Welcome to the Alpine Valley Wellness Center!

There are two reasons why there are probably more forms here than you are used to. The first is the increasing number of state, federal, and legal documents required by insurance and government agencies.

The second, however, is because we are passionate about doing comprehensive healthcare and we truly want to understand all the things are contributing to your health issues. This understanding then becomes part of the treatment approach Dr. Piscopo developed called Healthiscaping ™

Healthiscaping looks at your medical issues against the backdrop of what the scientific medical literature tells us are the key factors in quality of life, health, and longevity. These are often called the "pillars of health." In Healthiscaping, we use the analogy of a wheelbarrow to look at these:

- Wheel = Movement/Exercise
- Left strut = Diet/Nutrition
- Right strut = Connection/Emotional Health
- Left handlebar = Molecules (meds, drugs, supplements)
- Right handlebar = Cognitive/Choices/Brain Health
- The ground on which all this rests = **Sleep**

Thank you for taking the time to fill out the intake packet. Please take a moment to read the Office Policies form, which will help you get the most out of your visits with us.

We look forward to working with you!

Gary Piscopo, ND, LAc

Alpine Valley Wellness Center, PC

430 Elva Way. East Wenatchee, WA 98802 (509) 886-9355

Note: The information you provide is confidential and will be secured via HIPAA regulations. Please complete this questionnaire as thoroughly as possible. Thank you.

Name:_____ **Age**_____ **Birth Date**_____ **Gender Identity:**_____

Phone # Home: _____ Work: _____ Mobile: _____

Allergies (medications, foods, etc.): _____

Emergency contact: _____ Phone number _____

Why did you choose our clinic? _____

Your Current Health Care Team

Primary Care physician: _____ Clinic _____
Other physicians/ARNPs: _____ Specialty:_____
Other health care professionals you have seen (e.g. massage therapist, nutritionist, physical therapist, chiropractor etc.):
Practitioner Name: _____ Specialty: _____
Practitioner Name: _____ Specialty: _____
Naturopathic/Integrative Physician before? ❑ Yes ❑ No Name: Dr._____
Have you seen an acupuncturist before? ❑ Yes ❑ No Name: _____

Primary Health Concerns

Please list your top 3 health concerns in order of importance.

Concern *ex: Headache*	**Onset Date** *ex. June 1992*	**Severity** *Mild/Moderate/Severe*

Current Mental Health issues: _____

- Current spiritual/religious practices for mental/emotional health e.g., prayer, devotional? ❑ Yes ❑ No
- Current secular practices for mental/emotional health e.g. mindfulness, yoga ❑ Yes ❑ No

Please list any hospitalizations, surgery, or serious injuries with the date and type illness/operation/injury:

_____

_____

Please list the three most significant events in your life that currently impact your health or quality of life:

_____

_____

What are your top 2 therapeutic goals for your course of treatment with us?

1. _____
2. _____

What is your occupation? _____ Any work issues that negatively impact health? _____

Current relationship status: _____ Any relationship issues that negatively impact health? _____

How did you hear about our Clinic? _____

Personal Health Habits

Height _____ **Current Weight:** _____lbs Weight 1 year ago: _____lbs Maximum weight: _____lbs

Tobacco use ❑ Yes ❑ No If yes, ❑ Smoke or ❑ Chewed for _____years Amount per day___ Year stopped _____

Alcohol ❑ Yes ❑ No If yes, type_____ Frequency_____ Abuse history? ❑ Yes ❑ No

Recreational Drugs ❑ Yes ❑ No If yes, type_____ Frequency_____ Abuse history? ❑ Yes ❑ No

Exercise ❑ Yes ❑ No If yes, describe type and frequency _____

Stressors What are the top 3 stressors in your life?_____

How do you usually deal with stress? _____

How would you rate your current quality of life ? Rate from A to F: _____

Diet: Are you happy with your current diet? _____ If not, what would you like to change? _____

Special diet or food allergies _____ Intermittent fasting or Time-restricted eating? ❑ Yes ❑ No

Please briefly describe the usual items you would have for each meal:

Breakfast: _____
Lunch: _____
Dinner : _____
Snacks: _____

Medications/Supplements

Please list any vitamins, minerals, herbal supplements, homeopathics, over-the-counter and prescribed medications, or creams that you are taking

Supplement	Date started	Dosage	Frequency
example: Vitamin C	*4/8/12*	*500mg*	*once daily*

Medication	Date started	Dosage	Frequency

Your Medical History

Name:_____

Please circle or fill in where indicated if you have ever had any of the following :

Alcohol abuse
Allergies_____
Anemia
Arthritis
Asthma
Back pain
Bladder/urinary problems
Cancer_____
Chest pain
Chickenpox
Colitis/irritable bowel
Diabetes ❑ Type I ❑ Type II
Ear or hearing problems
Eating Disorders_____
Edema/water weight
Epilepsy
Eye problems/cataracts/ glaucoma
Fatigue, chronic
Fibromyalgia
Female gynecological problems
Frequent antibiotic use
Gall bladder/ Liver problems
Gastrointestinal problems_____
Gum/teeth problems
Hair loss
Hayfever
Heart problems_____
Hemorrhoids
Hepatitis ❑ A ❑ B ❑ C ❑ Other
Hypoglycemia
lmpotence/sexual problems
Jaundice
Kidney/ Urinary problems
Measles
Mental illness_____
Mononucleosis / Epstein Barr virus
Mumps
Panic Attacks
Parasites _____
Prostate problems
Rheumatic fever
Sexual abuse
Sexually transmitted diseases (herpes, chlamydia, gonorrhea, etc.)_____
Sinusitis
Skin problems/rashes_____
Stroke
Tuberculosis
Thyroid problems
Ulcers
Other _____

Family Medical History

*For each person below, complete those that are appropriate. Place a **check** in the appropriate column for relevant diseases*

	Father	Mother	Brother (s)	Sister (s)	Children	Grandparents
Age if Living:						
Age at Death:						
Cause of death						
Cancer						
Diabetes						
Depression						
Heart Disease						
High blood pressure						
Stroke						
Epilepsy						
Mental illness						
Asthma						
Kidney Disease						
Glaucoma						
Tuberculosis						
Endocrine Disease (thyroid,						
Multiple Sclerosis						
Neurological Diseases						
Autoimmune Disease						
OTHER (please list)						

Review of Systems

Please check any of the following that you are experiencing now or have experienced in the past 3 months.

Energy
- ❑ Decreased libido
- ❑ Fatigue
- ❑ Poor memory
- ❑ Difficulty focusing
- ❑ Decreased motivation
- ❑ Tend to be warm
- ❑ Tend to be cold
- ❑ Abnormal sweating

Sleep
(see Sleep Questionnaire)

HEENT
- ❑ Dizziness/ Vertigo
- ❑ Fainting
- ❑ Headache/ Migraines
- ❑ Facial Pain
- ❑ Ringing in the ears
- ❑ Poor hearing
- ❑ Earaches
- ❑ Teeth grinding
- ❑ Teeth problems
- ❑ Gum problem
- ❑ Sores on mouth/lips
- ❑ Poor vision
- ❑ Blurred vision
- ❑ Spots floating in eyes
- ❑ Light bothers eyes
- ❑ Dry eyes
- ❑ Nose bleeds
- ❑ Nasal congestion
- ❑ Recurrent sore throat

Other _____

Respiratory
- ❑ Daily cough
- ❑ Coughing with blood
- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Frequent colds/ flu
- ❑ Other _____

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Chest pain/ pressure
- ❑ Varicose veins
- ❑ Swelling in hands/ feet
- ❑ Other _____

Psychology
- ❑ Irritability
- ❑ Depression
- ❑ Anxiety
- ❑ Mood swings
- ❑ Increased stress
- ❑ Recent loss
- ❑ Anger issues
- ❑ Fear
- ❑ Ongoing worry
- ❑ Hyperactivity
- ❑ Suicidal thinking
- ❑ Other _____

Gastrointestinal
- ❑ Nausea/ Vomiting
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Indigestion
- ❑ Thirsty: Hot or cold drinks?_____
- ❑ Abdominal pain
- ❑ Flatulence
- ❑ Bloating
- ❑ Loose stools/ Diarrhea
- ❑ Constipation
- ❑ Blood or mucus in stool
- ❑ Black stool
- ❑ Rectal pain
- ❑ Other_____

Dermatology
- ❑ Acne
- ❑ Rashes/ Hives
- ❑ Itchy skin
- ❑ Dry skin

Genito-Urinary
- ❑ Pain/ Burning with urination
- ❑ Urgency to urinate
- ❑ Frequent urination
- ❑ Difficulty urinating
- ❑ Incontinence
- ❑ History of STD's

Male Reproduction
Last prostate exam_____
- ❑ Erectile dysfunction/Impotence
- ❑ Penile sores/ Discharge
- ❑ Other _____

Gynecology
Pregnancies: _____
Births: _____
Premature/ Miscarry: _____
Stillborn/ Abortion: _____
First menses:_____
Last Pap: _____
Date of last menses: _____
Duration of menses:_____
Days between menses:_____
- ❑ Vaginal discharge
- ❑ PMS
- ❑ Breast soreness/ lumps
- ❑ Vaginal sores

Musculoskeletal
- ❑ Joint pain/ stiffness
- ❑ Muscle weakness
- ❑ Bone problems
- ❑ Pain

Where:_____
- ❑ Better ❑ Worse with pressure
- ❑ Better ❑ Worse with heat
- ❑ Better ❑ Worse with cold

- ❑ Other _____

Neurological
- ❑ Seizures
- ❑ Spasms
- ❑ Paralysis
- ❑ Numbness/ tingling
- ❑ Loss of consciousness
- ❑ Other _____

Name:_____

Diet/Nutrition

1) Do you eat five or more "fast food" meals per week? ❑ Yes ❑ No
2) Do you eat ***less*** than two portions of fruits and vegetables per day? ❑ Yes ❑ No
3) Do you react adversely to any food? ❑ Yes ❑ No
4) Do you address weight management by dieting? ❑ Yes ❑ No
5) Are you on any special diet (vegetarian, dairy-free, etc.)? ❑ Yes ❑ No
6) Do you have difficulties (e.g. weakness, nausea, etc) you miss a meal? ❑ Yes ❑ No
7) Do you use artificial sweeteners (e.g. NutraSweet, Sweet&Low) ❑ Yes ❑ No

Genetics

1) Were there medical problems at your birth? ❑ Yes ❑ No
2) Do you have any genetic diseases that you know of? ❑ Yes ❑ No

Environment

1) Do you react adversely when you consume caffeinated beverages? ❑ Yes ❑ No
2) In your work or home environment, are you exposed to chemicals, cigarette smoke, pesticides, or radiation? ❑ Yes ❑ No
3) Do you have a history of alcoholism? ❑ Yes ❑ No

Psycho-Social

1) Do you feel less happy than you did a year ago? ❑ Yes ❑ No
2) Do you feel your life has little meaning and/or purpose? ❑ Yes ❑ No
3) Do you believe stress is presently reducing the quality of your life? ❑ Yes ❑ No
4) Is your sex life less than satisfactory? ❑ Yes ❑ No
5) Have you ever been hospitalized for mental or emotional illness? ❑ Yes ❑ No
6) Is your primary relationship less fulfilling than it was a year ago? ❑ Yes ❑ No
7) Have you experienced major losses that are negative impacting you? ❑ Yes ❑ No
8) Do you feel you still have significant issues from your childhood? ❑ Yes ❑ No
9) Was there a history of alcohol or drug abuse in your family? ❑ Yes ❑ No

Exercise/Aerobic Conditioning

1) Are your symptoms better with exercise? ❑ Yes ❑ No

Women Only

1) Do you experience regular problems with PMS? ❑ Yes ❑ No
2) Do you regularly have problems with menstrual cramps? ❑ Yes ❑ No
3) Do you experience irregular menstrual cycles? ❑ Yes ❑ No
4) Do you experience heavy menstrual periods? ❑ Yes ❑ No
5) Have you entered menopause? ❑ Yes ❑ No

Men Only

1) Are you currently using anabolic steroids or growth hormone? ❑ Yes ❑ No
2) Do you have trouble with urination? ❑ Yes ❑ No
3) Any pain in the area of your prostate gland? ❑ Yes ❑ No

HEALTHISCAPING ™ PROGRAM OPTIONS

Dr. Piscopo's health optimization system for addressing pain and dysfunction is called Healthiscaping (HS) and it has six areas of focus. Please rate these in the order of importance (1 most to 5 least) for you:

__ **Sleep** __ **Diet/Nutrition** __ **Movement**
__ **Connection:** psycho-emotional health, time in nature, emotional weight loss
__ **Molecules**: medications, supplements, entheogens __ **Attention/ Cognitive Enhancement**

Lifestyle Discussion/ Counseling/ Optimization
What is your primary requirement for a successful therapeutic relationship with a physician or therapist?
_____

Have you done counseling or psychotherapy before? ❑ Yes ❑ No
If yes, was it helpful? ❑ Yes ❑ No Counselor: _____
Is there a history of mood disorders, mental illness, or significant abuse? ❑ Yes ❑ No
Have you been hospitalized for a psychiatric illness? ❑ Yes ❑ No
If yes, details: _____
Are you taking psychiatric medications? ❑ Yes ❑ No

In order to reach my therapeutic goals, I am able and willing to (check all that apply):

❑ Optimize my sleep ❑ Take supplements ❑ Exercise ❑ Optimize my diet ❑ Establish effective health habits
❑ Address underlying psycho-emotional issues ❑ Do stress management/ relaxation/mindfulness practices

In addition to the Healthiscaping™ program, we also offer physical medicine interventions. Please check all additional options you are interested in and answer questions for each one.

❑ **Injection Therapy/ Neural Therapy/ Biopuncture**
Have you ever had injection therapy previously? If yes, please provide details _____
Any known allergies to anesthetics (e.g. Lidocaine, Procaine, etc.) or injectables? ❑ Yes ❑ No
Fainting or distress around injections? ❑ Yes ❑ No Bruise easily? ❑ Yes ❑ No
Are you taking any major pain medications or medications for neurological or psychiatric issues? ❑ Yes ❑ No
Have you been diagnosed with cancer? ❑ Yes ❑ No Are you currently pregnant? ❑ Yes ❑ No
Do you bleed easily? ❑ Yes ❑ No

❑ **Acupuncture/ Needless Acupuncture (Acutonics)/ Auriculotherapy**

Yes	No		Yes	No	
❑	❑	Have you had acupuncture before?	❑	❑	Do you have hepatitis, cancer, or HIV?
❑	❑	Do you bruise easily?	❑	❑	Do you have a pacemaker?
❑	❑	Are you prone to bleed easily?	❑	❑	Difficulty lying down for 30 minutes?
❑	❑	Do you have a tendency to faint?	❑	❑	Have you recently traveled outside the US?
❑	❑	Are you nervous about needles?	❑	❑	Women: are you pregnant?

❑ **Electrotherapy**
Have you have electrotherapy before? ❑ Yes ❑ No If so, have you had any negative reactions? ❑ Yes ❑ No
Are you taking any major pain medications or medications for neurological or psychiatric issues? ❑ Yes ❑ No
Have you been diagnosed with cancer? ❑ Yes ❑ No
Do you use a pacemaker? ❑ Yes ❑ No
Are you currently pregnant? ❑ Yes ❑ No

❑ **Injection Therapy/ Neural Therapy/ Biopuncture**
Have you ever had injection therapy previously? If yes, please provide details _____
Any known allergies to anesthetics (e.g. Lidocaine, Procaine, etc.) or injectables? ❑ Yes ❑ No
Fainting or distress around injections? ❑ Yes ❑ No Bruise easily? ❑ Yes ❑ No
Are you taking any major pain medications or medications for neurological or psychiatric issues? ❑ Yes ❑ No
Have you been diagnosed with cancer? ❑ Yes ❑ No Are you currently pregnant? ❑ Yes ❑ No
Do you bleed easily? ❑ Yes ❑ No

AVWC Healthiscaping™ Sleep Questionnaire

Name: _____ Age_____ Birth Date_____ Gender: _____

Sleep is a source of many chronic health problems, which is why we evaluate it comprehensively.

General Sleep

- What is the best amount of sleep for you to get each night (hours)? _____
- What time would you go to bed and get up if you could choose? Bedtime:_____ Rise time: _____
- Are you sleepy when you go to bed? ❑Yes ❑No Do you work nights or swing shift? ❑Yes ❑No
- Do you spend time awake in bed reading, watching TV, using screens, or other activity? ❑Yes ❑No
- Average hours in bed per night? _____ Average hours actually sleeping per night? _____
- # of times you wake at night: _____ Can you get back to sleep in less that 20 min? ❑Yes ❑No
- How many more hours do you sleep on weekends or vacation vs work days? _____
- Naps? ❑Yes ❑No Snoring? ❑Yes ❑No CPAP? ❑Yes ❑No Do you have nightmares? ❑Yes ❑No
- How much caffeine daily: _____ Do you fall asleep unintentionally during the day? ❑Yes ❑No
- Do you track your sleep? ❑Yes ❑No If so, how: _____

Chronotype: ❑ I'm a "morning person" ❑ I'm an "evening person" ❑ Mixed morning and evening person

Daytime effects: Please rate these on an A (best) to F (worst) scale

Energy: _____ Concentration/Focus : _____ Mood: _____
Daytime activity levels: _____ Memory: _____ Appetite: _____ Attention _____

Sleep medication(s)/aids/supplements

Name	Dose	How often?	How long have you used?

Sleep Environment:

- Is your bedroom quiet, dark, cool, comfortable? ❑Yes ❑No
- Do household members, outside noises, or pets wake you from sleep? ❑Yes ❑No
- How many pillows do you sleep with? _____ How old is your mattress? _____
- Do you wake with a headache, a dry mouth or sore throat, or feel mentally foggy on waking? ❑Yes ❑No
- Recreational agents before bed (i.e. alcohol, cannabis, etc.) _____

Sleep History

Sleep disorder or problem	Year diagnosed?	How do you manage it?

Sleep Problems (If no sleep problems, skip this section)

What is most distressing/ disturbing about current sleep? (Choose as many as needed below)

____ Difficulty falling asleep ____ Difficulty staying asleep _____ Partner/Pet disturbs my sleep
____ Waking early and can't get back to sleep ____ Difficulties waking at intended time
____ Restless sleep ____ Poor sleep environment _____ Racing thoughts _____ Restless Legs
Other: _____
What happens when you cannot get to sleep (thoughts/behaviors)? _____
_____

Finance/Insurance Form

PLEASE PRINT AND COMPLETE ALL ENTRIES				
Patient Name (Last, First, MI)	Date of Birth	Age	Marital Status	Today's Date
Address (Street, City, Zip)	Home phone:			
	Work phone:			
	Cell phone:			
Social Security #	Who is financially responsible for this bill?			

Spouse/Parent Name (Last, First, MI)	Date of Birth	Home Phone.	Work phone

Emergency contact	Relationship	Phone number
Email address:		

INSURANCE		
Insurance Primary Subscriber Name	Primary Subscriber SS#	Primary Subscriber Date of Birth

Note: Medicare does **not cover Naturopathic services at this time.*

I agree to make payments according to the policies of Alpine Valley Wellness Center (AVWC), including all payments due at the time of visit. I agree to allow AVWC to charge my credit card or utilize my deposit if I fail to follow the cancelation policy for my first visit.

By accepting services at AVWC, I am agreeing to pay for that service even if my insurance company denies payment. I understand that the restrictions imposed by my insurance company are constantly changing and that the staffs of AVWC are unable to track these changes. I understand that it is my responsibility to ensure that my insurance policy covers all treatments I am receiving. I agree to call my insurance company and verify benefits if I have any concerns. I understand that AVWC does collect co-payments at the time of my visit. I give permission for the release of information requested by my insurance company to assist in processing my insurance claims and assign directly to AVWC all appropriate payments from my insurance company for health care services rendered to me by AVWC.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OFFICE POLICIES

Welcome to the Alpine Valley Wellness Center (AVWC). If you have any questions or comments about our policies, please feel free to share them with us. For more information, please see our website: www.alpinebewell.com

1. Responding To Your Needs

Our two main ways of communicating with you are in person or by phone. Please ensure that your voice mail is operational and your voice mail box is not full. We are constrained from responding to medical issues by text message, email, or social media (e.g. Facebook, etc.) because of state and federal privacy laws (e.g. HIPAA). We can work with you by email on non-medical issues (e.g. supplements, logistical issues, etc.).

2. Missed Appointments, Cancelations, Deposits

- For new patients, a deposit of $75 will be charged to hold your appointment. If the deposit is not made you will have 24 hours to make the deposit before the appointment is cancelled. The deposit will become a credit on your account.
- For established patients, we require a minimum of 24 hours notice, received during our normal business hours, for canceled or rescheduled visits. Cancelations made with less than 24 hours notice will incur a $60 fee for a missed half hour appointment, a $75 fee for an hour missed appointment, and a $15 fee for a missed blood draw. Your insurance company will not cover this charge. Extenuating circumstances or emergencies are exceptions that will not be billed.

3. What Does My Insurance Company Cover? Treatment Limitation

- Our doctors frequently provide additional services to you that your insurance does not pay for, such as wellness education. Because of their commitment your health, they do not charge you for this.
- It is always a good practice to know what your insurance company will and will not cover to protect yourself financially from disappointment or unexpected charges. There are too many plans for us to advise you on this.
- There are limitations to what any physician is able to accomplish without actually seeing you. The most important limitation is that ***we cannot diagnose and/or treat medical conditions over the telephone or by email***. This constraint is imposed by state and federal government guidelines, insurance companies, and the boundaries of medical ethics.
- We cannot discuss a condition over the phone if it is an illness for which you have not been previously evaluated.
- We cannot prescribe supplements or medications over the telephone for someone who we have not seen previously as a patient, including family members who are not established patients of the clinic.
- We can only see the family member who is scheduled for an appointment slot. In the interest of doing optimal medicine, we cannot accommodate other family members without their own appointment time.

4. Phone Consultations and Telemedicine Visits

- Telemedicine visits, which uses video and audio, can be covered by some insurances. Please check with your insurance company on this.
- **Telephone consultations are NOT covered by insurance.** They can be provided for established patients under special circumstances determined by your doctor. There is a charge of $58 for 15 min and $96 for 16-30 minutes.
- Clarification of on-going therapy or medications under five (5) minutes is considered a “check in” and will not be charged. It is your doctor’s discretion whether an issue can be dealt with as a “check in” or whether it requires an office visit.

5. Dispensary Items

- All dispensary items are “cash and carry.” That is, payment is due at the time they are picked up from the clinic. If you do not have the funds available at the time, we will be hold them for you for a maximum of 1 month, as space allows.
- All sales on dispensary items are final except for the rare instances that they have expired within 3 weeks of purchase, they are the wrong supplement, or a refund is approved by the clinic director.
- If an item is not available during your visit, we will call you when it becomes available. Items are held for a maximum of 1 month, as space allows.

- Please be aware that we can no longer offer refunds on dispensary items that have been opened or are special orders. The only exception is that a partial refund may be given if it is determined by the doctor that there is a medical reason you cannot take a particular supplement. Unopened supplements may be returned for a full refund within four (4) weeks of purchase.
- Prescriptions for tinctures or other items that require our attention during the business day typically require ***24 to 48 hours*** to be filled. If you are refilling a tincture, please bring your old bottle to refill to avoid being charged the cost of a new bottle (first one is free) and to help us with our recycling efforts.
- We can mail supplements to you. In addition to the retail price, **there is a handling fee and a shipping fee** based on weight and distance. No refund can be made if the items fail to reach you.
- It is best to call ahead before picking up dispensary items to ensure they are available. Because the particular item may need to be ordered, try to plan to pick up the needed item before you run out.
- Nutritional supplements are not typically covered by insurance plans. However, supplements are not subject to sales tax if they are prescribed by a doctor. Health savings accounts can be used to pay for the supplements prescribed at our clinic.

6. Emergency Contact and After-Hours Services

- For all critical, psychiatric, or life-threatening emergencies, please call 911 or proceed immediately to your local hospital. An emergency is defined as a health problem which you feel requires immediate attention.
- After business hours, please limit calls to urgent matters only. Our pager number is always available by calling our office number, listed above. There is a charge of **$25 per page** unless one of the doctors specifically asks you to page them. Your insurance company will not cover this expense. While telecommunication technology is generally quite stable, there are a number of reasons it can fail. For this reason, it is **very important** that you proceed to an Emergency Room in a serious situation if you do not hear back from your physician after a short period of time.
- Our physicians' cell phone number may become visible to you due to emergency or after hours contact. Please do not use this to text our physicians as this is not HIPAA protected. Due to the time it takes our physician to process inappropriate text messages, there will be a **$25 charge** for each text sent.

7. Payments and Non-Sufficient Funds (NSF)

- If you do not have insurance, complete payment is expected at the end of each office visit. Cash or personal checks are preferred. Items not covered by insurance, such as supplements, need to be paid at the time of the visit.
- Checks or credit card payments that are denied for lack of funds (NSF) will incur a fee of $20. Upon receipt of an NSF issue, we will contact you and arrange for payment to be made in cash within the current business week.

9. Non-medical services

Personal requests for medical records will incur a charge based on the number of pages requested. Special requests such as letter writing, medical leave document processing by the doctors, health saving account letters, etc. will be billed at the regular rate of $60/hour. These fees are not reimbursed by your insurance company. Our ability to provide such services is limited and typically requires a minimum of 7 business days to process. Please check with the front desk for more information.

9. Waiting Room Etiquette: Chemical Sensitivity, Children, and Cell Phone use

Many of our patients are allergy or chemically-sensitive. For this reason, **please do not bring pets or wear perfumes, colognes, or other scented products to the clinic.** If your child is not coming to the clinic as a patient, please consider that all clinics have a variety of sick patients who your child may be exposed to. We ask that our patients turn off their cell phones prior to going into an exam room and that they step outside the waiting room if they are going to answer a call. This will help us to keep the clinic space relaxing, therapeutic, and enjoyable for all our patients.

10. Prescriptions Refills

For prescription refills, please call the pharmacy where the medication will be filled and have them fax our office a prescription refill request. Prescriptions refills typically take between 6 to 48 hours to address. **<u>Most</u> problems with prescriptions are due to your pharmacy not checking their voice mail, losing our prescription and so on.** Please check with them first.

11. Labs and Test Results

As a general rule, most lab results are received within 7 days except for Pap smears, biopsies, and special testing such as food allergy panels, which can take between 10-14 days. Please note that because of the complexity of some results that are positive, an appointment will be required to discuss them. Labs that are not urgent are discussed at the next follow up visit. If you would like the results sooner, please call us.

I have read, understood, and agree to follow the policies of Alpine Valley Wellness Center.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

Informed Consent for Treatment

This form is part of our effort to inform you about many aspects of your diagnosis and/or treatment options. Please read it carefully.

Your physicians at the Alpine Valley Wellness Center (AVWC) may perform the following procedures as part of the diagnosis and treatment of your health condition:

Common diagnostic procedures: e.g. venipuncture, Pap smears, laboratory tests, etc.
Minor office procedures: e.g. dressing a wound, ear cleansing, etc.
Prescription drugs: as medically necessary and allowed under naturopathic prescriptive rights
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and vitamin injections.
Botanical medicine: botanical substances may be prescribed as teas, alcohol-containing tinctures, capsules, tablets, crèmes, plasters, or suppositories.
Chinese medicine: Chinese medical interventions may include the use of acupuncture, electro-acupuncture, moxibustion, or Chinese herbs.
Electrotherapy: the use of electrical stimulation devices such as ultrasound or microcurrent devices.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: education and discussion concerning the promotion of wellness (e.g. recommendations for exercise, sleep, stress reduction, diet, etc.) as well as addressing obstacles to quality of life and health (e.g. smoking, poor lifestyle choices, food allergies, etc.)
Naturopathic psychological counseling: addressing minor mood and psychological problems.

I recognize the potential risks and benefits of these procedures, which include but are not limited to:

- Potential risks: allergic reactions to herbs and/or supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injection, venipuncture, or procedures.
- Potential benefits: restoration of health, return of maximal functional capacity, relief from symptoms including pain, injury and prevention of disease or its progression.

I agree to inform my AVWC clinician of any disease process that I am suffering from and any medications or over the counter drugs that I am currently taking. I will also advise my doctor immediately if I am presented with a cancer diagnosis, I am pregnant, suspect that I am pregnant, or if I am or will begin breast-feeding.

Having read and fully understood the items described above, I hereby authorize the AVWC to perform the described medical procedures, as necessary to facilitate my diagnosis and treatment. I understand that no guarantees have been given to me by AVWC 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 am also free to ask question about my care that my clinician will answer to the best of their ability.

I further understand that a medical record will be kept of the health services provided for me and that this record will be kept confidential unless otherwise directed by myself, my representative, or as required by law. I acknowledge that I can request to view my medical record at any time and can request a copy of it by paying a copying fee. My medical record will be kept for a minimum of three but no more than ten years after the date of my last visit. I understand that the clinicians at AVWC may be constrained in their activities by the rules and laws of the State of Washington, my insurance company, and the federal government.

_____ _____

Date Signature of Patient or Patient Representative

Electrotherapy Consent

I, the undersigned, authorize the Alpine Valley Wellness Center to perform the medical treatment known as Frequency Specific Microcurrent therapy, a form of electrotherapy. This therapy is a non-invasive means of treating various somatic disorders, including chronic pain. The equipment that we use has been classified by the FDA as a TENS unit type device. TENS has not been shown to have any short or long term complications to date. However, the possibility that the device may affect some sensitive users in a presently unknown way cannot be overlooked.

I understand that Frequency Specific Microcurrent therapy involves the use of tiny amounts of electrical current (i.e. one millionth of an ampere) applied to the body. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. However, I recognize that the chances of success are enhanced by following the directives of my clinician (for example, to be well hydrated on the day of my treatment). There are some people who may not be able to receive Frequency Specific Microcurrent therapy, including women who are pregnant and patients using a demand type pacemaker. Please initial the following statements below:

I am not currently pregnant _____

I am not currently using a demand type pacemaker _____

Like all medical procedures, I recognize that Frequency Specific Microcurrent therapy has potential risks and potential benefits. These risks and benefits are as follows:

Potential Risks: Frequency Specific Microcurrent therapy has a history of safety and side effects are uncommon. If they do arise, they typically start during or about 90 minutes after treatment and lasting for a few minutes to a few hours. Side effects are similar to any use of electrical media when applied to the body, such as Ultrasound, EKG, etc., or to having a massage. These includes irritation at the site of stimulation, soreness, fatigue, light-headedness, drowsiness, or transient weakness. Symptoms may also worsen transiently before improving.

Potential Benefits: Microcurrent treatment is painless, increases speed of recovery, and often promotes healing in conditions that have not responded to other treatment. Microcurrent treatment can also lead to the resolution of the health concern being treated and the inducement of a greater sense of well being. The effects are long lasting and occur without the side effect sof pharmaceutical drugs.

I hereby release Alpine Valley Wellness Center from all liability in connection with the Frequency Specific Microcurrent therapy I receive. I understand that I am free to discontinue treatment at any time.

_____ _____

Signature of patient Date

Acupuncture Consent

I, the undersigned, authorize Gary Piscopo, ND, L.Ac., to perform the Chinese medical treatment know as Acupuncture. I understand that acupuncture involves the insertion of sterilized needles through the skin at specific points on the body. I also understand that the practice of acupuncture includes the use of techniques such as cupping, electro-acupuncture, moxibustion, and others outlined by the Washington State law for licensed acupuncturists. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

Like all medical procedures, I recognize that acupuncture has potential risks and potential benefits. These risks and benefits are as follows:

Potential Risks: Many of the risks are similar to any insertion of a needle into a body, as in drawing blood or receiving an injection. These include light headedness, minor bruises or bleeding, a bent or broken needle at the site of insertion, possible infection, fainting, nausea, or weakness. There can also be discomfort at the site of insertion of the acupuncture needle. Additional risks include aggravation of symptoms existing prior to the acupuncture treatment and potential burns from the moxibustion technique.

Potential Benefits: Relief and resolution of the health concern being treated. Reduction and control of pain without the side effects of pharmaceutical intervention (i.e. addiction, mood changes, negative organ effects, etc.). Inducement of a greater sense of well being and an enhanced energetic balance leading to the prevention of further health concerns.

I hereby release Gary Piscopo, ND, L.Ac., from all liability in connection with the acupuncture and oriental medicine treatments I receive. I understand that I am free to discontinue treatment at any time.

_____ _____

Signature of patient Date

What are Non-Covered Services?

Your medical insurance benefits are governed by a contract with your insurance company. In this contract, the insurance provider details those medical interventions and procedure that are allowed, which are called covered services. Those medical interventions and procedure that are not covered are called **non-covered services**.

In deciding what an insurance company considers covered and non-covered services, they typically assesses if a procedure is "medically necessary." For example, medically necessary could be defined as a procedure that is required to identify or treat a recipient's medical issue. Such a procedure would have to be consistent with the defined standards of acceptable care by the insurance company. So even if a procedure is supported by research and by the medical community, the insurance company may not cover it. The following is a list of items that may be considered "non-covered services" or "experimental procedures":

- Dietary counseling, treatment and diagnostic procedures primarily for obesity or for weight reduction.
- Dental health services, particularly if preventative in nature.
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.
- Fertility testing, diagnosis, evaluation and treatment.
- Artificial insemination, in vitro fertilization and embryo transfer procedures.
- Genetic testing, genetic treatment, or genetic engineering:
- Nutrition care, supplements, supplies or other nutritional substances.
- Services related to any surgical, laser or nonsurgical procedures or alterations of the refractive character of the cornea for correction of near-sightedness and/or astigmatism.
- Orthopedic shoes or orthotics for the feet.
- Food antigen and/or sublingual therapy.
- Mental health services, psychological or alcoholism and drug abuse counseling services.
- Cosmetic service or cosmetic surgery.
- Organ and tissue transplantation.
- Home health, skilled nursing care, skilled nursing facility and hospice services.

Other phrases that you often see in your contracts with your insurance company are these:

- "A medically necessary procedure cannot be solely for the convenience of the recipient and/or their family."
- "If a non-covered service is provided to a covered person, the covered person has the responsibility for payment."

This and other phrases like it are important for you to understand. The bottom line is that while you may think something is medically necessary or critical for your health, that has no bearing on whether the procedure will be covered by your insurance company. And if the insurance company has decided it is not covered, either that service is not available to you or you will have to pay for it out of pocket.

While many of the services provided by naturopathic physicians are covered by medical insurance, some of the services that naturopathic medicine strongly believes to be an important part of health care, such as prevention, lifestyle interventions, and nutritional counseling, may not be covered by your insurance company. We are providing this handout to you in order to educate you about the realities of your health care coverage so that you will be in the position to make informed choices, both concerning the insurance companies you do business with and about the services that may or may not be available to you.

Non-Covered Services: Consent for Treatment

The following services are examples of medical procedures that may or may not be covered by your insurance plan.

❑ **Wellness services and counseling.** I understand that Dr. Piscopo and Dr. Thomas are licensed to provide counseling and wellness services but they are not psychologists or psychiatrists. Counseling services are focused on lifestyle issues, relationship issues, and wellness – not to treat or diagnose major mental illnesses. Wellness and counseling services may fall outside the guidelines for medically necessary treatment and therefore may not be covered by your insurance plan. I request and agree to pay for these services regardless of the insurance company's determination of benefits.

❑ **Nambudripad's Allergy Elimination Techniques (NAET)**. This service is typically billed as a regular office visit, though it could be considered a contract exclusion by some insurance plans.

❑ **Maintenance/ Palliative Care.** Services in this category, which include many treatments for chronic conditions, are not considered curative. They therefore may not be deemed medically necessary by your insurance company and may not be a covered service.

❑ **Laboratory Testing.** Some laboratory tests may not be covered by your insurance plan. These may include candida testing, cancer screening, blood typing, food allergy panels, digestive analysis, heavy metal testing or any laboratory testing not specifically approved by your insurance company.

❑ **Other** _____

I _____ hereby request and personally agree to accept full financial responsibility for the medical care received from the Alpine Valley Wellness Center, which many include non-covered services as determined by my current insurance benefits.

_____ Date _____

(Patient's Signature or Signature of Legal Guardian)

_____-_____-_____ OR _____-_____-_____

(Patient's Social Security Number) *(Legal Guardian's Social Security Number)*

Alpine Valley Wellness Center, PC

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.

At Alpine Valley Wellness Center (AVWC) we are committed to maintaining the confidentiality of your personal financial and health information. As part of providing care and services to you, we are required to maintain *Protected Health Information* or PHI about you. State and federal law protects this kind of information by limiting its use and disclosure. A more extensive version of our Privacy Practices is available for viewing at our clinic.

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), Omnibus Rule, and associated regulations and amendments.

If you have any questions about this notice or if you need more information, please contact
Alpine Valley Wellness Center
Attn: Gary Piscopo, ND, LAc., HIPAA Privacy and Security Officer
430 Elva Way
East Wenatchee, WA 98802

ABOUT THIS NOTICE

This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect. You may always obtain a copy of our current notice by any of the following means:

1. Accessing our website at www.alpinevalleywellnesscenter.com
2. Contacting our office
3. Asking for a copy at the time of your next visit

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

Treatment. We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

Payment. We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure 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 insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst AVWC providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
- **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. <u>You can only direct us in writing to submit your PHI to a third party not covered in this notice</u>. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your

record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.

- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.

Paper Copy of This Notice.
You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: *www.alpinevalleywellnesscenter.com/* or by contacting our office.

Changes to This Notice
AVWC reserves the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Alpine Valley Wellness Center, Privacy and Security Officer, at the address listed at the beginning of this Notice. You can also file a complaint by contacting the Secretary of Health and Human Services. **You will not be penalized for filing a complaint.**

Alpine Valley Wellness Center, PC
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the Alpine Valley Wellness Center Patient Notice of Privacy Practices.

Signature of Patient _____ Date _____

Signature of Patient Representative (If the patient is a minor or an adult who is unable to sign this form)
_____

Name of Patient (Print or Type) _____

Please submit all requests for medical records in writing to our office to assist us in tracking your request. There may be a charge for transferring medical records.

This notice became effective on April 14th 2004.NPP updated 8/18/15

Alpine Valley Wellness Center

430 Elva Way, East Wenatchee, WA 98802
Business: [509] 886-9355 Fax: [509] 886-9354

HIPAA GENERAL CONSENT FORM

Patient Name _____ **DOB** ___ / ___ / ___

I hereby give my consent for the Alpine Valley Wellness Center (**AVWC)** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

AVWC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Gary Piscopo, ND, LAc, HIPAA Privacy and Security Officer.**

With this consent, **AVWC** may call my home or other alternative location and leave a message on voice mail or answering machine in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. ❑Yes ❑ No

With this consent, **AVWC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.
❑Yes ❑ No

Please check off who we may release your medical information to and write their names(s). If you do not wish to release your information to anyone, please check "only the patient".
❑ Only the patient
❑ Spouse _____
❑ Parent _____
❑ Other _____

By signing this form, I am consenting to allow **AVWC** to use and disclose my PHI to carry out TPO. I have the right to request that **AVWC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. AVWC reserves the right to revise its HIPAA General Consent Form at any time.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **AVWC** may decline to provide treatment to me.

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