Vitae Health Center PLLC
16521 13th Ave West, Ste. 105, Lynnwood, WA 98037 (425) 742-3800 vitality, naturally

Date: _____

Intake Form

Name: _____ Date of Birth: _____ Gender (circle): M / F

Social Security #:_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (home): (_____) _____ (Work/Cell): (_____) _____
Please indicate which # we may leave a confidential message

Email Address: _____

Education:_____ Occupation: _____ Hours/week: _____

Employer:_____ Work Address: _____

Status (circle): Single Married Separated Divorced Widowed Partnership

Live with (circle): Spouse Partner Parents Children Friends Alone

Race/Ethnic Origin (circle): African African American/ Black Amer. Asian Caucasian
Native American Pacific Islander Native Hawaiian Hispanic Other

Spouse:

Name of spouse/partner:_____ Date of Birth: _____

Social Security #: _____

Telephone (home): (_____) _____ (Work/Cell): (_____) _____

Employer: _____ Work Address: _____

Name of parent(s) or guardian(s):_____ Relationship to you:_____

Emergency Contact: _____ Relationship to you: _____

Phone (Home): (_____) _____ Phone (Cell): (_____) _____

Address:_____

How did you hear about this clinic? _____

Any family members currently a patient at this clinic? _____

Have you ever seen a Naturopathic Doctor (ND) before? Yes / No

Would you like to receive health newsletters and education articles from the clinic as they become available? Yes / No

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of their patients, physically, mentally and emotionally. Please complete the following to the best of your ability. Your time, honesty and thoughtfulness in completing this overview will greatly aid me to assist your needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What **three** expectations do you have from **this** visit to our clinic?

1.
2.
3.

What **long-term** expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

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

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

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

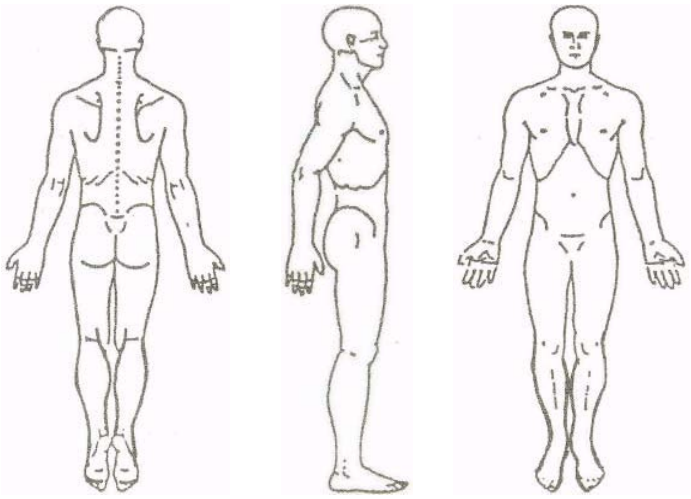
Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

Current Problem List

What are your most important health problems? List as many as you can in order of importance and include time of onset

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____



Please mark your areas of pain

Please indicate your CURRENT pain level on the chart below (ex. Hypertension, diabetes, MS, Irritable Bowel Syndrome, etc.)::

|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Pain

Please list any current diagnoses:

1. _____ 3. _____
2. _____ 4. _____

Do you have any known contagious diseases at this time? Y / N If yes what?_____

General Information

Height: _____ Weight:_____ Weight one year ago? _____ Maximum weight and when _____

Birth Weight: _____

How would you rate your energy? _____ When during the day is your energy best? _____

Exercise? Y / N If so, what kind and how often? _____

What are your main interests and hobbies? _____

Do you watch TV? Y / N if yes how many hours?_____ Do you read? Y / N if yes how many hours?_____

Do you have religious or spiritual practice? Y / N

Are you currently receiving healthcare? Y / N If yes where and from whom? _____

If no, are you planning to establish primary care with us? Y / N

When and where did you last receive medical or health care? _____ What was the reason?_____

_____

Do you currently have (circle): Advanced Directives Power of Attorney Will

Allergies

To drugs/medications (including over the counter) _____

To procaine or other dental anesthetics _____

To foods _____

To environmental or chemical agents _____

Environmental History

Do you have amalgam fillings? Y / N If yes how many and for how long? _____

Do you have past or current history of work related chemical exposures? Y / N If yes what chemicals? _____

Zip code of where you lived most of your life _____

Medication

Please list **all medications**, including over the counter you are currently taking and why (Please indicate dose and frequency)

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

Have you taken Aspirin, Ibuprofen, Naproxen or any steroids for a long period of time (3 weeks or longer)? Y / N

If yes for how long and for what? _____

Do you have a history of taking antibiotics? Y / N If yes for how long and what for? _____

Vitamins and Supplementation

Please list all vitamins and supplements you are taking and why (Please indicate dose and frequency)

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

_____ Starting date _____ _____ Starting date _____

Typical Food Intake

Breakfast: _____

Lunch: _____

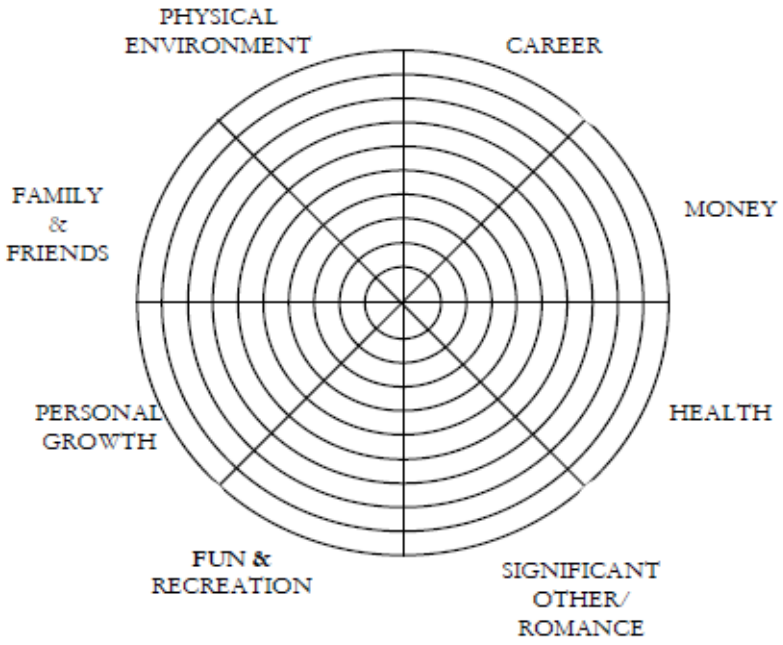
Dinner: _____

Snacks: _____

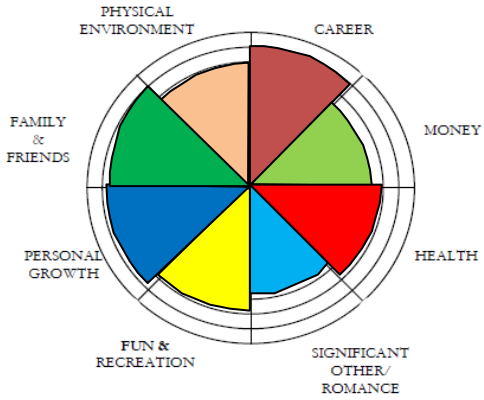
Please list # of ounces consumed per day below.

Water: _____ Coffee: _____ Alcohol: _____

Wellness is a balance of many factors. Please use the circle below to show your level of satisfaction in each area as it relates to you. For example if you are 50% satisfied with your health, shade in 50% of portion of the pie indicated for health. Do the same for each area.



Example



Family History

Do you or anyone in your family have a history of any of the following? (Please circle and indicate who & what type if appropriate)

Heart disease _____
Diabetes _____
Kidney disease _____
Asthma _____
Eczema _____

High cholesterol _____
Stroke _____
Arthritis _____
Glaucoma _____
Epilepsy _____

High Blood Pressure _____
Cancer _____
Anemia _____
Mental Illness _____
Hay fever/Hives _____

Other relevant family history? _____

What is your heritage (ex. German, Norwegian, Swedish, Spanish, etc.)? _____

Vaccine History: (check all that apply)

- ☐ DPT (Diphtheria, Pertussis, Tetanus)
- ☐ Tetanus Booster (Usually DT) When was the last booster? _____
- ☐ Polio injection / Polio oral
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ HBV (Hepatitis B Vaccine)
- ☐ Hepatitis A Vaccine
- ☐ Other (Flu shots, etc.) What? _____

When? _____

Hospitalizations/Surgery/Imaging

Please list any hospitalizations, surgeries or imaging such as X-ray, CAT scans, EEG, EKGs or MRI you have had

_____ Year _____ _____ Year _____

_____ Year _____ _____ Year _____

_____ Year _____ _____ Year _____

List of common surgeries:

- Adhesions
- Amputations
- Sleep apnea surgery (snoring)
- Appendectomy
- Brain surgery
- Breast (implants, biopsy, reduction)
- Bunionectomy
- Caesarian Section (C-Section)
- Cholecystectomy (Gallbladder removed)
- Colectomy (part colon removed)
- Cosmetic Surgery (implants, injections, other)
- Dialation and Curettage (D&C)
- Ear (Tube, Elective, Endocrine surgery, thyroidectomy, parathyroidectomy)
- Episiotomy (Pelvic Floor before childbirth)
- Gastroesophageal reflux (GERD)
- Hair Transplant
- Heart Surgery
- Hernia Surgery
- Hydrocele
- Hysterectomy (Abdominal, Vaginal, Total, Partial)
- Joint Surgery (Knee, Shoulder, Fingers, Hand, Feet, Hip)
- Laproscopy of Laparoscopic Surgery (abdominal pelvic, hernia)
- Liposuction
- Mastectomy
- Oncology surgery (cancer)
- Peripheral Vascular Surgery (Bypass, Stint)
- Plastic Surgery (Face lift, Eye lift, chin lift, brow lift, nose, rhinoplasty, tummy tuck, botox)
- Reconstructive surgery
- Scar revision
- Skin (graft, warts, moles, biopsy, cut, frozen, burned, skin tag)
- Spine surgery (back, neck, tail bone)
- Sports surgery
- Tubal ligation
- Varicose veins
- Varicocele repair
- Vasectomy or reversal
- Oral/Dental (Implants, Root canals, jaw, TMJ, reconstruction, palate, roof of mouth, gum, tonsils, adenoids, tongue, piercing

Scar history: (Please list all scars)_____

_____

_____

_____

List of common scars:

- Piercings
- Keloids
- Hypertrophic scar
- Contractures
- Acne
- Chicken Pox
- Small Pox Vaccine
- Vaccination with multi-dose gun
- Cut with glass
- Step on nail
- Barbed wire
- Hit with rock
- Cut with knife
- Split lip
- Face into windshield of car
- Burns
- Sunburns
- Wounds
- Scrapes
- Tattoos
- Chin split open when young
- Stitches

For the following Please Circle:

Y = YES **N** = NO **P** = significant problem in the past

General

Do you sleep well?	Y	N	P	Enjoy your work?	Y	N	P
Average 6-8 hours of sleep?	Y	N	P	Take vacations?	Y	N	P
Awaken rested?	Y	N	P	Spend time outside?	Y	N	P
In a supportive relationship?	Y	N	P	Eat 3 meals a day?	Y	N	P
Have a history of abuse?	Y	N	P	Treated for alcoholism?	Y	N	P
Experienced major traumas?	Y	N	P	Do you eat out often?	Y	N	P
Use recreational drugs?	Y	N	P	Do you drink coffee?	Y	N	P
Treated for drug dependence?	Y	N	P	How many cups? _____			
Currently using tobacco?	Y	N	P	Drink black or green tea?	Y	N	P
If yes how often? _____				Drink cola/soda?	Y	N	P
Smoke previously?	Y	N	P	Do you eat refined sugar?	Y	N	P
How many years? _____				Do you add salt to your food?	Y	N	P
How many packs per day? _____							

Review of systems

Y = a condition you have now **N** = never had **P** = significant problem in the past

Mental/Emotional

Treated for emotional problems?	Y	N	P	Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P	Mood swings?	Y	N	P
Considered, Attempted Suicide?	Y	N	P	Tension?	Y	N	P
Poor Concentration?	Y	N	P	Memory Problems?	Y	N	P

Head

Headaches?	Y	N	P	Head injury?	Y	N	P
Migraines?	Y	N	P	Jaw/ TMJ problems?	Y	N	P

Eyes

Spots in vision?	Y	N	P	Glasses or contacts?	Y	N	P
Impaired vision?	Y	N	P	Eye pain/strain?	Y	N	P
Blurriness?	Y	N	P	Tearing or dryness?	Y	N	P
Double vision?	Y	N	P	Glaucoma?	Y	N	P
Cataracts?	Y	N	P				

Ears

Impaired hearing?	Y	N	P	Ringing?	Y	N	P
Ear aches?	Y	N	P	Dizziness?	Y	N	P

Nose and Sinuses

Frequent colds?	Y	N	P	Nose bleeds?	Y	N	P
Sinus problems?	Y	N	P	Hayfever?	Y	N	P
Stuffiness?	Y	N	P	Loss of smell?	Y	N	P

Mouth and Throat

Frequent sore throat?	Y	N	P	Teeth grinding?	Y	N	P
Excessive saliva?	Y	N	P	Gum problems?	Y	N	P
Sore tongue or lips?	Y	N	P	Dental cavities?	Y	N	P
Hoarseness?	Y	N	P	Mercury filings?	Y	N	P
Jaw clicks?	Y	N	P				

Neck

Lumps in neck?	Y	N	P	Difficulty swallowing?	Y	N	P
Goiter?	Y	N	P	Pain or stiffness in neck?	Y	N	P

Respiratory

Cough?	Y	N	P	Shortness of breath?	Y	N	P
Sputum?	Y	N	P	Shortness of breath lying down?	Y	N	P
Asthma/wheezing?	Y	N	P	Pain breathing?	Y	N	P
Bronchitis?	Y	N	P	Emphysema?	Y	N	P
Coughing up blood?	Y	N	P	Tuberculosis?	Y	N	P

Cardiovascular

Chest pain?	Y	N	P	Cold hands/feet?	Y	N	P
Chest pain with exercise?	Y	N	P	Light headed?	Y	N	P
Heart palpitations?	Y	N	P	Fainting?	Y	N	P
Skipped heart beats?	Y	N	P	Rapid heart rate?	Y	N	P
Heavy feeling in chest?	Y	N	P				
Swelling in feet/legs?	Y	N	P				

Immune

Reactions to vaccinations?	Y	N	P	Chronic infections?	Y	N	P
Chronic Fatigue Syndrome?	Y	N	P	Slow wound healing?\	Y	N	P
Chronically swollen glands?	Y	N	P	Night sweats?	Y	N	P

Endocrine

Heat or cold intolerance?	Y	N	P	Diabetes?	Y	N	P
Hypothyroid?	Y	N	P	Excessive Hunger?	Y	N	P
Hypoglycemia (low blood sugar)?	Y	N	P	Fatigue?	Y	N	P
Excessive Thirst?	Y	N	P	Seasonal Depression	Y	N	P

Neurological

Seizures?	Y	N	P	Loss of memory?	Y	N	P
Paralysis?	Y	N	P	Vertigo or dizziness?	Y	N	P
Muscle Weakness?	Y	N	P	Loss of balance?	Y	N	P
Numbness or tingling?	Y	N	P				

Skin

Rashes?	Y	N	P	Eczema? Hives?	Y	N	P
Acne, Boils?	Y	N	P	Itching?	Y	N	P
Color changes?	Y	N	P	Perpetual hair loss?	Y	N	P
Lumps?	Y	N	P				

Gastrointestinal

Changes in thirst?	Y	N	P	Abdominal pain or cramps?	Y	N	P
Changes in appetite?	Y	N	P	Constipation?	Y	N	P
Nausea/vomiting?	Y	N	P	Diarrhea?	Y	N	P
Ulcer?	Y	N	P	Bowel movement how often?	_____		
Jaundice?	Y	N	P	Change in bowel habits?	Y	N	P
Gall bladder disease?	Y	N	P	Change in size/shape/color?	Y	N	P
Liver disease?	Y	N	P	Gas/bloating?	Y	N	P
Hemorrhoids?	Y	N	P	Undigested food in stool?	Y	N	P
Pancreatitis?	Y	N	P	Black stools?	Y	N	P
Heartburn?	Y	N	P	Blood in stools?	Y	N	P

Blood/Peripheral Vascular

Easy bleeding or bruising?	Y	N	P	Varicose veins?	Y	N	P
Deep leg pain?	Y	N	P	Cold hands/feet?	Y	N	P
Anemia?	Y	N	P	Thrombophlebitis?	Y	N	P

Urinary

Increase urinary frequency?	Y	N	P	Frequent urinary tract infections?	Y	N	P
Inability to hold urine?	Y	N	P	Kidney Stones?	Y	N	P
Pain with urination?	Y	N	P	Urgency?	Y	N	P
Frequency urination at night?	Y	N	P	Blood in urine?	Y	N	P

Female Reproduction

Age of first menses _____
Age of last menses (if menopausal) _____
Length of cycles _____
Duration of menses _____
Painful menses? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
If yes, what symptoms? _____
Are your cycles regular? Y N P
Bleeding between cycles? Y N P
Pain with intercourse? Y N P
Clotting? Y N P
Discharge? Y N P
Birth control? Y N P
What type? _____

Number of pregnancies? _____
Number of live births? _____
Number of miscarriages? _____
Number of abortions? _____
Menopausal symptoms? Y N P
Endometriosis? Y N P
Ovarian cyst? Y N P
Abnormal PAP? Y N P
Cervical dysplasia? Y N P
Date of last annual exam/ PAP _____
Breast pain/tenderness? Y N P
Breast lumps? Y N P
Nipple discharge? Y N P
Sexual difficulties/low libido? Y N P

Male Reproduction

Hernias? Y N P
Testicular pain? Y N P
Venereal disease? Y N P
Testicular masses? Y N P

Prostate disease? Y N P
Impotence? Y N P
Premature ejaculation? Y N P
Sexual difficulties/low libido? Y N P

Sexual History

Are you currently sexually active? Yes No
Partners (circle)? Male Female Both
Safe sex practices? Yes No
What type? _____
Ever tested for STI/STD's? Yes No
Dishcarge or sores? Y N P

Herpes? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Genital warts? Y N P
Syphilis? Y N P
HIV? Y N P

Musculoskeletal

Joint pain or stiffness? Y N P
Arthritis? Y N P
Broken bones? Y N P
Weakness? Y N P

Muscle spasms? Y N P
Muscle pain? Y N P
Sciatica? Y N P

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CONSENT FOR TREATMENT

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Vitae Health Center, PLLC having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic Medicine by doctors at Vitae Health Center, PLLC and/or other licensed doctors of naturopathic medicine serving as backup for him, hereafter called *allied health care provider*. I can request that students and preceptors not be included in my evaluation and treatment.

(Initial) _____ I acknowledge that the clinic or practice of Vitae Health Center, PLLC including its doctor(s) and staff, are distinctly and completely separate from (1) the doctor and or clinic and their staff that referred me, and or (2) the premises of the doctor(s) and or clinic in which care is being rendered.

I understand that I have the right to ask questions and discuss to my satisfaction with any doctor at Vitae Health Center, PLLC and/ or with the *allied health care provider* providing backup:

(1) my suspected diagnosis(es) or condition(s)
(2) the nature, purpose, goals and potential benefits of the proposed care
(3) the inherent risks, complications, potential hazards or side effects of treatment or procedure
(4) the probability or likelihood of success
(5) reasonable available alternatives to the proposed treatment procedure
(6) potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, muscle energy technique, visceral manipulation and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Trigger point injection therapy with vitamin substances
- Neural Therapy (scar, trigger point, deeper injections with procaine and homeopathic substances)
- Intravenous therapy (nutrient therapy where fluids with vitamins, minerals, amino acids, antioxidant compounds are administer by placing a needle in the arm)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, capsules, creams, powders, tinctures which may contain alcohol, suppositories, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Washington Naturopathic Physicians)

(CONTINUE TO THE BACK SIDE)

Potential risks: Pain, fracture, stroke, dislocation, sprain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed 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 and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, of these conditions.

Please Read And Initial:

_____ I understand that doctors at Vitae Health Center, PLLC are not licensed to prescribe any controlled substances.
_____ I understand that doctors at Vitae Health Center, PLLC will only prescribe medications that 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, China and the USA for years.
_____ I understand that doctors at Vitae Health Center, PLLC are not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Vitae Health Center, PLLC and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the doctor at Vitae Health Center, PLLC explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand that I am responsible for knowing where my personal items are at all times while in the office and if I choose to remove or place any of my personal items I am voluntarily and Vitae Health Center, PLLC and its associated doctors are NOT responsible or liable for any lost, stolen, or misplaced items. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

_____	_____
Printed Name of Patient	Signature of Patient
_____	_____
Printed Name of Guardian	Signature of Guardian
_____	_____
Date Signed	Print Provider's Name

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YOUR HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your healthcare. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- Threats to health or safety that involves you harming yourself or others.
- To make required reports to the police, such as gunshot wounds.
- Information about employees can be disclosed to employers regarding worker's compensation.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number: _____

___Please do not phone me at work. Use this alternate phone number: _____

___Please do not leave messages on my answering machine.

___Please do not contact me by email.

___Please send mail, including my bills, to this alternate address: _____

_____

___Other request (please describe): _____

I acknowledge that I have received a copy of Vitae Health Center's Notice of Privacy Practices and read the above HIPAA privacy rights.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) Date

E-Mail Authorization and Consent Agreement Between

I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems.
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
- There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of my medical record at Vitae Health Center. It is extremely important to include my name on each and every e-mail sent to Vitae Health Center.
- Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.
I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the following

Internet e-mail address: _____

_____
Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____
Patient Signature (Parent/guardian signature if minor) Date

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 the provided address below.

Vitae Health Center
16521 13th Ave West Ste. 105, Lynnwood, WA 98037

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.vitaehealthcenter.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).

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 Vitae Health Center.

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 425-742-3800 or by contacting the Secretary of Health and Human Services. We will take no punitive action against you for filing a complaint.

Vitae Health Center PLLC
16521 13th Ave West, Ste. 105, Lynnwood, WA 98037 (425) 742-3800 vitality, naturally

PAYMENT AGREEMENT

Dear New Patient,

Welcome to Vitae Health Center. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care.

Please read and initial the following statements:

_____ Payment for all services and medicinary items are due at the time of the visit. We accept cash, checks, Visa, or MasterCard. Returned checks will be subject to a $35.00 NSF fee.

_____ Doctors at Vitae Health Center are contracted providers with selected insurance plans. It is solely your responsibility to understand your benefits. You are responsible financially for all balances due once your insurance company has processed the claim for your visit.

_____ You will be charged a Missed Appointment Fee of $50.00 for missed appointments or late cancellations (less than 24 hours notice).

_____ You will be billed for phone or e-mail correspondence based on complexity, ***except*** those regarding questions about prescribed treatments and conditions already being treated that require less than 10 minutes of attention.

_____ I understand that if I choose to do a phone or Skype consult that I will be billed based on complexity the same as a regular office visit for any new health issue. I understand that phone and Skype visits will *NOT* be covered by insurance reimbursements and I will be responsible for full payment.

_____ All pharmacy items must be paid for at the time of purchase. Refunds or exchanges are given on unopened items in re-saleable condition if returned within 30 days. No refunds or exchanges will be given of opened items of after 30 days.

_____ Any ongoing bills that are not paid within 30 days of the visit are subjected to 12% per year (1% per month) interest charges. If Vitae Health Center assigns your account to a collection agency, you will be responsible for any collection fees.

Continue to next side…….

Your health care provider may prescribe medication, which may be purchased at Vitae Health Center or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense and certain lab tests that we may order. Other IV and injection services and supplies are ***NOT*** covered by insurance companies. Usual and customary Evaluation and Management or other medically necessary services may be billable to my insurance. I understand that this requires my payment in full for all IV / Injection services, supplies, medicinary items and I will not attempt to bill my own insurance company for any of these services.

I have read and understand the above-stated policies of Vitae Health Center and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) Date