Dear New Patient,

Welcome to Whole Health Naturopathy for your Lactation Consultation with Carrie DiStefano, IBCLC. This letter outlines the benefits of lactation services at Whole Health Naturopathy, what to bring to the appointment and, on the second page, how to inquire about your insurance benefits specific to this visit.

Benefits of scheduling at Whole Health Naturopathy:

- One-to-one, personal and in-depth interaction with lactation expert
- Payment for the visit at time of service is not required and insurance is billed on your behalf - except for the initial intake appointment (co-pays apply)
- All visits are overseen by a physician. The physician is available to step in if additional evaluation and management are required (i.e. prescription)

Please bring the following to each lactation visit:

- Mom and baby!
    - Please do not breastfeed or pump immediately before visit. Last feed is recommended to be no more than an hour before appointment time. We want to observe a feeding under normal conditions and need to assess milk supply and milk intake. Example: if appointment is at 1:30pm last feeding should be no later than 12:30. We know this is not always easy, but do your best!
- Nipple shields if you use them. Please bring all sizes you have as sometimes mothers may be using an incorrect size.
- A clean breast pump and all pump parts (if pumping is a part of your routine) so that we can check its fit
- Expressed breast milk and/or formula, and preferred device for feeding baby, if you are using either of these to supplement
- A (recent) weight history for your baby and medications/supplements that you or baby may be taking
- We welcome partners, grandparents, siblings, or helpers – as long as they are all healthy!

Please see the next page for instructions on checking insurance benefits.

Insurance coverage:

- All visits are billed under the overseeing naturopathic physician's license, and visits are billed separately for mom and baby
- Lactation visits are billed under Preventative Counseling codes. **Please call your insurance before your visit to verify if you have these benefits:**
    1. Ask if you have coverage to see a naturopathic doctor
    2. For mom and infant's portion of the visit, ask if you have Preventative Counseling benefits, CPT code 99403
    3. Inquire if your plan has benefit limits for counseling
- Insurance has not yet developed lactation codes that apply to the outpatient clinical setting (outside of a hospital or home visit setting), so inquiring about "Lactation Benefits" may be misleading
- Insurance coverage for your visits may be applied to your deductible and there may be an applicable co-pay or co-insurance.
- You will be financially responsible for the amount determined by your insurance coverage. Whole Health Naturopathy mails outpatient invoices monthly.

Thank you for taking the time to read through this and better understand insurance and lactation benefits.

Please contact us if any further clarification is needed. We look forward to meeting you and helping you meet your breastfeeding goals!

Sincerely,

Whole Health Naturopathy

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND
1212 4th Ave E / Olympia, WA 98506
T: 360-943-9519 F: 360-943-9534

REGISTRATION FORM - BABY

ESTABLISH LACTATION

Today's date	PCP

PATIENT INFORMATION

Patient's Legal Last Name	Legal First Name	Middle initial	Age	Birth Date / /	Legal Sex ❑ M ❑ F

Mother's Legal First & Last Name	Mother's Preferred Name	Father's / Partner's Legal First & Last Name	Father's / Partner's Preferred Name

Street address	E-mail Address	Home phone ( )

City	State	ZIP Code	Cell phone ( )

At which of these phone numbers can we leave a detailed message?

Chose clinic because/was referred to clinic by

Other family members seen here

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) It is your responsibility to contact your insurance company to verify coverage for Naturopathic physicians and services. Your policy may not cover claims made by this office, which will leave you responsible for the charges.

Person responsible for bill	Address (if different)	Home phone ( )

Is this person a patient here? ❑ Yes ❑ No	Date of Birth / /	Occupation

Employer	Employer address	Employer phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No		Referral needed from PCP?	
Name of primary insurance	Group number	ID number	Co-payment amount

Subscriber's name	Subscriber's Address	Subscriber's Date of Birth / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable)	Subscriber's name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home phone ( )	Work phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Whole Health Naturopathy or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

LACTATION CONSULTATION

INTAKE AND CONSENT FORM

MOTHER

Your Name _____ Your Birth Date ___/___/___ Your Age _____ Your Profession _____

Street Address _____ City _____ State _____ Zip _____

Partner's Name _____ Partner's Profession _____ Best phone to reach you: ❑ Home/Landline ❑ Cell

Phone (home/landline) _____ Phone (cell) Do you text? ❑ Yes ❑ No _____ Email _____

Note that text and email messages are not secure and cannot protect your private health information (PHI)

How would you prefer to receive the report from this consult? ❑ Email ❑ Regular Mail ❑ Faxed To: _____

Referred by: ❑ Friend/Family:_____ ❑ Hospital:_____ ❑ Doctor: _____

Website: ❑ _____ ❑ Internet search ❑ Other referral source: _____

BABY

Baby's Full Name _____ Sex: ❑ M ❑ F Due Date ___/___/___ Birth Date ___/___/___ Weeks Gestation at Birth _____

Place of Birth _____ City/State of Birth _____

INSURANCE

Insurance Company _____ Primary Insured's Name _____

Primary Insured's Employer _____ Date of Birth ___/___/___ ❑ Self ❑ Spouse ❑ Other Relationship to Mother

Member Number:_____ Group Number: _____

HEALTH CARE PROVIDERS

OBSTETRICIAN / MIDWIFE	PEDIATRICIAN
Name _____ Send report? ❑ No ❑ Yes (provide following info):	Name _____
City and State _____	City and State _____
Phone _____	Phone _____ Fax _____

I understand that:

- All medical care is to be provided by my own physician(s) and that any change from his/her/their recommendations should be discussed with him/her/them.
- A lactation consultation by the IBCLC may include a visual and manual assessment of the mother's breasts, the baby's mouth and suck, observation of the mother and baby breastfeeding, analysis of information relating to the breastfeeding situation, demonstration of techniques for improving breastfeeding, use of breastfeeding equipment, and recommendation of a care plan to resolve breastfeeding issues, which may be adjusted during the course of treatment.
- A student intern may accompany the IBCLC and participate in the consultation for training purposes.
- I am responsible for informing the lactation consultant(s) of any relevant information or changes that affect my breastfeeding situation.
- *It is my responsibility to call the lactation consultant(s) with progress reports, questions, or concerns.*
- This practice will submit a claim for direct payment of insurance benefits with participating insurance company and bill me for any remaining co-pay or fees. For those who are not insured or who are insured with a company with which we do not participate, payment for services and supplies are my sole responsibility and required at the time of service; a receipt will be provided for insurance reimbursement.

I grant consent for:

- Information about this consultation to be mailed, faxed, or emailed to my attending physician/health care providers.
- The release of any medical information necessary to process any insurance claim(s) and payment of any insurance benefits directly to this practice.
- Information from this consultation to be used for teaching purposes, with the understanding that no names or identifying features will be used.
- Treatment according to the scope of practice outlined above.

My signature below acknowledges my understanding of the conditions set forth above.

_____ _____

Client Signature **Date**

_____ **INITIALS** I give permission for photos and/or videos of my lactation visit to be taken and used solely for educational purposes, including presentations at professional conferences and workshops without further notice or compensation. No identifying information will be present in any photograph or video.

INTAKE HISTORY

PAGE ONE

Mother's Name _____

Consultation Date _____

Problem: ❑ nipple pain ❑ latch ❑ breast refusal ❑ undersupply ❑ oversupply ❑ slow weight gain ❑ multiples ❑ other_____

Others consulted about this breastfeeding issue: ❑ LC ❑ doctor ❑ nurse ❑ LLL ❑ friend ❑ family ❑ doula ❑ other _____

Ultimate breastfeeding goal: ❑ breastfeed exclusively ❑ pump exclusively ❑ bf and pump ❑ bf and supplement ❑ unsure ❑ whatever happens

YOUR HEALTH HISTORY

Any history of: ❑ thyroid ❑ ovarian cyst ❑ Polycystic Ovarian Syndrome (PCOS) ❑ diabetes (type ❑ I ❑ II) ❑ other: _____

_____

Medications currently taking (including herbs and vitamins): _____

Breast or chest surgery or injury: ❑ none ❑ reduction ❑ mastopexy ❑ augmentation ❑ biopsy ❑ injury ❑ other **Date:**_____

Conceive easily: ❑yes ❑ no (how long: _____) ❑ IVF ❑ IUI (donated: ❑ sperm ❑ egg ❑ neither)

Abortion(s): ❑ no ❑ yes (#_____ year(s) _____) **Miscarriage(s)**: ❑ no ❑ yes (#_____year(s) _____)

Miscarriage(s) reason(s): ❑ unknown ❑ _____

Number of other pregnancies: _____ **Number of other children living:** _____

BREASTFEEDING HISTORY

Number of other children breastfed: _____ **How long other child(ren) breastfed: #1:** ____ ❑ wks ❑ mos ❑ yrs

#2: ____ ❑ wks ❑ mos ❑ yrs | **#3:** ____ ❑ wks ❑ mos ❑ yrs | **#4:** ____ ❑ wks ❑ mos ❑ yrs | **#5:** ____ ❑ wks ❑ mos ❑ yrs

How did breastfeeding go with the older child(ren): ❑ easy ❑ difficult (describe): _____

_____

_____

THIS PREGNANCY

Breast changes: ❑ enlargement ❑ tenderness in first trimester ❑ leaking ❑ areola darkening **Any complications:** ❑ no ❑ yes: _____

_____

Bed Rest: ❑ no ❑ yes (start week: _____ until week_____**)** **Reason:** _____ **Pregnancy length:** _____ wks _____ day(s)

LABOR

How labor began: ❑ spontaneous ❑ induced (how: ❑ pitocin ❑ cervical gel ❑ membrane ruptured ❑ other:_____)

Where: ❑ home ❑ birth ctr ❑ hospital ❑ other **Labor:** ___ hrs **Pushing:** ____ min **Delivery:** ❑ vag (❑ VBAC) ❑ vacuum ❑ forceps ❑ C-sect

Medications during labor: ❑ pitocin ❑ epidural (#cm when started: _____) ❑ narcotic (demerol, nubain) ❑ other _____

Antibiotics: ❑ no ❑ yes (reason: ❑ strep B ❑ fever ❑ C-sect ❑ other _____) **Hemorrhage:** ❑ no ❑ yes (med to stop: _____)

LABOR EXPERIENCE: _____

_____

_____

HOSPITAL / POSTPARTUM

1st nursing: ____ min /hrs after birth ❑ easy ❑ difficult **Sides:** ❑ 1 ❑ 2 **When milk came in:** day ____ ❑ not noticed ❑ slight ❑ mod ❑ heavy

1st 24 hours frequency: every_____ hours **2nd 24 hours frequency:** every_____ hours **3rd 24 hours frequency:** every_____ hours

❑ **Circumcision** (Day _____) **Pacifier:** ❑ no ❑ yes (when began: day_____) **Separation:** ❑ none ❑ some ❑ night ❑ mostly nursery ❑ NICU

Baby complications: ❑ jaundice ❑ hypoglycemia ❑ other _____ **How treated:** _____

INPATIENT BREASTFEEDING EXPERIENCE: _____

_____

_____

_____

_____

INTAKE HISTORY

PAGE TWO

AT HOME

FEEDINGS: **How often**: ____ min/hrs **LATCHING**: ❑ easy ❑difficult ❑ impossible **Who ends:** ❑ me ❑ baby **Avg length:** ____ min

Nipple pain: ❑ none ❑ some ❑ moderate ❑ severe **Which nipple(s)**: ❑ L ❑ R **When began**: _____ ❑ days ❑ weeks ❑ months

SUPPLEMENTING: ❑ no ❑ yes **When began**: ____ days **How:** ❑ bottle ❑ cup ❑ syringe ❑ dropper ❑ spoon ❑ finger-feeder ❑ tube

When: ❑ before nursing ❑ after **How often:** ❑ every feed ❑ _____ x/day **How much:** ____oz/cc /feeding **What:** ❑ formula ❑ pumped milk

PUMPING: ❑ no ❑ yes **When began**: ____ days **How often:** _____ x/day **Avg amt:** _____ **Flange size** (imprinted on side): _____

Pump condition: ❑ new ❑ used (how long: _____ mths/yrs) **Pump Type**: ❑ rental ❑ owned (brand: _____)

POST-DISCHARGE BREASTFEEDING EXPERIENCE:_____

_____

_____

_____

_____

_____

_____

_____

Vaginal bleeding now: ❑ light ❑ moderate ❑ heavy ❑ over **Color:** ❑ bright red ❑ dark red ❑ brown

WHERE BABY SLEEPS: ❑ in our room ❑ in her/his room ❑ other:_____ **What baby sleeps in**: ❑ our bed ❑ co-sleeper ❑ crib/bassinet

NUMBERS

BABY'S WEIGHT HISTORY

DATE	WHERE WEIGHED	WEIGHT
BIRTH		

DIAPER OUTPUT HISTORY

DAY	Last 24 Hours	Last 25-48 Hours	Last 49-72 Hours	Last 73-96 Hours	Last 97-120 Hours
No. of Stools					
Stool Qty	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful	❑ More than a spoonful
Stool Color	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow	❑ Black ❑ Brown ❑ Green ❑ Yellow

Attend breastfeeding mothers' group: ❑ no ❑ yes (Where: _____)

Ideally, want to breastfeed: _____ ❑ months ❑ years ❑ until baby weans self **Returning to work (outside home):** ❑ no ❑ yes (At _____ ❑ wks ❑ mos)

Whole Health Naturopathy

Marnie Frisch ND & Savahn Rosinbum ND

Financial Policy

Health insurance is a contract between the patient and their insurance carrier. The insurance policy lists a package of medical benefits such as treatment services, tests, office visits and therapies. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are your covered services.

Your policy also lists the kinds of services that are not covered by your insurance company. These are your exclusions. You must pay for any uncovered medical care that you receive. Keep in mind that a medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy. Insurance companies determine what tests, therapies and services they will cover. Your insurance company's choices may mean that the test, therapy or service you need isn't covered by your policy.

By understanding your insurance coverage, you can help your doctor recommend care that is covered in your plan. Whole Health Naturopathy will try to be familiar with your insurance coverage so we can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor or our staff to know the specific details of each plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Your insurance company, not your doctor, makes decisions about what will be paid and what will not.
- Your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health.

Some services, tests or therapies recommended by your provider may not be covered by your insurance policy. When you have a test or treatment that isn't covered, your insurance company won't pay the bill. You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself. Claims may not be resubmitted with different codes if they have been denied for lack of coverage.

Preventive office visits

Well-child exams, annual gynecological exams, and routine physicals are coded differently from standard office visits and are based on the age of the patient and whether you are a new or established patient. Your preventive benefits only cover services provided in the absence of illness or complaints. Legally we are not permitted to resubmit claims with a new diagnosis or procedure code if the claim was accurately submitted as a non-preventive visit and covered differently by your insurance company. If there are additional concerns brought up at these preventive office visits, there will be an additional brief office visit fee.

Billing:

If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Please note: Labs and other ancillary services – i.e. testing, medical imaging, etc. are not part of our practice. Please call the number(s) listed on those statements for assistance.
It is the policy of Whole Health Naturopathy to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa or MasterCard.

We will submit your insurance claims directly to any insurance your provider is contracted with, provided the information we have obtained from you is accurate and complete, however the patient assumes responsibility for all unpaid balances, co-payments, and deductibles due, as well as any non-covered service by the insurance company, including cost of collection. It is the patient's responsibility to provide the most current insurance information to our office at the time services are rendered. A rebilling charge of **$5.00** will be added if claims need to be resubmitted to the correct insurance company.

It is your responsibility to know the limits and exclusions to your insurance coverage.

AUTOMOBILE ACCIDENT PATIENTS: We do treat automobile accident patients. However, we are unable to monitor long-term accounts and we will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.
SELF-PAY PATIENTS: If you have no insurance coverage for our services, we offer a discount on office visits and procedures. Payment in full is due at the time of service. We are unable to extend a payment plan on our self-pay rates.
NSF: All checks returned for non-sufficient funds will result in a **$30.00** service charge to be collected at the next visit, or within 30 days (whichever comes first).
UNPAID STATEMENTS: A **$5.00** rebilling fee will be charged each month on any outstanding balances. If no payment is received on an account after 90 days, the account will be sent to the collection agency. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance at 1% per month from the date of service, collection fees, reasonable attorney fees and court costs.

By accepting this form:

- I understand and agree that my health insurance is an arrangement between my insurance carrier and myself; that all services furnished to me are charged directly to me and that I am personally responsible for payment of all services.
- I authorize treatment and agree to pay all charges. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing.
- It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon.
- I agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance. **I am aware of and will pay a $40.00 late cancellation fee if my appointment is cancelled less than 24 hours from the time of my scheduled appointment.**

Whole Health Naturopathy firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (360) 943-9519.

Print Name _____

Signature _____ Date _____

Consent for Treatment

I hereby authorize Dr. Marnie Frisch & Dr. Savahn Rosinbum, naturopathic doctors to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

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

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

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

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

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

Electromagnetic and Thermal Therapies (includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.)

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

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

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. 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. Marnie Frisch and Dr. Savahn Rosinbum. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

_____	_____
Patient's Name (PRINT)	Guardian/Personal Representative's Name (PRINT)
_____	_____
Patient's Signature	Guardian/Personal Representative's Signature
_____	_____
Date	Relationship/Representative's Authority
	_____
	Date

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Carrie DiStefano IBCLC, Dr. Marnie Frisch, and Dr. Savahn Rosinbum of Whole Health Naturopathy to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Whole Health Naturopathy describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whole Health Naturopathy at the above address.

With this consent, Carrie Distefano IBCLC, Dr. Frisch & Dr. Rosinbum may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Marnie Frisch restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Carrie Distefano IBCLC, Dr. Frisch & Dr. Rosinbum to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Carrie DiStefano IBCLC, Dr. Frisch & Dr. Rosinbum may decline to provide treatment to me.

_____	_____	_____
Print Name of Patient or Legal guardian	Signature of Patient or Legal Guardian	Date

Notice of Privacy Practices Acknowledgement

This section is used to ensure that you have had the opportunity to read and review the healthcare practitioner's Notice of Privacy Practices which are available on the website www.olympianaturopath.com and in the Whole Health Naturopathy office. The Notice of Privacy Practices describes how medical information about you may be used and disclosed, how you can get access to this information and who to contact if you have questions, concerns, or complaints. Healthcare practitioners have a responsibility to protect the privacy of your information. You are entitled to receive their Notice of Privacy Practices that describes the health information privacy practices that have been put in place to protect your privacy. If you have any questions, contact the privacy officer identified in the Notice of Privacy Practices. Any significant change in these privacy practices will be posted. You may request a copy of the Notice of Privacy Practices at any time by contacting the practitioner or the privacy officer. You may request a copy of this signed acknowledgement.

By signing below, I agree that I have received the Notice of Privacy Practices.

_____	_____	_____
Print Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date