes	Scarlet Fever
Bladder infection	High blood pressure	Schizophrenia
Bleeding disorders	High Cholesterol	STDs
Breast Lump	HIV/AIDS	Strep throat
Bronchitis	Hives or Eczema	Stroke
Bulimia	IBS	Suicide Attempt
Cancer	Infectious Mono	Thyroid disease
Cataracts	Kidney disease	Tonsillitis
Chemical Dependency	Liver Disease	Tuberculosis
Chickenpox	Low blood pressure	Typhoid Fever
Crohn's disease	Lupus	Ulcer
Depression	Measles	Ulcerative colitis
Diabetes	Migraines	Vaginal Infections
Emphysema	Miscarriage	Venereal Disease
Epilepsy	Mitral valve prolapse	Whooping cough
Fibromyalgia	Multiple Sclerosis	Other (please list):

HEALTH HISTORY

Known allergies:			
Iodine	Sulfa drugs	Aspirin	Scents
Penicillin/antibiotics	Local anesthetics	Nuts	Other:

Please describe (indicating the date) any serious illnesses, hospitalizations, or operations:

Have you ever been physically or emotionally abused?	y	n
Do you have concerns with abuse/violence currently?	y	n

Have you ever had a blood transfusion?	y	n	Date?

Does your occupation expose you to:	Heavy lifting Standing long hours Sitting long hours Stress	Hazardous substances: _____ _____ _____

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	
Other:			

IMMUNIZATION HISTORY

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

HOSPITALIZATIONS

Year	Hospital	Reason & Outcome

SOCIAL & LIFESTYLE

Habits	Yes	No	Details
Current Tobacco Use			Packs per day:
Past Tobacco Use			Packs per day:
Quit?			When?
Alcohol consumption Types?			Per day? Per week?
Recreational drug use			Type:
Drug/Alcohol abuse treatment?			When?
Caffeine (coffee, tea, soda)			Cups per day: Type:
Regular exercise? Types:			How much?
Health Hazards at home/work			

Social			
Are you happy with the status of your relationship?	y	n	
Do you have a strong support network (family/friends)?	y	n	Who?
What is your predominant emotion?			

Lifestyle				
Do you enjoy your work?	y	n	Hours per week:	
Stress level:	low	medium	high	
Source of stress:	money	job	family/relationship	
What do you do to relieve stress?				

MALE HEALTH INFORMATION

Condition	Never	Past	Current
Difficult urination			
Testicular pain/swelling			
Impotence/sexual difficulties			
Prostate problems			

FEMALE HEALTH INFORMATION

Obstetric history			
Are you currently pregnant?	y	n	# of months:
Have you ever been pregnant?	y	n	When?
Age at first pregnancy?	Number of pregnancies?		
Adopted children?	y	n	When?
Number of living children?	Number of stillbirths?		
Number of miscarriages?	When in pregnancy?		
Number of tubal pregnancies?			
Number of abortions?	When in pregnancy?		
Number of Caesarean sections?	Date of last pregnancy?		
Difficulty conceiving?	y	n	
Difficulty with pregnancy?	y	n	
Difficulty with labor or delivery?	y	n	
Difficulty with breast feeding?	y	n	
Future OB plans	y	n	

Menstrual history						
Age at first period:			Date last menstrual period began:			
Age at first pregnancy:			Periods regular?		y	n
# of pregnancies:			Days between periods:			
# of living children			Length of flow			
# of stillbirths			Heaviness of flow			
# of miscarriages	When in pregnancy?		Color of flow?			
# of tubal pregnancies			Clots?		y	n
Number of abortions:			Clot size?	Small	Medium	Large
When in pregnancy?			Pain with ovulation?		y	n
Pain with menses?	y	n	Menopause?		y	n
PMS symptoms	None Bloating/swelling Breast tenderness		Acne Digestive changes Fatigue		Mood swings Headache Other:	

Vaginitis symptoms	**Never**	**Past**	**Current**
Discharge			
Irritation			
Itching			
Odor			
Pain with sex			
Trichomoniasis			
Bacteria (BV)			
Yeast			
Risk Factors			
History of abnormal paps?		y	n
Did your mother take DES?		y	n
Did your mother ever miscarry?		y	n
Do you do self breast exams?		y	n
Long term hormone replacement?		y	n

FAMILY HISTORY

Mother:	Living	Age:	Deceased	Cause:
Father	Living	Age:	Deceased	Cause:
Brother	Living	Age:	Deceased	Cause:
Brother	Living	Age:	Deceased	Cause:
Brother	Living	Age:	Deceased	Cause:
Sister	Living	Age:	Deceased	Cause:
Sister	Living	Age:	Deceased	Cause:
Sister	Living	Age:	Deceased	Cause:
Child:	Living	Age:	Deceased	Cause
Child:	Living	Age:	Deceased	Cause
Child:	Living	Age:	Deceased	Cause
Has any family member had:			**Which relative?**	**Age of onset**
Diabetes				
Arthritis				
Asthma				
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 disease				
HIV/AIDS				
Tuberculosis				
Birth defects				
Drinking/drug problems				
Breast cancer				
Colon cancer				
Ovarian cancer				
Uterine cancer				
Other cancer: _____				
Mental illness/depression				
Alzheimer's				
Other: _____				
Other: _____				

I certify that the information provided in this form is correct to the best of my knowledge. I will not hold Dr. Fasig responsible for any error or omission I may have made in the completion of this form.

Patient's signature Date

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

NOTICE OF PRIVACY PRACTICES

Effective December 8, 2006

The following is the privacy policy ("Privacy Policy") of Dr. Amy Fasig ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

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. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a

summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Dr. Amy Fasig, 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law.

We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Dr. Amy Fasig, 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Dr. Amy Fasig at 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109; by telephone at 206-599-6030, or by e-mail at dr.amyfasig@gmail.com. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent Dr. Amy Fasig, 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Dr. Amy Fasig at the address, telephone number, or e-mail address listed above.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT

I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

Name _____Date of Birth_____

Signature _____ Date _____