



**CONFIDENTIAL PERSONAL INFORMATION**

Full Legal Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Preferred Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(street#/PO Box) (city) (state) (Zip code)

Telephone # (\_\_\_\_) \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_ / (\_\_\_\_) \_\_\_\_\_  
(home) (work) (cell phone or other)

E-mail address: \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Are you (check one): Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_ Partner's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ (circle) Full time/ Part time /Student/ Retired

Employer / School: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact \_\_\_\_\_  
(Name) (Relationship)

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).  
Is there any place you do **NOT** want me to leave a message? \_\_\_\_\_

**Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.**

May Dr. Hodsdon send you educational/promotional materials such as newsletters via e-mail?  Yes  No

May Dr. Hodsdon discuss your private medical information with you via e-mail?  Yes  No

**Insurance Information – Please provide copy of front and back of Insurance card.**

**Group Insurance:** Insurance Co: \_\_\_\_\_

Insured Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / (\_\_\_\_)  
(street / PO Box) (City) (State) (Zip Code) (Phone Number)

**MVA:** Date of MVA: \_\_\_\_\_ State MVA occurred: \_\_\_\_\_ Claim number: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Claim submitted  Y  N Adjuster: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ PIP Coverage: \_\_\_\_\_

**Do you have any secondary or additional Insurance plans?**  Yes  No Name: \_\_\_\_\_

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature of Patient \_\_\_\_\_ Today's Date \_\_\_\_\_

**CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE**



Name: \_\_\_\_\_ Date: \_\_\_\_\_

What are the concerns for which you are seeking care? (Primary concern first)

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_
2. \_\_\_\_\_ Date of onset: \_\_\_\_\_
3. \_\_\_\_\_ Date of onset: \_\_\_\_\_
4. \_\_\_\_\_ Date of onset: \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_  
(Name) (Phone if known)

For what concern did you last receive health or medical care? \_\_\_\_\_

**Medications and Supplements**

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you currently taking? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Check each that you currently use:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Laxatives      | <input type="checkbox"/> Pain relievers         | <input type="checkbox"/> Antacids            | <input type="checkbox"/> Cortisone          |
| <input type="checkbox"/> Antibiotics    | <input type="checkbox"/> Heart/Blood medication | <input type="checkbox"/> Allergy Medication  | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Anti-depressants       | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Hormones           |

Do you have any known contagious diseases at this time?  Yes  No If yes, what? \_\_\_\_\_

**Family History**

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

- |                     |                           |                      |
|---------------------|---------------------------|----------------------|
| Cancer _____        | Diabetes _____            | Epilepsy _____       |
| Heart Disease _____ | High Blood Pressure _____ | Stroke _____         |
| Anemia _____        | Kidney Disease _____      | Glaucoma _____       |
| Allergies _____     | Asthma _____              | Mental Illness _____ |
| Arthritis _____     | Tuberculosis _____        | Alzheimer's Dz _____ |

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Have you have any of the following Childhood Illnesses (check if yes)**

Scarlet fever \_\_\_ Diphtheria \_\_\_ Rheumatic fever \_\_\_ Mumps \_\_\_ Measles \_\_\_ German measles \_\_\_

Have you had any immunizations?  Yes  No Negative Reactions? \_\_\_\_\_

**Hospitalizations, Surgery, X-Ray and Special Studies**

What hospitalizations, surgeries, x-rays, or special studies have you had?

\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_  
\_\_\_\_\_ year: \_\_\_\_\_      \_\_\_\_\_ year: \_\_\_\_\_

**Allergies**

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

\_\_\_\_\_

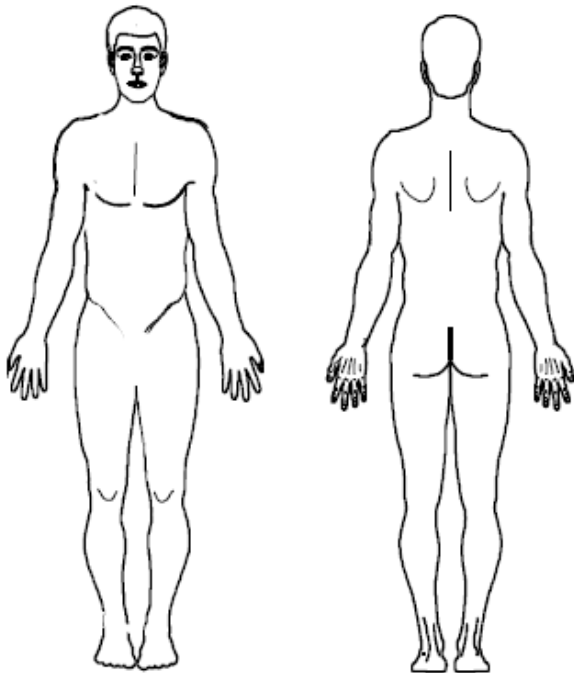
**General**

Weight \_\_\_\_\_ lbs. Height \_\_\_\_\_ Weight 1 year ago \_\_\_ lbs.  
Maximum (non pregnant) Weight \_\_\_\_\_ lbs. When \_\_\_\_\_

**Review of Symptoms**

**Answer questions or check any of the following you have or have had in the past 6 months.**

**Please shade in areas where you are experiencing pain on figures (if applicable).**



**LIFESTYLE HABITS**

- Main interests and hobbies? \_\_\_\_\_
- Exercise, what kind? \_\_\_\_\_
- How often do you exercise? \_\_\_\_\_
- \_\_\_Y \_\_\_ N Have a religious/spiritual practice
- \_\_\_Y \_\_\_ N Average 6-8 hrs. of sleep
- \_\_\_Y \_\_\_ N Have a supportive relationship
- \_\_\_Y \_\_\_ N History of abuse
- \_\_\_Y \_\_\_ N Major traumas
- \_\_\_Y \_\_\_ N Use recreational drugs
- \_\_\_Y \_\_\_ N Treated for drug dependence
- \_\_\_Y \_\_\_ N Drink coffee
- \_\_\_Y \_\_\_ N Drink black or green tea
- \_\_\_Y \_\_\_ N Drink cola or other sodas
- \_\_\_Y \_\_\_ N Add salt to your food
- \_\_\_Y \_\_\_ N Eat refined sugar
- \_\_\_Y \_\_\_ N Enjoy your work
- \_\_\_Y \_\_\_ N Take vacations
- \_\_\_Y \_\_\_ N Spend time outside
- \_\_\_Y \_\_\_ N Watch TV? How much? \_\_\_\_\_
- \_\_\_Y \_\_\_ N Read? How often? \_\_\_\_\_
- \_\_\_Y \_\_\_ N Use alcoholic beverages  
# per week \_\_\_\_\_
- \_\_\_Y \_\_\_ N Treated for alcoholism
- \_\_\_Y \_\_\_ N Use tobacco currently
- \_\_\_Y \_\_\_ N Used tobacco in the past  
How many years? \_\_\_\_\_  
How many packs per day? \_\_\_\_\_

## Review of Symptoms

**Check any of the following you have or have had in the past 6 months.**

**SKIN**

- Rashes
- Eczema, Hives
- Acne, Boils
- Itching
- Fungal Infections
- Color change
- Hair Loss
- Dry skin / scalp
- Lumps
- Night Sweats
- Slow healing ulcerations
- Flushing or hot flashes

**NOSE AND SINUSES**

- Frequent colds
- Nose Bleeds
- Stuffiness
- Hay fever
- Sinus problems
- Loss of smell

**EYES AND EARS**

- Itchy eyes
- Watery eyes
- Dry eyes
- Swollen/painful eyes
- Red Eyes
- Impaired vision/Blurriness
- Floaters in vision
- Cataracts
- Color blindness
- Double Vision
- Glaucoma
- Hearing difficulty
- Ringing
- Earaches/Infection

**MOUTH AND THROAT**

- Sore throat
- Copious saliva
- Teeth grinding
- Sore tongue/lips
- Gum problems
- Hoarseness
- Gagging/choking
- Difficulty swallowing

**HEAD / NECK**

- Headache/migraine
- Faintness
- Dizziness
- Jaw Pain
- Swollen Glands
- Goiter
- Pain or stiffness
- TMJ

**RESPIRATORY**

- Chest congestion
- Wheezing
- Asthma
- Bronchitis/Pneumonia
- Emphysema
- Difficulty/Pain breathing
- Shortness of breath
- Tuberculosis
- Cough \_\_\_ Wet or \_\_\_ Dry
- Coughing blood

**CARDIOVASCULAR**

- Heart disease
- Angina/Chest pain
- High/Low Blood Pressure
- Murmurs
- Blood clots
- Irregular heart beat
- Palpitations/Fluttering
- Swelling in ankles

**CIRCULATION**

- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Varicose veins
- Cold hands/feet

**ENDOCRINE**

- Hypothyroid
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger
- Fatigue
- Seasonal depression

**IMMUNE**

- Chronic Fatigue Syndrome
- Chronic infections
- Chronically swollen glands
- Slow wound healing

**MUSCLES / JOINTS/ BONES**

- Joint pain
- Muscle pain
- Muscle spasms / cramps
- Restless leg Syndrome
- Sciatica
- Osteoporosis

**NEUROLOGIC**

- Seizures
- Paralysis
- Muscle weakness
- Numbness or tingling
- Easily stressed
- Vertigo or dizziness
- Loss of balance
- Tics

**DIGESTION**

- Trouble swallowing
- Heartburn / Acid Reflux
- Change in thirst/appetite
- Ulcer
- Nausea/Vomiting
- Gas/Bloating
- Belching or passing gas
- Diarrhea
- Constipation
- Pain or cramps
- Mucous in stools
- Black / Bloody stool
- Hemorrhoids
- Itchy / Burning Anus
- Rectal Pain
- Liver/Gall Bladder trouble
- Jaundice (yellow skin)
- Bowel Movements: How often? \_\_\_
- Is this a change? \_\_\_\_\_
- Stools \_\_\_ Hard \_\_\_ Firm
- \_\_\_ Soft \_\_\_ Loose

### Review of Symptoms

Check any of the following you have or have had in the past 6 months.

#### URINARY

- Pain on urination
- Increased frequency
- Frequency at night
- Frequent infections
- Inability to hold urine
- Kidney stones
- Blood in urine

#### MENTAL/ EMOTIONAL

- Mood Swings
- Anxiety or nervousness
- Considered/Attempted suicide
- Depression
- Poor concentration
- Poor Memory
- Other: \_\_\_\_\_

#### GENERAL

- Poor Sleep / Insomnia
- Dream disturbed Sleep
- Fatigue / Low Energy
- General feel Hot
- General feel Cold
- Chills
- Fevers
- Poor Appetite
- Constant Hunger
- Cravings \_\_\_\_\_
- Peculiar taste in mouth
- Low Libido
- Experience High Stress

#### MALE ONLY

- Hernias
- Testicular masses
- Testicular pain
- Prostate disease
- Sexually transmitted disease
- Discharge or sores
- Sexual dysfunction
- Are you sexually active? Yes No
- Sexual orientation? \_\_\_\_\_
- Birth control? Type? \_\_\_\_\_

#### FEMALE ONLY

- Irregular cycles
- Bleeding between cycles
- Pain during intercourse
- Clotting
- Heavy or excessive flow
- PMS
- Endometriosis
- Difficulty conceiving
- Painful menses
- Vaginal discharge? Color? \_\_\_\_\_
- Vaginal Odor
- Ovarian cysts
- Menopausal symptoms
- Abnormal PAP
- Sexually transmitted disease
- Breast pain/tenderness
- Nipple discharge
- Breast Lumps
- Age at which menses began \_\_\_\_\_
- Age of last menses (if menopausal) \_\_\_\_\_
- Length of Cycle (Day 1 to Day 1) \_\_\_\_\_
- Duration of Flow \_\_\_\_\_
- Date of last period \_\_\_\_\_
- Are you sexually active? Yes No
- Sexual orientation? \_\_\_\_\_
- Birth control? Type? \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of live births \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_
- Number of abortions \_\_\_\_\_
- Difficult or premature births
- Do you do breast self-exams? Yes No
- Date of last Pap smear \_\_\_\_\_
- Date of last mammogram \_\_\_\_\_
- Could be pregnant now?
- Any other feminine difficulties? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Optional Context of Care Overview

I would like to take a moment to welcome you to my practice. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, I look forward to my role in your care. Below are a few questions that really assist me in understanding “where you’re coming from” and how I can best support your health.

1) How did you discover this clinic and how did you decide to see Dr. Wendy Hodsdon now?

2) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)  
0%    **0**    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**    100%

If you answered less than “10”, what stands between your current commitment and 100%?

3) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

4) What do you love most about your life at this time?

5) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

6) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you?

7) What are your top three expectations of me?



1) **Unless prior arrangement is made, full payment is due at the time of service.**

Your payment options are: cash, check, or credit/debit cards.  
We accept Visa, Master Card, Discover, or American Express.

2) Insurance Billing

- If you would like us to bill your insurance, we will contact your insurer(s) and bill them based upon the **non-guaranteed** information they provide to us.
- You are responsible for all co-payments, deductibles and other adjustments made by your insurer(s).
- **If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service.**
- Insurance companies may reimburse differently than the information they initially provide to us.
- **You are responsible for and will be billed for any resulting unpaid balance.**

3) Discounts

We offer the following discounts. Only one discount may be applied to a bill.

- "Time Of Service Discount"

If you are paying in full for a treatment at the time of service, you will receive a 20% discount on Naturopathic, and Massage services. This discount does not apply to co-payments, products, individual payment plans, or services other than those listed above.

- "Time Of Service Student Discount"

Students, currently enrolled in accredited natural health academic programs, will receive a 30% discount on all services and 20% discount on all products if they pay in full at the time of service.

4) Missed Appointments/Late Cancellations

All appointment cancellations must occur within 24 hours of the appointment. If it is less than 24 hours, **you will be charged \$25 for the missed appointment.**

5) Past Due Accounts

**Accounts greater than 30 days past due will be charge a \$10 administrative fee.**  
**Accounts greater than 90 days overdue will be sent to a collections agency.**

These policies are subject to change without notice.

We also post our financial policy at [www.PortlandAlternativeMedicine.com/financialpolicies](http://www.PortlandAlternativeMedicine.com/financialpolicies)

I have read, understood and agree to the policies described above:

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_



## **INFORMED CONSENT**

The purpose of this form is to present risks and benefits of the therapies I offer. **Please initial the sections that apply to you. This must be signed before treatment is rendered.** Ask me if you have any questions or concerns at any time.

### **NATUROPATHIC MEDICINE**

**Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather than focusing on symptomatic treatment. The doctors in our clinic treat a variety of conditions including women's health, stress, pain, organ dysfunction, infections, and much more. There is risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

### **MASSAGE, TRIGGER POINT THERAPY, EXERCISES, STRETCHING**

**Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The goal of massage/soft tissue therapy is to decrease the tension and tenderness, while increasing blood/lymph flow. Your problem may be caused by poor mechanics/repetitive stress, in which case, exercises or stretches may be indicated. Deep tissue work, overstretching and over-exercise may cause discomfort or injury. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased motion, and relaxation are experienced.

### **SUPPLEMENTS, HERBALS, HOMEOPATHICS**

**Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

These are products that can aid in healing by nutritional, energetic, and mechanical support; They can be effective for many conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, or orthotics may be suggested for your particular case.

### **IMAGING, REFERRALS**

**Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management (referral to a specialist such as neurologist, ENT, allergist, ect), physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

There are many alternatives to the therapies I offer. I recommend consulting with your Primary Care Physician if you have any concerns about my recommendations.

**Please inform Dr. Hodsdon of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care.**

- **I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments initialed above.**

Patient Name (Please Print) \_\_\_\_\_

Signature (Patient or Guardian if a minor) \_\_\_\_\_

Date \_\_\_\_\_

**Wendy Hodsdon, ND**  
Portland Alternative Medicine, LLC  
4425 SW Corbett Ave Portland, Oregon 97239  
Phone (503) 227-8700 Fax (503) 227-8702

[www.PortlandAlternativeMedicine.com](http://www.PortlandAlternativeMedicine.com)  
[DrWendy@PortlandAlternativeMedicine.com](mailto:DrWendy@PortlandAlternativeMedicine.com)



## Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Portland Alternative Medicine clinic and you may obtain one at any time. This Notice goes into effect February 3, 2008.

### ***Uses and Disclosures***

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

### ***Authorization***

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

**Wendy Hodsdon, ND**  
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[DrWendy@PortlandAlternativeMedicine.com](mailto:DrWendy@PortlandAlternativeMedicine.com)



### ***Patient Rights***

**Right to request restrictions on uses and disclosures:** To request a restriction, please write a request to Portland Alternative Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.

**Right to receive confidential communications:** This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact Portland Alternative Medicine Clinic. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.

**Right to inspect and copy.** Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Portland Alternative Medicine Clinic and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.

**Right to amend:** If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Portland Alternative Medicine Clinic. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.

**Right to receive an accounting of disclosures.** This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.

**Right to get a paper copy of this Notice.** At any time even if you previously agreed to receive an electronic copy.

**Right to file a complaint.** If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Portland Alternative Medicine Clinic to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

**I acknowledge having carefully read this copy of the Notice of Privacy Practices.**

Patient Name (Please print) \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_

Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.