Harmonizing Natural Medicine: a Naturopathic Clinic
3417 Evanston Ave N Suite 429, Seattle, WA 98103
Ph) 425-270-7187 Fax) 425-249-7448 Email) Info@hnhclinic.com

Patient Name ____Today's Date________________

WELCOME

Patient Information			
Last Name		Date of Birth	
Frist Name		SEX	
Street Address, City, State, ZIP			
Secure Phone #		Secure Email Address	

Emergency Contact			
Name		Cell Phone #	
Relationship		Email	

Associations			
Occupation		Employer or School if student	
Referred By		How did you hear about us?	

Insurance Information		
	Primary	**Secondary**
Name of Insurance		
Type of plan (PPO, Selections, Care, Basic Health…)	Simply ask us to photo copy your Health Insurance card to skip this part	Simply ask us to photo copy your Health Insurance card to skip this part
ID Number (Subscriber #)		
Policy Number (Group#)		

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Harmonizing Natural Health, PLLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or the behalf of my dependents. I authorize Harmonizing Natural Health, PLLC to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize Harmonizing Natural Health, PLLC to leave personal medical information for me on the secure phone number I have indicated on this form.

____

Signature of Responsible Party and Date

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A Note to patients: Holistic health care and preventive medicine are only possible when the physician has a clear understanding of the patient physically, mentally, and emotionally. Therefore, please complete this questionnaire as thoroughly as possible in order to aid with your diagnosis and treatment. Print all information and mark anything you don't understand with a question mark. This is a confidential record of your medical treatment and will not be released except when you have provided written authorization to do so. Thank you.

Social Information

Are you Single Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐
Live With: Spouse Partner ☐ Relatives ☐ Friends ☐ Alone ☐
Do you have any children? Yes ☐ No ☐

Heath Care Status

Current Height		Weight	
Are you currently working with a doctor or any health care practitioner? Yes ☐ No ☐			
If yes, where and from Whom? For what reason? If no, when and where did you last receive medical or health Care?			
Date of Last physical/annual exam		Date of last blood tests	
Last Chest X-ray?		Last eye exam	
Are ask vaccines current?		Last Dental Visit	
If adult, when was your last Pneumonia Vaccine:_______________ Tetanus Booster :_________________Flu Vaccine :_____________			
If Male, Last prostate exam /PSA evaluation?			

If Female	Last Pap test		Last Breast Exam	
	Last Mammogram		Do you do self-breast exam? Yes ☐ No ☐	
	Any abnormal finding from breast/pap exam?			
	Number of Pregnancies _____Number of Births___________ How many children? ________ (Circle) Miscarriage, abortions, vaginal birth, C-section Current Birth Control Method:			

Reason for visit: Please list your present health concerns, problems or symptoms

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Medication List

Medication Name	Dosage and Frequency	Approx. start Date	Reason for use

Supplements and Over the Counter medication

Supplement /OTC	Dosage and Frequency	Approx. start Date	Reason for use

Allergies: Do you have any allergies to any of following:

☐ NO KNOWN ALLERGIES	
List of allergen	**If yes, list the allergen(s) and the reason(s) experienced:**
Local anesthetics	(e.g.lidocaine, novocaine)
Penicillin or other antibiotics	
Over-the-Counter or Other Rx drugs	
Chemicals	
Herbs	

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List of allergen	If yes, list the allergen(s) and the reason(s) experienced:
Inhalants	
Perfume	(e.g. essential oil)
Pets	
Supplements	
Others	

Family History

Problems	Brothers	Sisters	Mother	Maternal GM	Maternal GF	Father	Parental GM	Parental GF
Age								
Diabetes								
Cholesterol								
Thyroid								
Heart								
Stoke								
High BP								
Cancer								
Mental illness								
Others								

Past Hospitalization, Surgeries, Trauma, Serious/Childhood illness, Injuries, Situations of Abuse

List	Type and your approx. Age or year it occurred

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Patient Name ____ Today's Date________________

Life Style History

	Describe	
Breakfast		
Lunch		
Dinner		
Snack		
Water	How many cups of water a day?	
Beverage	e.g. coffee, tea, soda	
Alcohol	If yes, What kind? How often you drink? How much you drink each time?	
Smoke Tobacco	If yes, How many packs per day? How many years?	
Substance	If Yes, what kind Recreational drugs How often	
Hobbies		
Weight	Any loosing or gaining excess weight? Reason?	
Exercise	If yes, what kind? How often? Do you perspire when you exercise? Lightly, Moderately, Heavily, None	
Sleep	How many hours do you sleep each night? DO you sleep well? Do you fall asleep easily? Do you wake up middle of night? How often? How would rate the Quality of your sleep? On a scale of 1-10 (1 = poor and 10 = great)	
Stress level	Rate your stress level, On a scale of 1-10 (1 = low, 10 = high) Describe your stress	Indicate painful or distressed areas
Energy Level	Rate your energy level following times On a scale of 1-10 (1 = low and 10 = highest) : _____8AM_______12PM________4PM_________10PM	
Pain level	Rate your pain level, On a scale of 1-10 (1= low, 10 = high) Describe your pain	

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Patient Name ____Today's Date________________

Please add comments as needed to clarify the symptoms listed, leave blank any which do not apply.

HEAD:
Y N Headaches
Describe: ____
Y N Dry Scalp
Y N Acne
Y N Dizzy______________________________________

EYE / EAR / NOSE / THROAT:
Y N Vision blurry
Y N Dry eyes
Y N Dark circles under eyes
Y N Earwax builds up
Y N Earaches
Y N Hearing loss
Y N Ringing in ears
Y N Sinus pain / infection
Y N Nose / sinuses dry
Y N Nose runs
Y N Seasonal allergies
Y N Voice hoarse
Y N Sore throat
Y N Postnasal drip
Y N Nose bleeds

CHEST:
Y N Heart pounds
Y N Heart "flutter"
Y N Shortness of breath
Y N Asthma (Triggered by ___________________________)
Y N Chest pains
Y N Wheezing
Y N Coughing
Diagnosed heart / cardiovascular disease: what, when?
____

GASTROINTESTINAL:
Y N Heartburn
Y N Stomach aches
Y N Gas / Bloating
Y N Fatty meals bother
Y N Constipation
Y N Diarrhea
Y N Blood or Mucus in stools
Y N Vomiting
Y N Hemorrhoids
Bowel movements:
__________ Daily, color, well form? ____________________
Y N Increased appetite
Y N Decreased appetite

URINARY TRACT:
Y N Bladder infections
Y N Kidney infections
Y N Burning with urination
Y N Frequent urination
Y N Blood in urine
Y N Urinary incontinence (Constant Occasional)

MUSCULO-SKELETAL:
Y N Joint pains
Y N Back pain Upper Lower All
Y N Neck pain
Y N Muscle aches
Y N Bruising Easy Only with trauma
Y N Sprains Locations:______________________________
Y N Joint stiffness
Y N Arthritis
Y N Diagnosed with Fibromyalgia YES NO When_________

NEURO-ENDOCRINE:
Y N Panic / Anxiety attacks
Y N Irritability
Y N Feel bad when not eating regularly
Y N Weight gain
Y N Weight loss
Y N Mood swings
Y N Snack often
Y N Increased thirst
Y N Insomnia
Y N Feel restless at bedtime
Y N Wake up easily at night

MALE ONLY: Circle what applies to you.
Frequent urination (Specify: Day Night)
Incomplete urination
Discharge from urethra
Trouble initiating urination
Hernias (Specify: Current Past)
Increase Decrease in sex drive
Erectile difficulty
Rectal burning / itch

FEMALE ONLY: Circle what applies to you.
PMS symptoms_________________________________
Duration: 1 - 2 - 3 – ALL: Week(s) before period
Menses painful Heavy flow Light flow
Color: Light red Dark red, Medium red with clots
Menses change (duration, regularity, flow, pain)
Avg. cycle length 22-25 days, 26-30 days, other___________
Date last period started: ______________________________
Age at first onset of period: ___________________________
Acne (At / Before/After) menses
Pain in breasts (Specify With cycle / Constant)
Menopause Began: __________________________________
Ages your mother & Grandmother entered menopause?_____
Hot flushes____
Increase Decrease No Changes in sex drive
Vaginal discharge
Yeast infections
Hot flushes
Hair growth on face
Difficulty in: (Conception, Carrying to term)
Hernias (Specify Current Past)

♣ **Write your Name and Date at the Top of each page, Please**

Patient Name ____Today's Date________________

Informed Consent for Harmonizing Natural Health, PLLC

I, ____Acknowlege that I am accepting treatment from a naturopathic physician at Harmonizing Natural Health, PLLC. I understand that there are intrinsic differences between the care provided by naturopathic doctors and by medical doctors. These differences are elaborated Consent for treatment of this document. I also understand that, the practice of medicine is not exact sciences, and I acknowledge that no guarantees or assurances can be made to me concerning the results treatments, exam and procedures to be regarding my care while a client of Harmonizing Natural Health, PLLC will be shared with me, and decisions, regarding my care will be made in consultation with me. At this time, it is my decision to peruse naturopathic treatment for my health conditions.

____

Patient/Guardian/Personal Representative's **Signature** and **DATE**

CONSENT FOR TREATMENT

I hereby authorize Harmonizing Natural Health's Naturopathic Physician o perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

General Diagnostic Procedures: Including but not limited to venipuncture, pap smears, blood, urine; stool lab work, physicals, neurological and musculoskeletal assessments and examinations.
Methods, Procedures and Therapeutic Approaches: Providers may perform any of the following procedures as necessary for proper assessments, to determine treatment approaches, or otherwise address your health concerns.
Lifestyle counselling: involves identifying risk factors and helping patients to make informed choices to reach and maintain optimal health, Psychological, lifestyle, exercise and relationship counseling.
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 also include IM injections and IV nutrients.
Pharmaceutical Prescriptions: Prescribing of various pharmaceutical drugs within the scope of practice for Naturopathic Physicians which includes all Legend Drugs and specific Schedule III, IIIN, 4, & 5 per the WAC.
Soft Tissue and Osseous Manipulation: Use of massage includes gua sha technique, and cupping technique, hydrotherapy, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, acutonics, and craniosacral therapy.
Potential Risks: Pain, discomfort, blistering, discolorations, infection, burns, death, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; allergic reactions to prescribed medications herbs or supplements; soft tissue, nerve, or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Patient Name ____Today's Date________________

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 or OB/GYN provider authorizing or recommending such a treatment.

Notice to Patients: cancer, bleeding disorders, pacemaker, and infectious disease: Patients must alert the practitioner of this condition prior to any treatment.

I understand that Washington state law does not authorize naturopaths to treat me for any Cancer or malignancy and that I required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care at Harmonizing Natural Health, PLLC. I am currently under the care of

____________________________________.

I recognized that I am here for supportive therapies ONLY.

Please INITIAL the following:

_______ I understand that HHN naturopathic physician is not licensed to prescribe any controlled substances.

_______ I understand that HNH physician, will only prescribe medications if she believes that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescriptive medication needs.

_______ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however, these have been used widely in Europe, Asia, and the USA for years.

_______ I understand that is HNH physician, not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies

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 Harmonizing Natural Health, PLLC. Further, I will hold a Harmonizing Natural Health physician harmless and will not ask for indemnity for any of the side effects that may be caused. 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.

____

Patient/Guardian/Personal Representative's **Signature** and **DATE**

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Patient Name ____Today's Date________________

Client Email and Text Message Informed Consent

You may give permission to Harmonizing Health Clinic, PLLC 's Clinic staff to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

Important note

Emergency Problems: Email/Text should never be used for emergency problems. In the event of an emergency dial 911.
Urgent problems: Email/Text should never be used for urgent problems, in the case you should go to an urgent care or call any medical care center.
Sensitive Medical Information: Email/Text should be concise. If there is a problem that is complex or sensitive to discuss via email, you SHOULD schedule an office visit.
Reliability: Email/Text Messages should never be relied upon as a lone source of relying information I has mechanical and human errors.

♦*Harmonizing Natural Health clinic prefer to use TXT messaging for* ***ONLY scheduling.***

1. **How we will use email and text messaging**: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to another HHN Clinic staff member as necessary for appropriate handling. We will not disclose your emails or text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
2. **Risk of using email and text messages**: The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to, the following:
   a) Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b) Senders can easily misaddress an email or text and send the information to an undesired recipient.
   c) Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   d) Employers and on-line services have a right to inspect emails and texts sent through their company systems.
   e) Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f) Emails and texts can be used as evidence in court.
   g) Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.
3. **Conditions for the use of email and text messages**: HNH Clinic cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:
   a) **IN A MEDICAL EMERGENCY, DO NOT USE EMAIL/TXT, CALL 911.** Do not email for urgent problems, *in the case you should go to an urgent care or call any medical care center.*
   b) Emails should not be time-sensitive. While we try to respond to email messages within 72 hours, we cannot guarantee that any particular email will be read and responded to within any particular period of time. If you have not heard back from us within three days, call our office to follow up if we have received your email.
   c) You should *schedule an office visit* to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
   d) Email and text messages may be filed electronically into your medical record.
   e) Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.

Patient Name ____Today's Date________________

f) You should use your best judgment when considering the use of email or text messages for communication of **sensitive medical information**. Clinical staff are not responsible for the content of messages.
g) HNH Clinic is not liable for breaches of confidentiality caused by you or any third party.
h) It is your responsibility to follow up with your staff person if warranted.
i) It is your responsibility to inform your new email or new txt information

4. **Withdrawal of consent**: I understand that I may revoke this consent at any time by so advising HNH Clinic in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.
5. **Client Acknowledgement and Agreement**: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between HNH Clinic staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that HNH Clinic may impose to communicate with me by email or text message.

Patient Authorized EMAIL Address	
Patient Authorized TEXT phone number	

____
Signature of patient or authorized representative Date

Payment

All Treatments and Visits are to be paid at the time service is rendered except where there is reasonable except your insurance will pay for your visit. I understand that there is a 24-hour cancellation policy and that I will be subject to a $50 cancellation fee if change to my appointment are made within 24 hours.

We prefer you give us at least 48 hours' notice so that we may **give another patient that appointment.*

____
Signature of patient or authorized representative Date

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to have corrections made to that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the clinic business during normal business hours. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. This form acknowledging your receipt of our **Notice of Privacy Practices** will be retained in your medical record. ***By my signature below I acknowledge receipt of the Notice of Privacy Practices.***

____
Signature of patient or authorized representative Date

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Notice of Privacy Practices

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

If you have questions concerning this notice, please contact us at

Harmonizing Natural Health
Phone) 425-270-7187 Fax) 425 2407448
www.hnhclinic.com, Email: info@hnhclinic.com

We respect your privacy and understand that your medical information is personal and sensitive. Moreover, we are required by law to make sure that medical information that identifies you is kept private. This Notice of Privacy Practices describes how we may use or disclose your protected health information at our clinic. We are required to give you this notice of our legal duties and abide by the terms of this notice, however, we may change our notice at any time.

Please note that any new notice adopted will be effective for all protected health information maintained at the time of change. You will not be notified individually if a change is made to our notice, however, upon request, we will provide you with a copy of our current notice. You may always obtain a copy of our current notice by any of the following means:

1. Accessing our website at http://www.hnhclinic.com
2. Contacting our office by mail or by phone at the above address and phone number
3. Asking for a copy at the time of your next visit.

SECTION 1: We use and disclose your protected health information to carry out your treatment, obtain payment and conduct health care operations.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes disclosures to other third parties that are involved in your health care elsewhere. Specifically, we would disclose your protected health information to other physicians who may be treating you when we have the necessary permission from you to do so. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may occasionally disclose your protected health information to another physician or health care provider, such as a medical specialist or laboratory, who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for coverage of future treatment with some medical modalities may require that your relevant medical information be disclosed to the health plan to obtain approval for future scheduling. Similarly, insurance companies may require that copies of your applicable medical records accompany any requests for payment of services already provided to you.

Healthcare Operations: We may use or disclose, as necessary, your protected health information in order to support various business activities of our clinic. These activities include, but are not limited to, quality assessment activities, employee reviews, licensing, marketing and fundraising activities, and conducting or arranging for similar business activities.

For example, we may call you by name in the waiting room when ready to see you, and we may use or disclose your protected health information, as necessary, to contact you and remind you of your upcoming appointment(s).

Patient Name ____Today's Date________________

We will share your protected health information with third party business associates that perform various activities—such as billing, collections, or records management—for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your information.
We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our clinic and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities. If you do not wish to be contacted for these purposes, please call or write to our office at the address or phone number specified on page one.

SECTION 2: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.
Per Your Authorization: If you give us authorization to use or disclose your protected health information, you may revoke such authorizations at any time, in writing, except to the extent that our clinic has already taken action in reliance on the use or disclosure permitted in the authorization.

Legally Permitted/Opportunity to Object: We may use and disclose your protected health information in the following instances, but you will be given the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of such information, then we may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

1. **To Others Involved in Your Healthcare**: Unless you object, we may disclose your protected health information to a member of your family, a relative, a close friend or any other person you identify, to the extent the information directly relates to that person's involvement in your health care. For example, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
2. **In Emergencies**: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably possible after the delivery of treatment. If your physician or another physician in the practice must treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.
3. **With Communication Barriers**: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances and the use or disclosure is done in accordance with other applicable laws.

Legally Permitted/No Opportunity to Object: We may use or disclose your protected health information in the following situations without your consent or authorization:

1. **When Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law(s) and will be limited to the relevant requirements of the law. You will be notified of any such uses or disclosures only if required by law.
2. **For Public Health**: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information,

if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority. We may also disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

3. **For Health Oversight/Compliance Monitoring:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
4. **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your protected health information to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
5. **To the FDA:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
6. **Legal Proceedings**: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, in certain conditions in response to a subpoena, discovery request or other lawful process.
7. **Law Enforcement**: We may disclose protected health information for law enforcement purposes, so long as applicable legal requirements are met. Such purposes generally include: 1) those required by law; 2) limited information requests for identification and location purposes; 3) those pertaining to victims of a crime; 4) suspicion that death has occurred as a result of criminal conduct; 5) those where a crime occurs on the premises of the practice; and 6) medical emergencies where it is likely that a crime has occurred.
8. **Research:** We may disclose your protected health information to researchers when an institutional review board has approved their research. The institutional review board will have reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
9. **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel to authorized authorities; such as for determinations of your eligibility for benefits. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President, foreign heads of state or others legally authorized.
10. **Workers' Compensation:** We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.
11. **Coroners, Funeral Directors, and Organ Donation:** We may disclose your medical information to a coroner, medical examiner or funeral director, if necessary, for them to carry out their duties should you die.
12. **Inmates:** We may disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of a correctional facility or under the custody of a law enforcement official and your physician created or received your protected health information in the course of providing care to you. Such information may be released only for the following purposes: 1) to enable the correctional institution or law enforcement official to provide you with necessary healthcare services; 2) to protect your own health and safety or the safety of others; and 3) for the safety and security of the correctional institution.

SECTION 3: Specially-Protected Information

Special laws may restrict the use and disclosure of medical information related to mental health conditions, substance abuse, sexually transmitted diseases and HIV/AIDS. For example, we generally do not disclose specially protected information in response to a subpoena or other compulsory process unless: 1) you provide written authorization; or 2) a court orders the disclosure and mandates the necessary safeguards to protect the information after it is released.

SECTION 4: Your Rights

The following is a list of your rights with respect to your protected health information and a brief description of how you may exercise those rights. Should you have questions about this section or if you wish to exercise your rights, please contact the medical records office at the address listed on page one.

The right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of the protected health information we maintain about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the institution use for making decisions about you. We may deny you access to some records as state and federal laws permit, however, if you are denied access, you may request a review or designate a health care provider with equal qualifications to receive the information instead.

The right to request a restriction on the use or disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations as described in Section 1 of this notice. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes. Your request must be in writing and state the specific restriction requested and to whom or in what situation you want the restriction to apply. Please note that we are not required to agree to a restriction that you may request. If we believe it to be in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. However, if we agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with any doctor at Harmonizing Natural Health Clinic.

The right to request that you receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

The right to request an amendment/correction to your health record. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us, and the statement of disagreement you provide will be released along with the information challenged whenever it is released. We may also include a letter of rebuttal, which will also be released along with the challenged information. You are entitled to a copy of any letter of rebuttal we may place in your record.

The right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

The right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

SECTION 5: Complaints, Comments and Inquiries

If you believe your privacy rights have been violated, you may report the suspected violation to us by contacting our clinic at 425-270-7187 or by contacting the Secretary of Health and Human Services. We will take no punitive action against you for filing a complaint.

This notice becomes effective on ***April 14th 2003***