PATIENT INFORMATION SHEET

Patient:

Last Name: _____ First Name:_____ Middle initial: _____
Date of Birth: _____ / _____ / _____ Age: _____ SS#: _____
Birth Gender (please circle one): Male Female
Current Gender: Male Female Transsexual Other explain: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Telephone: (h) _____(w) _____(cell)_____

Email _____ What is the best way to contact you? _____

Employer Name: _____Occupation: _____

Employer Address: _____

Relationship status: Single _____Married ____ Partner ____ Separated ____ Divorced ____Widowed ____
Live with: Spouse____ Partner _____ Parents _____ Children _____ Friends _____ Alone _____ Other _____

Spouse or Guardian (Please circle one):

Last Name: _____ First Name: _____Middle initial: _____

Telephone: (h) _____ (w) _____(cell) _____

Emergency contact: Name and address of nearest relative or trusted friend:

Last Name: _____ First Name: _____ Middle initial: _____

Telephone: (h) _____ (w) _____ (cell) _____

Relationship to Patient: _____

Passion for Healing Naturopathic Policies

I give permission to Dr. Curry to contact me via telephone or email. I understand if I am not available, a message with information about my appointment or my medical condition may be left. If this is unacceptable please communicate in advance how you would like to be contacted. NOTE: Email is not a secure communication.

Please refrain from using your phone during your House Call unless it is an emergency or necessary to obtain health information. Loosely, you are paying by the hour. Thank you.

Payment by check, money order, MasterCard or Visa is due at the end of your Naturopathic House Call. If you want to discuss full or partial fair trade for services or goods, please arrange this prior to your visit. At Dr. Curry's discretion, phone consultations may be charged either by time, or per consult depending on case complexity. There is a $25.00 fee for returned checks to cover bank fees. Dr Curry understands that on occasion, financial problems

may affect timely payment of your account. If such a situation arises, please contact Dr. Curry promptly so payment arrangements can be made.

Insurance Policy: In order to keep overhead low in this economic recession and thus enable Dr. Curry to offer affordable rates for appointments, *Passion for Healing Naturopathic* does Not currently accept insurance. Full payment by cash, check or Mastercard/Visa is due at the end of each appointment. Upon request Dr. Curry can create for you a "superbill" that you can submit yourself to your insurance. This invoice will include medical billing codes and descriptions of rendered services your insurance may be willing to reimburse you for. In my experience patients are far more likely to receive full reimbursement from insurance companies for Naturopathic care, even if I hire a relatively costly medical billing specialist. As these inequities in insurance reimbursement for fields still considered "CAM" (complimentary alternative medicine) are overcome, Dr. Curry will periodically reconsider accepting insurance directly. Please look again for updates on this policy.

Supplement Policy: Payment in full is expected at time of purchase. There is no requirement to purchase recommended supplements from Dr. Curry; local stores and websites may carry similar products. Be aware that quality varies between manufacturers.

Return Policy on Supplements: Unopened, undamaged and unused pre-packaged supplements may be returned for their full value within one month of purchase. Clearance items and individualized supplements that are formulated by Dr. Curry cannot be returned. We are prohibited from accepting returns once a safety seal has been broken.

Late Cancellation/Missed Appointments: Please call 24 hours in advance to cancel or change an appointment. A missed appointment fee of $50 will be assessed for appointments cancelled with less than 24 hours notice. Please note, we place appointment reminder calls as a courtesy. If you do not receive a reminder call prior to your appointment, the missed appointment fee still applies.

I have read and understand the above policies. Initial Here: _____
If you have questions about any of the above please contact Dr Curry. We appreciate that you have chosen us for your health care and are glad to be of service to you.

Responsible Party: Fill out if you are not the patient but are responsible for the bill.

Responsible Party: _____ Relationship to the patient: _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Telephone: (h) _____ (w) _____ (cell) _____

Email _____ What is the best way to contact you? _____

SIGNATURE: (Adult Patient, Parent, Legal Guardian or Responsible Party)

I request services X_____

Patient Authorization: I agree to pay for all medical services rendered by *Passion For Healing Naturopathic*.

Patient's or Authorized Person's Signature: _____

Name (please print): _____ Date:_____

Last Name_____ First Name_____

Passion for Healing New Patient Intake Form

This form is a detailed questionnaire designed to help you communicate your medical history, family risk factors, current and other health complaints, allergies, prescription/supplements list, and more, enabling Dr. Curry rapid understanding of your personal health needs. Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Ultimately it will help her serve you and make your Naturopathic House Call more productive. You can download and print one from this website or Dr Curry can send you a paper version by mail. Please have it filled out and ready for review during your first visit. You may also want to prepare your own list of any additional questions or concerns that you have for Dr. Curry. If you are unable to fill out this form, Dr Curry can assist you on the first visit.

What are your expectations from this first Naturopathic House Call?

_____

_____

_____

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

_____

_____

_____

What do you know about our approach?

_____

_____

Are there any potential obstacles you foresee in addressing unhealthy lifestyle factors Naturopathically?

_____

_____

Are you currently receiving healthcare (circle)? Yes No

If yes, where and from whom: _____

_____

If no, when, where and for what reason did you last receive medical or health care? _____

_____

In order of importance please list your most important health problems: _____

_____

_____

_____

_____

_____

_____

Last Name_____ First Name_____

Please list any contagious diseases you may have at this time: _____

_____

Any major traumas, accidents, broken bones?_____

_____

Any other health complaints not listed? _____

_____

Hospitalization, Surgery, Imaging Please list dates of any hospitalizations, surgeries, procedures, X-Rays, CAT Scans, MRIs, Bone density scans, EEG, EKG's or other imaging that have you had:

_____

_____

_____

Allergies or Hypersensitivities

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

Current Medications Please circle any you take:

Pain relievers Antacids Cortisone Antibiotics Tranquilizers Thyroid medication
Sleeping pills Laxatives Appetite suppressants Inhalers Allergy pills

Please list all prescription medications and over-the-counter medications you take (attach list if necessary):

_____

_____

_____

Supplements Please list any vitamins or other supplements you take:

_____

_____

_____

Family History Do you have a family history of any of the following (please circle)?

Diabetes Heart Disease High Blood Pressure Kidney Disease Epilepsy Arthritis
Glaucoma Tuberculosis Stroke Anemia Mental Illness Cancer Asthma
Allergies/Hay fever/Hives Sickle cell anemia Hemachromatosis

Any other relevant family history? _____

Last Name_____ First Name_____

Childhood Illnesses Please circle whether you had any of these as a child:

Scarlet fever Diphtheria Rheumatic fever Mumps Measles German measles

Other: _____

General
Height: _____Weight (lbs): _____ Unexplained weight gain/loss? _____
Maximum Weight: _____When: _____ Desired Weight: _____

When during the day is your energy: Best? _____ Worst?_____

Typical Food Intake Please describe a typical days worth of meals and snacks:

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Deserts/Candy: _____

Water (cups): _____Soda/juices/energy drinks: _____Coffee/tea: _____

Do you eat three meals a day? Yes No Do you go on diets often? Yes No

Do you eat out often? Yes No If yes, how often? _____

Do you eat refined sugars? Yes No Do you add salt? Yes No Fried foods regularly? Yes No

Habits For the following please circle

Y=Yes, a condition you have now N=No, never had P=Past problem

Main interests and hobbies:_____
Enjoy your work? Y N Take vacations? Y N Spend time outside? Y N

Do you have a religious or spiritual practice? Y N If yes, what? _____

Watch television? Y N Hours per day? _____ Video games/web surfing? Y N Hours per day? _____

Have a supportive relationship? Y N Have a history of domestic abuse? Y N

Can you read? Y N P If no, are able to access health information via audio books or DVD? Y N

Exercise Do you exercise? Y N If yes, what kind? _____ How often? _____

Sleep Average 6-8 hours sleep? Y N If no, how much? _____ Sleep well? Y N Awaken rested? Y N

Alcohol/Tobacco/Drugs Use alcoholic beverages? Y N P If yes, how much? _____

Treated for alcoholism? Y N P Use recreational drugs? Y N Treated for drug dependence? Y N P

Use tobacco? Y N P Past smoker Y N P How many years? _____ Packs per day? _____

Last Name_____ First Name_____

Review of Systems

Y=Yes, a condition you have now N=No, never had P=Past problem

Mental
Fatigue Y N P Memory loss Y N P Poor concentration Y N P Easily stressed Y N P
Alzheimer's Y N P Learning Disability Y N P Developmentally disabled Y N P
Other: _____

Emotional
Have you been treated for troubling emotions? Y N P Depression Y N P Mood Swings Y N P
Anxiety/Nerves Y N P Considered/Attempted suicide Y N P Stress Y N P Anger Y N P
Bipolar Y N P Schizophrenia Y N P Paranoia Y N P ADHD Y N P OCD Y N P
Seasonal depression Y N P
Other: _____

Neurologic
Paralysis Y N P Loss of balance Y N P Muscle weakness Y N P Numbness/tingling Y N P
Stroke Y N P Loss of speech Y N P Vertigo/dizziness Y N P Cerebral Palsy Y N P
Seizures Y N P Brain Injury Y N P Brain Tumor Y N P Sensory Loss Y N P
Other: _____

Immune
Chronic infections Y N P Frequent Flu's/Colds Y N P Swollen glands Y N P HIV/AIDS Y N
Chronic Fatigue Syndrome Y N P Slow wound healing Y N P Reactions to immunizations Y N P
Other: _____

Endocrine
Hypothyroid Y N P Hyperthyroid Y N P Heat/cold intolerance Y N P Hair Loss Y N P
Dry skin Y N P Night Sweats Y N P Hypoglycemia Y N P Diabetes Y N P
Excessive thirst Y N P Excessive hunger Y N P
Other: _____

Skin
Rashes Y N P Itching Y N P Eczema, Hives Y N P Acne, Boils Y N P Psoriasis Y N P
Lumps Y N P Lesion with Irregular Border Y N P Rapid Growing Y N P Won't heal Y N P
Color Change Y N P Ulcer Y N P Shingles Y N P Diaper rash Y N P Dry/Oily Y N P
Other: _____

Head
Headaches Y N P Migraines Y N P Jaw/TMJ problems Y N P Head Injury Y N P
Other: _____

Eyes
Impaired vision Y N P Glasses/ contacts Y N P Cataracts Y N P Glaucoma Y N P
Macular Degeneration Y N P Eye pain/strain Y N P Blurriness Y N P Spots in Eyes Y N P
Blindness Y N P Tearing or dryness Y N P Double Vision Y N P
Other: _____

Ears
Hearing loss Y N P Ringing Y N P Earaches Y N P Infections Y N P Dizziness Y N P
Other: _____

Last Name_____ First Name_____

Nose and Sinuses
Frequent colds Y N P Nose Bleeds Y N P Stuffiness Y N P Nasal drip Y N P
Hay fever/Allergies Y N P Sinus congestion Y N P Loss of smell Y N P
Other: _____

Mouth and Throat
Frequent sore throat Y N P Dental cavities Y N P Gum problems Y N P Cold sores Y N P
Sore tongue/lips Y N P Drooling Y N P Dry mouth Y N P Hoarseness Y N P
Trouble swallowing Y N P Loss of voice/larynx Y N P Jaw clicks Y N P Teeth grinding Y N P
Other: _____

Neck
Pain or stiffness Y N P Lumps Y N P Swollen glands Y N P Goiter Y N P
Other: _____

Respiratory
Cough Y N P Spitting up mucus Y N P Spitting up blood Y N P Difficulty breathing Y N P
Pain on breathing Y N P Shortness of breath Y N P Shortness of breath lying down Y N P
Wheezing Y N P Asthma Y N P Emphysema Y N P Bronchitis Y N P Pleurisy Y N P
Pneumonia Y N P Black lung/Asbestosis Y N P Tuberculosis Y N P Lung cancer Y N P
Other: _____

Cardiovascular
High/Low Blood Pressure Y N P Heart disease Y N P Angina Y N P Chest pain Y N P
Murmurs Y N P Palpitations/Fluttering Y N P Rheumatic Fever Y N P Blood clots Y N P
Fainting Y N P Phlebitis Y N P Swelling in ankles Y N P
Other: _____

Blood / Peripheral Vascular
Deep vein thrombosis Y N P Deep leg pain Y N P Varicose veins Y N P Swollen ankles Y N P
Feeling loss in feet Y N P Hands/feet fall asleep Y N P Cold hands/feet Y N P
Hands turn white in cold weather Y N P Easy bleeding/ bruising Y N P Thrombophlebitis Y N P
Anemia Y N P Iron overload/hemachromatosis Y N P
Other: _____

Gastrointestinal
Nausea/vomiting Y N P Heartburn Y N P Abdominal pain/cramps Y N P Ulcer Y N P
Gall Bladder disease Y N P Liver Disease Y N P Jaundice (yellow skin) Y N P Belching Y N P
Change in appetite/ thirst Y N P Is this a recent change? Y N
Bowel Movements: How often?_____
Constipation Y N P Diarrhea Y N P Passing gas Y N P Hemorrhoids Y N P
Blood in stool Y N P Black stools Y N P Pale stool Y N P Intestinal parasites/worms Y N P
Irritable bowel syndrome Y N P Inflammatory bowel disease Y N P Colon cancer Y N P
Other: _____

Urinary
Increased frequency Y N P Frequency at night Y N P Inability to hold urine Y N P
Difficulty urinating Y N P Pain on urination Y N P Blood/pus in urine Y N P
Frequent infections Y N P Kidney stones Y N P Interstitial cystitis Y N P
Other: _____

Last Name_____ First Name_____

Musculoskeletal
Back pain Y N P Joint pain/stiffness/swelling Y N P Arthritis Y N P Weakness Y N P
Muscle wasting Y N P Muscle spasms or cramps Y N P Carpel Tunnel Y N P Sciatica Y N P
Osteoporosis Y N P Broken bones/trauma Y N P Dislocation Y N P
Other: _____

Male Reproduction
Hernias Y N P Testicular masses Y N P Testicular pain Y N P Prostate disease Y N P
Are you sexually active? Y N Number of partners: _____ Have you ever been tested for STIs? Y N
Sexually Transmitted disease Y N P Discharge /sores Y N P Chlamydia Y N P Gonorrhea Y N P
Syphilis Y N P Herpes Y N P Genital Warts Y N P HIV Y N P
Impotence Y N P Erectile dysfunction Y N P Premature ejaculation Y N P
Birth control? Y N Type: _____
Sexual orientation: _____
Other: _____

Female Reproduction / Breasts
Are you pregnant? Y N Due date: _____
Age of first menses: _____ Date of last annual exam/ PAP: _____
Date of last menses _____ Are cycles regular? Y N Length of cycle:_____days
Bleeding between cycles Y N P Duration of menses:_____days Pain during intercourse Y N P
Painful menses Y N P If yes, what are your symptoms?_____
Clotting Y N P Heavy/excessive flow Y N P PMS Y N P
Endometriosis Y N P Ovarian cysts Y N P Uterine fibroids Y N P Abnormal PAP Y N P
Cervical Dysplasia Y N P Cervical cancer Y N P Hysterectomy Y N Ovaries left? Y N
Do you do breast self-exams? Y N P Mammogram Y N If yes, last date: _____
Breast lumps Y N P Breast pain/tenderness Y N P Nipple discharge Y N P
Menopausal symptoms Y N P Hot Flashes Y N P Vaginal dryness Y N P Loss of libido Y N P
Prolapse Y N P Chronic Fatigue Y N P Hair changes Y N P Night sweats Y N P
Are you sexually active? Y N Number of partners: _____ Have you ever been tested for STIs? Y N
Sexually Transmitted disease Y N P Discharge /sores Y N P Chlamydia Y N P Gonorrhea Y N P
Syphilis Y N P Herpes Y N P Genital Warts Y N P HIV Y N P
Sexual orientation: _____
Birth control Y N P Type:_____
Number of pregnancies: _____ Number of live births: _____ Miscarriages: _____ Abortions: _____
Difficulty conceiving Y N P Sexual difficulties Y N P Inability to orgasm Y N P
Other: _____

Thank you for your time and effort.
Dr. Curry sincerely looks forward to meeting you and fulfilling your health care needs and goals.

Last Name_____ First Name_____

Informed Consent for Naturopathic Medical Treatment

I, _____, hereby authorize Dr. Mindy Curry or other licensed doctors of naturopathic medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., laboratory, venipuncture, UA, Pap smears, radiography, allergy testing,
Minor medical procedures: e.g., ear cleansing, nail care, nasal specific, wound care, minor surgery,
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, IM vitamin injections, IV therapy,
Botanical medicine: botanical substances may be prescribed fresh or as teas, alcohol tinctures, syrups, powders, capsules, tablets, troches, creams, essential oils, gels, or suppositories,
Hydrotherapy: the use of water, warm, hot or cold to stimulate circulation, immune function, and relieve pain,
Naturopathic physical medicine: e.g. naturopathic manipulation therapies, Positional release techniques, Strain/Counterstrain, Post-Isometric Relaxation stretch, Physiotherapy,
Therapeutic massage techniques: heat and cold therapies, electric stimulation, manual therapies, energywork,
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses,
Environmental counseling: identification and removal of environmental obstacles to health, e.g., toxins, allergens.
Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction, balancing of work with social activities, art therapy and spiritual awareness,
Psychological counseling: Discussion of emotional concerns, origins thereof, and options for management,

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections, venipuncture, or physical medicine, aggravation of pre-existing conditions.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it (fees apply for subsequent copies).

_____	_____	_____
Printed Name of Patient	Signature	Date
_____	_____	_____
Printed Name of Legal Guardian	Signature	Date

Passion for Healing Naturopathic Privacy Policy

Physician Legal Duties:
Dr. Mindy Curry is required by state and federal law to maintain the privacy of the protected health information in your patient file, to provide you with this notice of our privacy practices, and to abide by the terms of this notice while it is in effect. Dr. Curry reserves the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice Dr. Curry will notify you in writing as soon as possible.

Dr. Curry may obtain these types of Protected Health Information about you:

Your protected health information may be used and disclosed by Dr. Curry, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing Naturopathic services to you, to pay your medical bills, to support the operation of the doctor's practice, and any other use required by law.

Demographic Information: including your name, date of birth, phone number(s), home/billing address, address name of your employer, your spouse or other family members, and emergency contact (s).

Health Information: including your health history such as your current and/or ongoing health problems, including medications, allergies, advised treatment and outcomes of that treatment, past illnesses or injuries, family medical history, your social habits including use of tobacco, alcohol, or drugs, and your lifestyle including living situation and family structure.

Payment Information: including your record of medical fees, adjustments, payments to *Passion for Healing Naturopathic*, and your insurance carrier if applicable.

Insurance Information: including the name of the insured person, your insurance carrier, insurance policy numbers, benefits and eligibility information.

Dr. Curry may use and disclose Protected Health Information about you in these ways:

Protected Health Information used or disclosed for the following purposes does not require your consent:

For Treatment: Dr. Curry will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another 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. We may use and disclose your health information to doctors, nurses, technicians, office staff or other personnel to provide, coordinate or manage your health care and any related services. For example, your protected health information may be disclosed to another health care provider treating you, a nurse or technician who is assisting in your treatment, a hospital in which you are admitted as a patient, a pharmacy so that they can fill or refill a prescription for you, or to schedule tests for you with a laboratory. Your health information may also9 be used provide you with appointment reminders.

For Payment: We may use and disclose your information to obtain payment for Naturopathic services you receive. For example your information including your conditions or reasons for seeking care and the care received may be used to obtaining approval for a hospital stay, determine eligibility for insurance or benefits, to file, process or pay a claim for you, or for insurance approval payment for recommended tests and treatment. We may provide information about your services to a health care clearinghouse so that they may distribute a claim to your insurance carrier on our behalf.

For Health Care Operations: *Passion for Healing Naturopathic* may use or disclose protected health information about you in order to evaluate ourselves or to meet a business need of the organization such as quality assessment activities, treatment efficacy reviews, employee reviews, training medical students or residents, compliance audits by your insurance carrier, and conducting or arranging for other business activities. Your protected health information may also be used use or disclosed to our Business Associates in the performance of health care operations such as a medical chart transcription service, our accountant, Naturopathic licensing agencies, or qualified business management consultants. Our Business Associates are obligated by contract to protect health information they receive or generate about you.

Family Members or Other Persons Involved in Your Care: If you are not available or incapacitated, Dr. Curry will determine if whether, in her professional judgment, a disclosure to an individual identified by you (such as family, friends or representative) is in your best interest or for the payment of your care. Only protected health information that is directly relevant to their involvement in your care will be disclosed. You will be given an opportunity to object to these disclosures if you are available. If you object, these disclosures will not be made.

Other Contact Situations: Dr. Curry may use your information to call and remind you of an appointment or to tell you about/recommend health-related products or services or possible treatment options and their alternatives.

Special Situations:

Emergencies: Your protected health information may be used/disclosed in the case of a medical emergency.

Required By Law/ Law Enforcement: Your health information will be disclosed when required by federal, state or other applicable laws. Your protected information may be given at the request of a law enforcement official if you are, or are suspected to be, a victim of a crime and we are unable to obtain your authorization, to alert a law enforcement official of your death if we suspect your death may have resulted from criminal conduct, if your health information is evidence of criminal conduct that has occurred on our premises, in an emergency to report a crime, the location or victims of a crime and the identity of the person who committed the crime, or to prevent/lessen a serious imminent threat to the health or safety of a person or the public.

Public Health: Protected health information about you may be disclosed to public health officials in order to prevent or control disease, injury or disability, to report births or deaths, to report child or elderly abuse, neglect or domestic violence, to report reactions to medications or problems with FDA-regulated products, or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. Dr. Curry will only make this disclosure if you agree or when required or authorized by law.
Your health information will also be disclosed when needed to prevent a threat to your health and safety or the health and safety of the public or another person. Also, we will disclose your health information to a public health authority for the purpose of preventing or controlling disease/injury or to a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition if we are authorized by law to notify such a person. If the doctor believes you are the victim of abuse, neglect or domestic violence and you agree to the disclosure your information may be disclosed to an authorized governmental authority, including a social service or protective service.

Serious Threats: As permitted by applicable law and standards of ethical conduct, your information may be disclosed to prevent /lessen a serious and imminent threat to the health/safety of a person or the public.

Coroners, Medical Directors and Funeral Directors: A coroner or medical examiner may require protected health information in order to identify a deceased person or determine the cause of death. Information about patients may be released to funeral directors as necessary to provide services.

Organ and Tissue Donation: If you are an organ or tissue donor, your protected health information may be disclosed to organizations that engage in the procurement, banking or transportation of organs, eyes or tissues for transplantation or donation.

Health Oversight: Protected health information may be disclosed to health oversight agencies for the execution of audits, civil, criminal or administrative investigations, inspections, disciplinary actions and as necessary governmental monitoring of the health care system, government programs and compliance with civil rights laws.

Lawsuits or Disputes: In response to a subpoena, court or administrative order, your medical information may be disclosed.

Workers Compensation: Medical information about you may be disclosed to programs that provide benefits for work-related injuries or illness.

Military Activities, National Security and Intelligence Activities:
If you are a member of the armed forces, your health information may be disclosed as required by the military. The health information of foreign military personnel may be disclosed to their appropriate foreign military authority, or to determine compliance with civil rights laws. Your health information may be disclosed to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security actions or for the provision of protective services to the President, foreign heads of state and other authorized persons.

Judicial and Administrative Proceedings Your protected information may be disclosed in order to comply with a court or administrative order, a subpoena, a discovery request or other lawful process that is not accompanied by a court or administrative order if (i) we receive satisfactory assurances that reasonable efforts have been made to ensure that you have been given notice of the request; or (ii) we receive satisfactory evidence that reasonable efforts have been made to secure a qualified protective order.

Inmates: Your medical information may be released to a correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official. This disclosure may be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others or for the safety and security of the correctional institution.

Information that is not personally identifiable: Your information may be used or disclosed in a way that does not personally identify you.

If available, you must be given the option to agree or object to Protected Health Information used and disclosed in the following ways:

If you are not available, Dr. Curry will determine whether a disclosure to an individual identified by you (such as family, friends or representative) is in your best interest or for the payment of your care. Only protected health information that is directly relevant to their involvement in your care will be disclosed. You will be given an opportunity to object to these disclosures if you are available; if you object these disclosures will not be made.

Your specific authorization is absolutely required for disclosure of the following Protected Health Information:

Other undisclosed uses and disclosures of your protected health information require your written authorization, unless otherwise permitted or required by law as described below. Authorization may be revoked at any time by notifying Dr. Curry in writing.

Your Rights as a Patient

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Certain documents pertaining to laboratory services are also exempt under federal law. You will be charged for the cost of copying, mailing or associated supplies. Under certain circumstances, for example if Dr. Curry concludes that access to your health information will endanger your life or physical safety, your request may be denied; however, you may appeal this decision. Your appeal will be reviewed by another licensed health care professional selected by us whose recommendation Dr. Curry will comply with. If you would like a copy of your health information, Requests to access your protected health information must be made in writing. Please tell Dr. Curry of your need.

You have the right to request a restriction of your protected health information. You have the right to restrict our use or disclosure of your health information for purposes of treatment, payment or health operations. For example, you may request that we not disclose your health information to a family member or a friend involved in your care who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request to restrict the use or disclosure of your health information should be in writing and must state: 1)What health information you do not want used or disclosed, 2) Whether you want to limit our use, 3)limit our disclosure, 4)or both and 5) The names of the persons or entities to whom disclosure should not be made. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. Dr. Curry may decide for similar reasons to terminate our agreement to restrict use or disclosure. Our termination will be effective only for your health information created or received after you are informed of this termination.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You may request that *Passion for Healing Naturopathic* communicate with you in a certain way or at a specific location. Dr. Curry will attempt to accommodate all reasonable requests made in writing. Your request must specify where or how the communication is to be directed. For example, you can request that we contact you only at your home by mail or by telephone.

You have the right to request that we correct or clarify your protected health information. You have the right to submit information that amends your health information. The information you submit will be retained with our record of your treatment. If a statement is made in your chart in response to your request, you will be provided a copy of the statement. The information you desire to submit must be in writing and should include the reasons why your health information should be corrected or clarified. Your request may be denied if the protected health information that is the subject of your request was not created by our organization, is not a part of your medical or billing records, is information that you are not permitted to inspect or copy or is already a complete and accurate record. If your request is denied you have the right to file a statement of disagreement. You will be sent any rebuttal of your rebuttal, if made.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to request a written accounting of certain disclosures made of your health information. The accounting will include the date of each disclosure, name and, if known, the address of the person or entity receiving the disclosure, a brief description of your disclosed health information and brief statement of the purpose of the disclosure. Some disclosures are exempt including disclosures made/authorized by you, those used to carry out treatment, payment and health care operations as described above, to persons involved in your care or for other notification purposes as provided by law, for national security or intelligence purposes as provided by law, and those to correctional institutions or law enforcement officials as provided by law. Your request must be in writing. It should state the period for which you desire an accounting. The period cannot be longer than six years and cannot include any date prior to April 14, 2003. You are allowed one free disclosure per each twelve-month period. If you wish additional disclosures within that twelve-month period, you will be charged the cost of providing the disclosure list. Your request for a disclosure accounting must be made in writing.

You have the right to file a complaint. If you believe your privacy rights have been violated**,** you may file a complaint with Dr. Curry or with the Secretary of the Department of Health and Human Services. Your complaint should be in writing. We will not discriminate or take any retaliatory action against you by reason of your filing a complaint or exercising any of your privacy rights.

Other Authorized Uses and Disclosures: You may authorize us to use and disclose your health information in ways not described in this notice. Your authorization must be in writing and must comply with applicable law. You may revoke any authorization made by you. Once you revoke an authorization, your information will no longer used or disclosed for the purposes that you had previously authorized. Your revocation must be in writing and will be effective when received by Dr. Curry.

Your personal representative*:* If you are legally or otherwise incapable of exercising your privacy rights, or choose to designate someone to act on your behalf, that person authorized to act on behalf you is your "personal representative." A personal representative may have broad authority to make health care decisions for an individual or authority may be limited to specific treatment or care. For example, a legal guardian may have broad authority while a person with an individual's limited health care power of attorney may only have authority regarding a specific treatment. The personal representative for an Unemancipated Minor is a parent, guardian or other person authorized by State law to make health care decisions on behalf of the minor child. For an Adult or Emancipated Minor, the personal representative is usually a person with legal authority to make health care decisions on behalf of the individual such as a health care Power of Attorney, Court Appointed Guardian, or other person(s) authorized by State law. A person with legal authority to act on behalf of the decedent's estate is the personal representative for a deceased individual.

Under certain circumstances regardless of whether a parent is the personal representative of a minor child, disclosure of a child's health care information to the parent is prohibited. A minor child's health information to a parent cannot be given under the following circumstances: When State or other law does not require the consent of a parent or other person before a minor can obtain a particular healthcare service, and the minor consents to the healthcare service; when a court determines, or other law authorizes, someone other than a parent to make treatment. Under certain circumstances, Dr. Curry may choose not to recognize a person as the personal representative of our patient. A personal representative may not be recognized if, for example, a minor child or incompetent adult has been, or may be subjected to, domestic violence, abuse or neglect by that personal representative. If treating a person as personal representative could likely endanger the minor child or incompetent adult, Dr. Curry may choose not recognize that person's authorization.

Revisions to Our Privacy Notice: We are required to abide by the terms of this Privacy Notice. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Privacy Notice. You may obtain this by calling *Passion for Healing Naturopathic* and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your next appointment.

You have the right to request and receive a paper copy of this notice from our office.

Questions / Contact: If you have questions about this document, or have questions about privacy or patient rights, please contact Dr. Mindy Curry. Phone Number: 503-995-8674.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. This notice becomes effective on January 1, 2010.

Your signature below is only an acknowledgment that you have received this Notice of our Privacy Practices:

_____	_____	_____
Patient Name (Printed)	Signature	Date
_____	_____	_____
Responsible Party (Printed)	Signature of Responsible Party	Date