205 Clark Place SE, Tumwater, WA 98501
www.heartofwellness.org
(360) 570-0401

Thank you for scheduling your appointment with Heart of Wellness! We provide a comprehensive and coordinated care approach, offering the following modalities:

Naturopathic Primary Care
Naturopathic Specialty Care
Nutritional Therapy
Acupuncture & East Asian Medicine
Functional Medicine
Myofascial Release Therapy

Many of these services may be covered by your insurance but may not. **We will do our best to help you understand your benefits, but to prevent the stress of unexpected bills we urge you to contact your insurance directly to review your coverage.** We can provide a form to assist you in contacting your insurance.

Please be aware that your physician may recommend lab tests. What you might owe for lab tests and what is covered by insurance varies from network to network. **To prevent the stress of unexpected bills we urge you to contact your insurance directly to get a clear understanding of your lab benefits prior to completing any lab tests.** For your convenience we have a lab company phlebotomist stationed in our building. However, we have no financial relationship with this or any other lab. Your relationship with the lab companies is independent of your relationship with us.

Appointments are often filled several weeks in advance. **There is a $50 NO SHOW fee if a cancellation is not made at least 24 hours prior to your appointment.** We thank you in advance for your cooperation.

Our in-house dispensary stocks hundreds of natural medicines, supplements and nutraceuticals. It is important to purchase or reorder these before you run out as **refill of prescriptions may take up to 48 hours**, please plan accordingly.

Please help us protect our patients and staff who are chemically sensitive to fragrances and other scented products (perfume, lotions, hair products, etc.) **Thank you for not wearing scented products the day of your appointment**.

Please complete the attached forms that gather the information needed for us to best serve you:

- **Patient Demographics** – your contact information
- **Health History Questionnaire** – the basic health information your provider needs to begin your care
- **Financial Information** – how your care will be paid for
- **Financial Policy** – an agreement between you and Heart of Wellness regarding payment for services, requires signature
- **Informed Consent** – permission for our providers to perform your care, and confirmation you have had the opportunity to review our Notice of Privacy Practices, requires initials on first page and signature on second

Heart of Wellness
Patient Demographics

Date Completed: _____ **How did you hear about us?** _____

Full Legal Name: _____

How would you like to be addressed? _____

Name of Parent(s) if patient is a child: _____

Date of Birth: _____ **Legal Gender:** Male Female

Gender Identity (optional)? _____

Marital Status: Single Married Widowed Divorced/Separated Other: _____

Physical Address: _____ **Mailing Address:** _____

_____ _____

_____ _____

_____ _____

Home Phone: ( ) _____ **Work Phone: ( )** _____

Cell Phone: ( ) _____ **Other Phone: ( )** _____

Email Address: _____

Would you like to receive email reminders of appointments? Yes No

Employment Status: Full-Time Part-Time Retired Self Disabled Unemployed Student

Employer's Name: _____

Employer's Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Do you have a primary physician (other than Heart of Wellness)? Yes No

Physician Name: _____

Preferred Pharmacy: _____

Location: _____

Updated: 01-01-19

Heart of Wellness
Insurance and Payment Information

If the patient is a minor or an incapacitated adult, who is the Guarantor?_____

Guarantor Email: _____

Guarantor Address: _____

Health Insurance Coverage: Please provide a copy of the front and back of all insurance card(s) for billing. We cannot bill your insurance without copies on file.

Primary Insurance:_____

Subscriber Name:_____ Subscriber Date of Birth: _____

Relationship to Patient: _____

Is this an employer sponsored plan? Y N

Secondary Insurance:_____

Subscriber Name:_____ Subscriber Date of Birth: _____

Relationship to Patient: _____

Is this an employer sponsored plan? Y N

Self Pay Options:

- ☐ Payment at time of service
- ☐ Membership program Bronze Silver Gold Platinum

Medicare and Tricare: Heart of Wellness cannot bill Medicare or Tricare for our services. Medicare and Tricare will not pay for any services we recommend, including labs. In lieu of billing Medicare or Tricare for labs we have made arrangements with a cash-only lab that offers significantly reduced cash rates, but we must know in advance if you have Medicare or Tricare. **We therefore require all patients to complete either Option A (you are not a subscriber) or Option B (you are a subscriber) below.**

Option A:

No, I am not a Medicare or Tricare subscriber. Name:_____

Signature:_____ Date:_____

Option B:

Yes, I am Medicare or Tricare subscriber of the following plan:

- ☐ Medicare Part A – Hospital, SNF and Hospice Coverage
- ☐ Medicare Part B – Physician, Lab and Diagnostic Coverage
- ☐ Medicare Part C – Combination of A and B via a 3rd Party (aka Medicare Advantage)
- ☐ Medicare Part D – Prescription Drug Coverage
- ☐ Tricare or other military insurance administered by the federal government

Name:_____

Signature:_____ Date:_____

Heart of Wellness
205 Clark Place SE, Tumwater, WA 98501 * PH: (360) 570-0401 * info@heartofwellness.org

HEALTH HISTORY QUESTIONNAIRE

Name: _____

Reason for Visit (list your main health concerns or reason for scheduling an appointment):

Primary Concern: _____

Is the concern related to: Work? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

What treatments have you tried? _____

_____

To what extent does it interfere with daily activities? (work, sleep, eating, etc...)_____

_____

Other Health Goals: _____

_____

Current Care (list ongoing care by providers outside Heart of Wellness, and conditions monitored)

Provider Name	Provider Type	Condition(s) Monitored

Surgeries/Hospitalizations: _____

_____

Health History (conditions and symptoms experienced in last 6 months)

Generals
- ☐ Fatigue/Tiredness
- ☐ Loss of Sleep/Poor Sleep
- ☐ Night Sweats or Hot Flashes
- ☐ Weight Gain or Weight Loss
- ☐ Chills (recent or persistent)
- ☐ Fever (recent or persistent)
- ☐ Sweat Easily
- ☐ Other _____

VISION AND HEARING
- ☐ Dizziness or Vertigo
- ☐ Blurry Vision
- ☐ Floaters
- ☐ Eye Strain or Pain
- ☐ Eye Dryness
- ☐ Excessive Tearing
- ☐ Ringing in Ears
- ☐ Other

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema ___using supplemental O2
- ☐ Pneumonia
- ☐ Sleep Apnea ___using C-pap
- ☐ Earaches
- ☐ Nose Bleeds
- ☐ Sores on Lips/Tongue/Mouth
- ☐ Recurrent Sore Throats
- ☐ Frequent Colds
- ☐ Swollen Glands
- ☐ Nasal Drainage
- ☐ Sinus Congestion
- ☐ Cough
- ☐ Shortness of breath
- ☐ Other

CARDIOVASCULAR
- ☐ Heart Attack
- ☐ Stroke
- ☐ Elevated Lipids
- ☐ Varicose Veins, Phlebitis
- ☐ High or Low Blood Pressure
- ☐ Edema, Swelling of Hands or Feet
- ☐ Bleed or Bruise Easily
- ☐ Chest Discomfort or Pain
- ☐ Rapid or Irregular Heartbeat
- ☐ Heart Palpitations
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Pacemaker or defibrillator
- ☐ Other

METABOLIC/ENDOCRINE
- ☐ Diabetes or pre-Diabetes
- ☐ Thyroid Disease

Health History (Continued)

DIGESTIVE
- ☐ Hemorrhoids
- ☐ IBS, Crohn's, or Ulcerative Colitis
- ☐ Gastritis or Peptic Ulcer
- ☐ Gallstones or Gallbladder Disease
- ☐ Liver Disease or Hepatitis
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Belching
- ☐ Heartburn or Acid Reflux
- ☐ Gas or Bloating
- ☐ Constipation or Chronic Laxative Use
- ☐ Blood in Stools/Black Stools
- ☐ Abdominal Pain/Cramps
- ☐ Rectal Pain
- ☐ Nausea or vomiting
- ☐ Other

SKIN
- ☐ Eczema or Psoriasis
- ☐ Acne
- ☐ Fungal Infection/Athletes Foot

GENITAL AND URINARY
- ☐ Kidney Stones
- ☐ Pain with Urination
- ☐ Urgency to Urinate
- ☐ Incontinence
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Waking to Urinate
- ☐ Frequent Urinary Tract Infections
- ☐ Change in Libido
- ☐ Erectile Difficulties
- ☐ Other _____

INFLAMMATORY/IMMUNE
- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease (e.g. RA, Lupus)
- ☐ Herpes (Oral or Genital)
- ☐ HIV Positive
- ☐ Cancer, type:_____
- ☐ Other

NEUROLOGIC
- ☐ Cognitive Impairment
- ☐ Memory Problems
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Concussion or TBI
- ☐ Migraines
- ☐ Headaches
- ☐ Slurred speech
- ☐ Tremors
- ☐ Other_____

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Other_____

Women's Health History

Age at First Period _____
Last Menstrual Period _____
- ☐ Irregular Cycle
- ☐ Hormonal Contraception Use
- ☐ Heavy Flow
- ☐ Pain or Cramps

Are you pregnant? ☐ Yes ☐ No
- ☐ PMS Symptoms
  Describe _____
- ☐ Perimenopausal
- ☐ Menopause
- ☐ Infertility
- ☐ Fibrocystic Breasts

- ☐ Endometriosis
- ☐ Fibroids
- ☐ Frequent Yeast Infections

____ Number of Pregnancies
____ Number of Births
Other_____

Family History

Check if Applicable	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Mental Illness								
Allergies/Asthma/Hives								
Other								

Heart of Wellness
HEALTH HISTORY QUESTIONNAIRE

Known Allergies or Hypersensitivities

Drugs: _____

Foods: _____

Environmental Allergens (e.g., lotions, oils, fragrances): _____

Nutrition History

Height (feet/inches) _____ Current weight/usual weight range _____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No
If yes, describe: _____
Avg oz water per day_____

Caffeine, Alcohol, and Tobacco

Drinks per day of coffee, tea, or soda: _____ Drinks a week containing alcohol: _____

Currently Smoking: ☐ Yes ☐ No Previous Smoking: ☐ Yes☐ No

Exercise

Current Exercise Program: (activity, sessions/week, and duration)_____

_____

List any problems that limit activity:_____

Sleep

Average number of hours you sleep per night: < 6 6-8 8-10 >10

Do you have trouble falling or staying asleep: ☐ Yes ☐ No Do you use sleeping aids: ☐ Yes ☐ No

Stress and Coping

Are currently in counseling or therapy: ☐ Yes ☐ No

Stressors (Rate 1-10): Work___ Family___ Social___ Finances___ Health___ Other_____

Do you practice meditation or relaxation techniques: ☐ Yes ☐ No How often?_____

MEDICATIONS (Please ask reception for an additional sheet if you need more space)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Have medications or supplements ever caused you unusual side effects or problems ☐ Yes ☐ No

Describe:

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

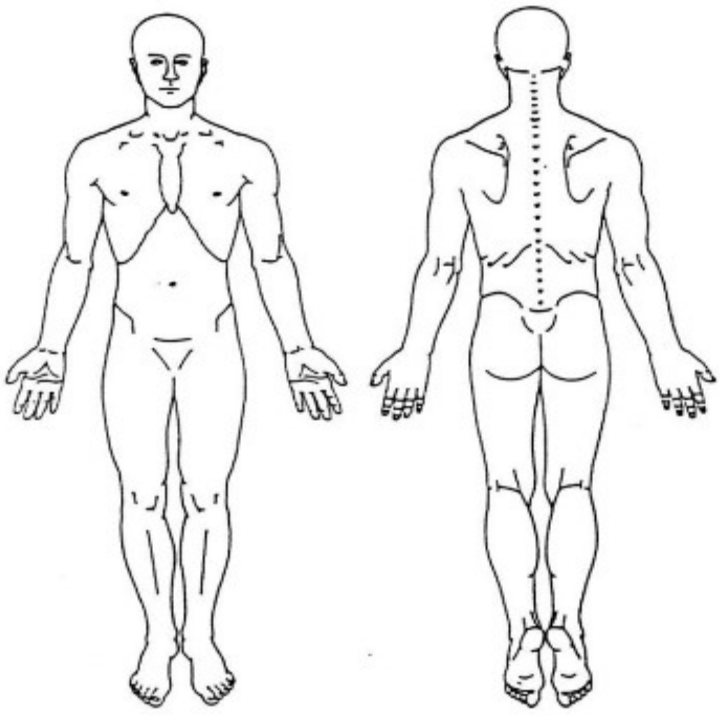
Supplement	Dose	Frequency	Start Date (month/year)	Reason For Use

Physical History (indicate if you experience any of the following)

- ☐ Muscle Cramps or Spasms
- ☐ Easily Bleed or Bruise
- ☐ Swelling
- ☐ Hand, Wrist, or Elbow Pain
- ☐ Numbness in Hands or Feet
- ☐ Carpal Tunnel Syndrome
- ☐ Neck Pain or Whiplash
- ☐ Thoracic Outlet Syndrome
- ☐ Upper or Mid Back Pain
- ☐ Low Back Pain
- ☐ Herniated or Bulging Disk(s)
- ☐ Sciatic Pain
- ☐ Arthritis
- ☐ Fibromyalgia or Chronic Pain
- ☐ Other _____

Use the following diagram to indicate painful or distressed areas:

☒ pain ~ radiating/electrical pain ◯ numbness



Additional Details:

How severe the pain now (0-10)? _____ The most severe in the last week (0-10)? _____

Frequency of pain: ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Since onset, pain is: ☐ Better ☐ Same ☐ Worse

Symptoms are most present: ☐ Waking ☐ Morning ☐ Mid-day ☐ Evenings ☐ Night

Do you sit for long hours at a computer workstation or driving? ☐ Yes ☐ No

Heart of Wellness
FINANCIAL POLICY

Financial Responsibility: Our providers are credentialed with numerous insurance companies. If we have accurate insurance information, we will bill your insurance company for you. However, it is important you understand that **you are ultimately responsible for payment for all services you receive.**

Payment at Time of Service: High-quality integrative medical care should be accessible to everyone, including patients without health insurance. We offer a discount when you pay at the time of service. The amount of the discount represents the savings in not having to bill you or an insurance company. If you want to pay at the time of service, please let us know when you schedule your appointment.

Insurance Billing: We require a copy of your driver's license/identification and current valid insurance card at the time of your appointment. Insurance is a contract between you and your insurance company; we are NOT a party to this contract. All copays/coinsurance must be paid at the time of service.

Non-covered Services: we are not able to know for certain your insurer will cover all services you receive. If we believe a service will not be covered, you may be asked to pay at the time of service.

Account Balances & Statements: You are responsible for paying any balance your insurance does not pay. Unpaid balances are due upon receipt of a statement. Partial payments or payment plans must be negotiated with Heart of Wellness in advance.

Past Due Balances: If unpaid after 28 days of receipt of a statement the following additional charges will apply; $20.00 per incident administrative fee, and 1.5% outstanding balance charge per month until all balances are paid in full. If a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be dismissed from this practice.

Cancellations: We ask that you give us notice by 2:00 pm the day before the appointment for any cancellations, for Monday appointments notice by 2:00 pm the Friday before. **There is a $50 charge for all missed appointments or for cancellations with less than a 24-hour notice.** This fee is not billable to insurance. At our discretion, unavoidable emergencies may be considered reasonable exceptions. If you miss three appointments or have three late cancellations, you and your immediate family members may be dismissed from this practice.

Special Fees: We reserve the right to charge for the following services. These fees are not generally billable to insurance.

- MVA, Disability, FMLA, & Other Reports $30.00
- Medical Records $26 clerical fee + per page fee
- Returned Checks $30.00
- Emergency Phone Calls $50.00

Supplement Sales: With some limited exceptions, all supplement purchases are final.

Choose Option 1 OR Option 2:

☐ **Option 1 (CREDIT CARD ON FILE):** I **authorize and request Heart of Wellness to charge the credit/debit card account named below**. After Heart of Wellness has submitted charges to my insurance carrier and after my insurance carrier processes my claim, any amounts remaining due will be charged to my card within 3 business days of the 20th of the month with a receipt to be sent to me via email. This authorization is good until I revoke it in writing with a 30-day notification period and choose another payment option to start at the end of that period.

Card Type: Discover Visa Mastercard **Card Number:**_____-_____-_____-_____

Expiration Date:_____ **3 Digit Security Code:**_____

Name as it appears on card:_____ **Email address:**_____

Credit Card Billing Address:_____

☐ **Option 2 (MAILED STATEMENT):** In the event a balance remains due after Heart of Wellness has submitted charges to my insurance carrier, and after my insurance carrier processes my claim, then **please send me a statement**. I agree to remit payment immediately on receipt of this statement. If I do not pay any outstanding balance within 28 days of receipt of the statement, additional charges will apply. See **Past Due Balances** above.

I, _____, acknowledge that I have read and agree to Heart of Wellness's Financial Policy. I agree to pay at the time of service all applicable co-pays, cash-pay services, non-covered service charges, and service charges going toward deductibles. I agree to either Option 1 or 2, above, for any additional balance incurred.

Patient/Guarantor Signature:_____ **Date:**_____

Updated: 19.07.11

Heart of Wellness

INFORMED CONSENT AGREEMENT

This Document Constitutes an Agreement: We have written this document to inform you about our practice, to ensure you understand our professional relationship, and to obtain your informed consent in this relationship. Your informed consent is important not only because it protects both parties in this agreement, but also because it helps you to feel empowered in your own healing process. When you sign this document, it will authorize us to initiate care and commence treatment in accordance with this document. Please read this document carefully and bring any questions you might have to your first meeting with a Heart of Wellness practitioner. Please also be responsible for maintaining clarity and communication regarding your ongoing informed consent. If at any time you are uncomfortable or dissatisfied with your care or treatment, for any reason, please let us know immediately.

Purpose of Treatment & Therapeutic Orientation: Heart of Wellness is an integrative and collaborative medical group practice dedicated to helping you achieve and maintain optimum health. We will help you as best we can to resolve your complaints and to achieve your health goals. We understand healing as a natural process and our fundamental goal in relation to this is to support, facilitate, and empower you in your own healing journey.

Naturopathic Medicine Practice & Limitations: Naturopathic Physicians currently practicing at Heart of Wellness include Dr. Morgan Schuster ND (NT60811436), Dr. Tim Shannon ND (NT60332027), Dr. Michele Deisering ND (NT60332030), Dr. Diana Duncan ND (NT60464581), Dr. Katie Shaff ND (NT00001331), Dr. Michelle Kent ND (NT60912971), and Dr. Mark Fredericksen ND (NT00000737). In the State of Washington, naturopathic medical practice includes the prescription, administration, dispensing, and use of: nutrition and food science, homeopathy, hygiene, immunizations & vaccinations, contraceptive devices; non-legend medicines including vitamins, minerals, botanical medicines, homeopathic medicines, and hormones; and legend drugs with the exception of Botox and certain controlled substances. The practice of naturopathic medicine also includes manual manipulation, physical modalities, minor office procedures, common diagnostic procedures, and suggestion. Naturopathic physicians may not treat malignancies except in collaboration with a Medical Doctor (MD) or Osteopathic Physician (DO). Therefore, if you have cancer, or suspect you have cancer, we require you be under the care of a board-certified oncologist or other MD or DO with experience working with cancer. If you have cancer or suspect you have cancer, by signing this document you hereby agree to remain under the continuing care of a qualified MD or DO and you agree that your relationship with this MD or DO shall be the primary therapeutic relationship, and that the care you receive at Heart of Wellness shall be secondary and supportive of your general health and shall not be understood as treatment of a malignancy.

East Asian Medicine Practice & Limitations: Acupuncture & East Asian Medicine Practitioners currently practicing at Heart of Wellness include David Lerner MTCM, EAMP (AC00000217) and Morgan Tougas MAOM, EAMP (AC00002943). East Asian Medicine includes the following diagnostic tools and treatment methods used to promote health and treat organic or functional disorders: acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; moxibustion; acupressure; cupping; dermal friction technique; infrared; sonopuncture; laserpuncture; point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; Qi Gong; East Asian massage; Tui Na; and superficial heat and cold therapies. Potential side effects of these therapies may include, but are not limited to, the following: discomfort during treatment, pain following treatment; minor bruising or swelling; infection; minor burns, “needle sickness” (including dizziness or fainting); and broken needle. In addition, it is important that you understand that under Washington State law the techniques of East Asian Medicine are not considered capable of resolving certain potentially serious health disorders, including but not limited to uncontrolled high blood pressure, other serious cardiac conditions, acute abdominal symptoms, acute neurological changes, unexplained weight loss or gain, fracture or dislocation, systemic infection, any serious bleeding disorder, or acute respiratory distress. If you have or suspect you may have any of these disorders, or any equally serious condition, or if you have a pacemaker installed, or if you are pregnant, by signing this agreement you hereby agree; (1) to inform your EAMP practitioner of this condition, (2) to remain under the continuing care of a qualified physician (MD, DO, or ND), and (3) to provide us with continuing authorization to consult with this physician. By signing this agreement, you further agree that your relationship with this physician shall be the primary therapeutic relationship and that the East Asian Medicine care you receive shall be secondary and supportive in nature.

Heart of Wellness
INFORMED CONSENT AGREEMENT

Occupational Therapy Practice & Limitations: The licensed Occupational Therapist currently practicing at Heart of Wellness is Amy Howell (OT00002292). Occupational therapy is the scientifically based use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process in order to maximize independence, prevent disability, and maintain health. The practice encompasses evaluation, treatment, and consultation. Specific occupational therapy services include but are not limited to: Using specifically designed activities and exercises to enhance neurodevelopmental, cognitive, perceptual motor, sensory integrative, and psychomotor functioning; administering and interpreting tests such as manual muscle and sensory integration; teaching daily living skills; developing prevocational skills and play and avocational capabilities; designing, fabricating, or applying selected orthotic and prosthetic devices or selected adaptive equipment; wound care management as provided in RCW 18.59.170; and adapting environments for persons with disabilities. These services are provided individually, in groups, or through social systems.

Massage Therapy Practice & Limitations: The licensed Massage Therapist currently practicing at Heart of Wellness is Gary Black (MA60326924). Massage therapy involves the external manipulation or pressure of soft tissue for therapeutic purposes, including techniques such as tapping, compressions, friction, reflexology, gymnastics or movements, gliding, kneading, shaking, and fascial or connective tissue stretching, with or without the aids of superficial heat, cold, water, lubricants, or salts. Massage does not include diagnosis or attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force, nor does it include genital manipulation. By signing this agreement you assert your understanding of the scope of massage therapy and acknowledge that massage therapy is not a substitute for medical examination or diagnosis. Massage Therapy as practiced at Heart of Wellness does not include breast massage but can include chest massage, which includes manipulation of the muscle, fascia and connective tissue of the upper torso and traction engaging the sternum and rib cage. Massage Therapy does not include genital manipulation but can include manipulation of the gluteal muscles and manipulation of muscle attachments located on the pubic and pelvic bones. Draping is provided so that the breasts, genitals, and tailbone are always covered. You always have the right to discontinue the entire massage therapy session, or any part of the session, at any time and for any reason. You have the right to request, at any time and for any reason, that the massage be given through a drape rather than directly on your body. You also have the right to provide a witness to be in the room with you while you receive massage therapy. Please let your therapist know immediately if you change your mind or if any part of the treatment process feels uncomfortable in any way.

Having read and understood the foregoing: By signing below you are asserting your understanding of and agreement with the entirety of this agreement and voluntarily consenting to treatment as outlined here, while also acknowledging that you are free to withdraw consent and to discontinue treatment at any time. By signing below you are authorizing physicians and other practitioners at Heart of Wellness to provide all examinations, treatments and/or diagnostic procedures which now or during the course of your care they deem advisable. By signing below you are acknowledging that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable, and that there is no guarantee that there will be any benefit from treatment. By signing below you are agreeing that you and no one else is responsible for your own healing and that maximum benefit will occur with consistent treatment and compliance and when you take full responsibility for your own healing journey. By signing below you acknowledge that Heart of Wellness is responsible only for the failure to perform your treatment with appropriate care. By signing below you are certifying that you have read and understood all preceding information and you are committing to immediately notifying your Heart of Wellness practitioner or other Heart of Wellness staff if you have any questions or should concerns arise at any time during the course of your treatment.

Mailing List: By signing below I consent to be added to the Heart of Wellness mailing list. I can unsubscribe at any time.

Confirmation of Review of Notice of Privacy Practices: By signing below I confirm I have reviewed and understand the Heart of Wellness **Notice of Privacy Practices**, that I understand that I am entitled to keep a copy of the notice for my records, and that a copy is for download on the Heart of Wellness website.

Patient's Name (Please print): _____

Patient's Signature: _____ **Date Signed:** _____