EVERGREEN NATUROPATHIC

Alycia Policani, ND
Tanya Paynter, ND
316 W. Boone Ave, Ste 777
Spokane, WA 99201
Phone 509-755-5100
Fax 509-747-6646

Patient Information Sheet
Please Print

Name_____
(Last) (First) (M)

Date of Birth _____/_____/_____ Age_____ Sex M / F

Social Security Number _____-_____-_____ Marital Status_____

Mailing Address _____

City_____ State_____ Zip Code_____

In which way(s) may we contact you with confidential messages, including but not limited to, appointment date/time, lab results, and treatment plan information? **Please check all that apply.**

- ☐ Home Phone (_____)_____
- ☐ Cell Phone (_____)_____
- ☐ Work Phone (_____)_____
- ☐ Email _____
- ☐ Other_____

Employer_____ Occupation_____

Employer Address_____
(City) (State) (Zip Code)

How did you hear about us?_____

In case of emergency, who should we notify? (Please include phone number & relationship)

_____

I, the undersigned, hereby authorize that my insurance benefits be paid directly to Evergreen Naturopathic, and I acknowledge that I am financially responsible for all charges that may apply. The balance of my account will be paid in full on the day of my appointment. A fee equivalent to the cost of the scheduled appointment will be assessed for all appointments missed without 48 hour notification. Please refer to our fee schedule on the following page. If you are 20 or more minutes late for your appointment, you will need to re-schedule and you will be charged for the missed appointment. I hereby authorize my physician to release information to support my claim. I authorize the use of this signature on all insurance forms. I have read and completed all information supplied on this form and certify that this information is true and correct to the best of my Knowledge.

Patient Signature_____ Date_____

Legal Guardian_____ Date_____

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Missed Appointment Fee Schedule

30 Minute New Patient Appointment (US BioTek Only): $131.00

60 Minute New Patient Appointment: $255

5 Minute Established Patient Appointment: $28.00

15 Minute Established Patient Appointment: $88.00

30 Minute Established Patient Appointment: $132.00

Fees may be subject to change without notice.

Patient Signature: _____

Date: _____

Evergreen Naturopathic

Patient Intake Form

Name: _____ Date: _____

Present Health Concerns: Please list your reason(s) for your visit / health concerns in order of importance.

1.) _____ 4.) _____

2.) _____ 5.) _____

3.) _____ 6.) _____

Allergies: Please list any known allergies and your reactions to them. If you do not have any, please circle "none".

Drugs: None	Food: None	Environmental: None
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: Please list any medications (including dosage) you are currently taking (if more than 5, please list on back).

Name and dose of drug	Reason for taking	For how long

Supplements: Please list any supplements you are currently taking (if more than 5, please list on back).

Name, brand, and dose	Reason for taking	For how long

Lifestyle Habits: Please circle

Current Tobacco Use

None Daily Weekly Monthly Amount? _____

Previous history of smoking? Yes No How long? _____ Quit Date? _____

Lifestyle Habits (con't): Please circle

Recreational Drug Use

None Daily Weekly Monthly Type/Amount? _____

Exercise

None Frequency? _____ Type? _____

Past Medical Hx: Please list the following:

Major Events and year (including hospitalizations, accidents, broken bones, surgeries, and serious illnesses)

_____

_____

_____

Ongoing problems including current diagnoses

_____

_____

Date of latest complete blood work: _____

Antibiotic use: Have you taken any antibiotics in the past year? Yes No (If yes, please list how many times and for what purpose) _____

Approximately how many times have you taken antibiotics in the past 10 years? _____

Family History: Please check each box below for every condition and person that applies.

Autoimmune Dz	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Chemical Dependency	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Heart Disease/Attack	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Kidney Disease	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family
Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Grandparent	☐ Extended Family

Other:

Social History: Please circle.

Marriage Status

Single Married Divorced In relationship Number of children _____

Current Occupation: _____

Dietary History: Please list any special dietary guidelines or avoidances (such as gluten free, vegetarian, avoid sugar...)

_____

Current Water Intake Estimated daily amount _____

Coffee / Black Tea Estimated frequency and amount _____

Soft Drinks Estimated frequency and amount _____

Alcohol Estimated frequency and amount _____

Sleep/Energy: Do you have problems with any of the following (please circle):

Falling asleep Staying asleep Waking frequently Waking refreshed

Please rate your energy level on a scale of 0-10 (10 being the best) _____

REVIEW OF SYSTEMS: N = Never C = Currently experiencing P = Past

For the following, please circle whether you have had the below listed conditions never, currently, or have had in the past. "N" means you have never had the condition, "C" means you have the condition currently, "P" means you have had the condition in the past (please be complete - every condition listed below helps point us to the underlying source of your health concerns).

GENERAL

Fever / Chills	N	C	P
Night Sweats / Hot flashes	N	C	P
Memory Loss / Brain Fog	N	C	P
Insomnia	N	C	P

HEAD/NOSE/THROAT

Headache/Migraines	N	C	P
Sinus problems/congestion	N	C	P
Recurrent sinus infections	N	C	P
Seasonal allergies	N	C	P
Difficulty swallowing	N	C	P
Frequent sore throat	N	C	P
Nose bleeds	N	C	P
Frequently runny nose	N	C	P

EYES

Dryness	N	C	P
Eye pain	N	C	P
Blurring	N	C	P
Eye discharge	N	C	P

EARS

Impaired hearing	N	C	P
Ringing (tinnitus)	N	C	P
Recurrent ear infections	N	C	P

MOUTH

Gum problems/bleeding	N	C	P
Hoarseness	N	C	P
Dental problems	N	C	P
Dental pain	N	C	P

HEART

Heart disease	N	C	P
High blood pressure	N	C	P
Chest pain	N	C	P
Swelling in ankles	N	C	P
Palpitations, fluttering	N	C	P
Deep leg pain	N	C	P
Cold hands/ feet	N	C	P
Varicose veins	N	C	P
Anemia	N	C	P
Easy bleeding or bruising	N	C	P

LUNGS

Persistent Cough	N	C	P
Spitting up blood	N	C	P
Wheezing	N	C	P
Difficulty breathing	N	C	P
Shortness of breath	N	C	P

DIGESTION

Abdominal pain	N	C	P
Gas or bloating	N	C	P
Nausea or vomiting	N	C	P
Constipation	N	C	P
Loose stools/diarrhea	N	C	P
Heartburn/acid reflux	N	C	P
Hoarseness/loss of voice	N	C	P
Change in appetite	N	C	P
Blood in stools	N	C	P
Liver/gall bladder disease	N	C	P
Hemorrhoids	N	C	P

MUSCULOSKELETAL

Joint pain or stiffness	N	C	P
Broken bones	N	C	P
Muscle spasms or cramps	N	C	P
Date of last DEXA scan?			_____

NEUROLOGIC

Fainting	N	C	P
Seizures	N	C	P
Paralysis	N	C	P
Muscle weakness	N	C	P
Numbness or tingling	N	C	P
Loss of memory / brain fog	N	C	P
Concussion / head injury	N	C	P
Dizziness	N	C	P

MENTAL / EMOTIONAL

Depression	N	C	P
Anxiety or nervousness	N	C	P
Eating disorder	N	C	P
Suicidal thoughts	N	C	P
Suicide attempts	N	C	P

SKIN

Acne	N	C	P
Eczema	N	C	P
Hives	N	C	P
Rashes	N	C	P
Infection	N	C	P

ENDOCRINE

Tend to run hot or cold	N	C	P
Fatigue/very low energy	N	C	P
Goiter / enlarged thyroid	N	C	P
Cold hands/feet	N	C	P
Sensitivity to light	N	C	P
High stress	N	C	P
Sugar cravings	N	C	P
Excessive worry	N	C	P
Fluid retention/bloating	N	C	P
Mood swings	N	C	P
Easily cry/tearful	N	C	P
Difficulty concentrating	N	C	P
Incontinence	N	C	P
Hot flashes	N	C	P
Night sweats	N	C	P
Acne	N	C	P
Hair loss	N	C	P
Weight gain around hips/waist	N	C	P
Decreased libido	N	C	P
Decreased muscle mass	N	C	P
Increased joint pain	N	C	P
Bone loss	N	C	P

GENITOURINARY

Pain on urination	N	C	P
Increased frequency	N	C	P
Urgency	N	C	P
Increased urination at night	N	C	P
Frequent bladder infections	N	C	P
STD	N	C	P
Discharge or sores	N	C	P

Female Specific

Bleeding between periods	N	C	P
Excessive flow / clotting	N	C	P
Cramps	N	C	P
PMS	N	C	P
Breast tenderness before menses	N	C	P
IUD/Birth control use	N	C	P
Abnormal PAP?	N	C	P

Date of last exam: _____

Supplemetnal estrogen/progesterone	N	C	P

If C, for how long: _____

Hysterectomy Y N -- Full Partial (ovaries in tact)

Date of last menstrual period: _____

Male Specific

Hernias	N	C	P
Testicular masses	N	C	P
Testicular pain	N	C	P
Difficulty stopping or starting urination	N	C	P
Prostate issues	N	C	P
Difficulty initiating/maintaining erection	N	C	P

Morning erections present Y N

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form.

I acknowledge that I am financially responsible for all charges that may apply during the course of my treatment that are not covered by my insurance company. I accept that Evergreen Naturopathic will bill my insurance one time as a courtesy. After that, I am responsible for my charges. The balance of my account will be paid in full on the day of my appointment.

I acknowledge that **a charge will be assessed equal to the cost of the scheduled appointment for all appointments missed** without 48 hour notification. I understand that **if I am more than 20 minutes late to my appointment** (for either my initial one hour office visit or subsequent 30 minute follow up visits) **it will be counted as a missed appointment** and I will be charged the missed appointment fee.

Patient Signature: _____ **Date:** _____

Legal Guardian: _____ **Date:** _____

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INFORMED CONSENT

I hereby request and consent to examination and treatment with naturopathic care, including various modes of physical therapy for:

☐ Myself ☐ _____, for whom I am legally responsible, by Alycia Policani, ND and/or Tanya Paynter, ND. I understand that there may be times during which I seek immediate treatment that my normal physician is not available and consent to be seen by the other physician employed at Evergreen Naturopathic. I also understand that this consent to care includes treatment received by nursing staff employed at Evergreen Naturopathic at the direction of the above physicians. I understand that naturopathic evaluation includes commonly used physical examination methods and movements to test bones, joints, nerves, muscles, and other tissues and organs to help determine the diagnosis and course of treatment. I understand that I am in full control of my body during the examination and it is my responsibility to inform the health care provider of any procedure I feel may cause injury or want stopped for any reason.

I, as a patient, have a right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as to whether or not I want to undergo care after having had the opportunity to discuss potential benefits, risks, and hazards involved.

I understand that naturopathic evaluation and treatment may include, but is not limited to, various modes of physical therapy (ultrasound, diathermy, low volt electrical stimulation, hydrotherapy, heat, cold, traction, stretching, exercise, etc.), collecting specimens for laboratory evaluation including blood draws, cultures, and/or ordering diagnostic imaging and tests, prescription of certain medications and nutritional supplements, counseling and dietary therapy, biofeedback, and homeopathy. I understand that naturopathic modalities continually change and that Evergreen Naturopathic seeks to keep pace with new and effective modalities and may add or stop providing certain services at any time. I understand that, at this time, the US Food and Drug Administration has not yet approved nutritional, herbal, and homeopathic supplements but that they have been widely used in the US and Europe for many years. I understand that, as with drugs, nutritional supplements, herbal remedies, and homeopathic remedies may exhibit some side effects in certain sensitive individuals, interact with certain allopathic medications or lab tests, or exacerbate symptoms in certain pre-existing disease conditions. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment in recommending treatments that the doctor(s) feel at the time, based on the facts then known, are in my best interest.

I have had the opportunity to ask questions and discuss, to my satisfaction, with either Dr. Alycia Policani or Dr. Tanya Paynter, the following:

1) My suspected diagnosis or condition,
2) The nature, purpose, and potential benefit of the proposed care,
3) The inherent risks, complications, potential hazards, or side effects of the treatment or procedure,
4) The probability or likelihood of success,
5) Reasonable available alternatives to proposed treatment/procedure,
6) The possible consequences if treatment advice is not followed and/or nothing is done.

I understand and am informed that in the practice of naturopathic medicine there are some risks of examination and treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results of treatment. By signing below, I acknowledge that I have read, or have had read to me, and understand the above consent. I consent to care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment or care from Evergreen Naturopathic and its employees.

Signature of Patient PRINT Patient's Name

Signature of Legal Guardian PRINT Guardian's Name

Date: _____

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Alycia Policani, ND 316 W. Boone Ave, Ste 777 Phone 509-755-5100
Tanya Paynter, ND Spokane, WA 99201 Fax 509-747-6646

Notice of Privacy Practices Acknowledgment

I, _____ acknowledge that I have received and read a copy of the Notice of Privacy Practices of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). If at any time I have questions regarding this notice, I am aware that I may contact Evergreen Naturopathic at (509) 755-5100.

Patient's Printed Name: _____

Patient Signature: _____ Date_____

OR

Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: it is your right to refuse to sign this Acknowledgement

Office Use Only

We attempted to obtain acknowledgement of the receipt of our Notice of Privacy Practices by the individual noted above, but it could not be obtained because:

☐ An emergency prevented us from obtaining acknowledgement

☐ A communication barrier prevented us from obtaining acknowledgement

☐ The individual was unwilling to sign

☐ Other: _____

Staff Member Signature: _____ Date_____

Evergreen Naturopathic

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
509-755-5100

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and

nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we

will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,

- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and

safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Evergreen Naturopathic, 316 W. Boone, Rock Tower, Suite 777, Spokane 99201,** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Evergreen Naturopathic, 316 W. Boone, Rock Tower, Suite 777, Spokane 99201.** Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Evergreen Naturopathic, 316 W. Boone, Rock Tower, Suite 777, Spokane 99201** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Evergreen Naturopathic, 316 W. Boone, Rock Tower, Suite 777, Spokane 99201*. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Evergreen Naturopathic, 316 W. Boone, Rock Tower, Suite 777, Spokane 99201**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, call **509-755-5100**.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, call **509-755-5100**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please call **509-755-5100**.

EVERGREEN NATUROPATHIC

Alycia Policani, ND 316 W. Boone Ave, Ste 777 Phone 509-755-5100
Tanya Paynter, ND Spokane, WA 99201 Fax 509-747-6646

Non Covered Services Agreement

I, _____ being a patient of Evergreen Naturopathic, do hereby acknowledge that it has been explained to me the following services are not or may not be covered by the benefits available to me under the terms of my Health Plan or Insurance Policy:

- Biopuncture
- Labrix Hormone Panel
- Neuroscience Basic Neurotransmitter Panel
- IV Therapy
- Frequency Specific Microcurrent
- Biofeedback
- B12 Injections
- Venipuncture (Blood Draw)
- Naturopathic Soft Tissue Techniques
- DUTCH Precision Analytical Urinary HormoneTest
- Us BioTek Food Allergy Panel/Testing
- Doctors Data Testing
- Common Wealth Lactose Breath Test
- Diagnostic Solutions GI Testing
- Any Testing through Genova Diagnostics

The reason(s) these services might possibly not be covered could be, but are not limited to these reasons:

- This service(s) is excluded from my plan coverage.
- This service(s) has not been authorized by my health plan by referral to this practitioner.
- This service(s) may be determined to be a maintenance, preventative, or wellness procedure when submitted for a pre-authorization review.
- This lab test(s), and/or services are not likely to be covered by my insurance.
- My deductible has not been met.

I acknowledge that I have been told, in advance of treatment, what portion of my care is considered not covered by my health plan/insurance policy. I agree to pay for these services at the time of my visit.

Patient's Printed Name: _____

Patient Signature: _____ Date_____

EVERGREEN NATUROPATHIC

Alycia Policani, ND, Tanya Paynter, ND

316 W. Boone Ave, Ste 777, Rock Point Tower, Spokane, WA 99201

509-755-5100 Fax 509-747-6646

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I _____ (print your name), authorize Evergreen Naturopathic to disclose certain protected health information (PHI) about me to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information to be released (initial all that apply):

___ Diagnosed Conditions
___ Information Discussed During Office Visits
___ Treatment Plans
___ Supplements
___ Billing Information/Balance Due
___ Labs, Imaging, and Other Test Ordered and/or Results
___ Referrals
___ Other: _____
___ Other: _____

The Practice *will not* receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

Patient Authorization:

I understand that my record may contain information regarding the diagnosis or treatment or HIV (AIDS virus), other sexually transmitted diseases (STDs), sexual history, drugs and/or alcohol use/abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

****Exclude the following information from the records released** (please initial):

____ Drug/Alcohol use/abuse treatment and diagnosis
____ HIV/AIDS diagnosis/treatment/testing
____ Sexual history/STDs
____ Mental Illness diagnosis/treatment

I do not have to sign this authorization in order to receive treatment from Evergreen Naturopathic. I have the right to make changes to or revoke this authorization in writing at any time. To review the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Date of Birth

We are located in the Rock Pointe Corporate Center in Rock Pointe Tower at 316 W. Boone on the corner of Boone and Washington.

You may park in any parking spot in the parking garage that is not reserved or in the parking spaces marked visitor parking in front of the building. Please note: There is no street parking available on Boone.

If you need further directions please don't hesitate to call us at 509-755-5100.

*****Please be advised that Google may direct you to the wrong location*****