PORTLAND CLINIC of Holistic Health

**Portland Clinic of Holistic Health**
Naturopathic and Chinese Medicine
833 SW 11th Ave, Suite 525, Portland, OR 97205
Phone: (503) 294-7070, Fax: (971) 200-8962

## CONFIDENTIAL NEW PATIENT INFORMATION

Name: _____ Date: _____

Age: _____ Date of birth: _____ Sex: F M

Address: _____

City: _____ State: _____ Zip: _____

Phones: Cell _____ Work: _____ Home _____

Social Security # _____ Email: _____

Occupation: _____ Retired: Y N

How did you hear about us: _____

Please circle: Married Single Separated Divorced Widowed Partnership

Emergency contact: _____ Relationship: _____ Phone: _____

## YOUR PRESENT HEALTH

First of all, do you have any special needs? ☐ No ☐ Yes : _____

When and where did you last receive medical or health care and for what reason?

_____

Current Physician(s) – please identify which is your Primary Care Physician (PCP)

Name: _____ Phone: _____

Name: _____ Phone: _____

What are your goals for coming to see us today? Would you like us to be considered your PCP?

_____

What are you most important health problems? List as many as you can in order of importance.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

List any previous diagnoses: _____

## MEDICATIONS, SUPPLEMENTS & OVER THE COUNTER DRUGS

Current prescriptions: _____

Allergies to foods, drugs, etc: _____

Over the counter medications: _____

Supplements: _____

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## PERSONAL HEALTH HISTORY

Please tell us about any accidents, injuries, surgeries, hospitalizations, traumas & significant diagnoses you have had:

_____

_____

_____

X-Rays & Special Studies: ☐ X-Rays ☐ CAT Scans ☐ MRI's When/why? _____

_____

_____

Did you ever have: ☐ Scarlet Fever ☐ Rheumatic fever ☐ Diptheria ☐ Mumps
☐ Measles ☐ German Measles ☐ Other: _____

Immunizations: ☐ Polio ☐ Tetanus ☐ Measles/mumps/rubella
☐ Pertussis ☐ Diptheria ☐ Other: _____

## FAMILY HISTORY

| Check all that apply | Father | Mother | Brothers | Sisters | Spouse | Child |
|---|---|---|---|---|---|---|
| Age (if living) | _____ | _____ | _____ | _____ | _____ | _____ |
| Health: G=Good, P=Poor | _____ | _____ | _____ | _____ | _____ | _____ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Neurologic, MS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autoimmune conditions | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma, Hay fever, Hives | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anemia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Age (at death) | _____ | _____ | _____ | _____ | _____ | _____ |
| Cause of death | _____ | _____ | _____ | _____ | _____ | _____ |

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# REVIEW OF SYSTEMS

Height: _____ Weight: _____ Weight 1 year ago: _____ Maximum Weight: _____

Fatigue: ☐ Y ☐ N When during the day is your energy the best? _____ Worst? _____

Average hours sleep: _____ Sleep well? ☐ Y ☐ N Awake rested? ☐ Y ☐ N

Main Interests and hobbies: _____

Exercise: ☐ Y ☐ N If so, what kind and how often: _____

Watch TV: ☐ Y ☐ N If so, how many hours? _____ Read: ☐ Y ☐ N If so, how many hours? _____

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

**Please circle one:** **Y** for a condition you have now; **P** for a condition you have had in the past; **N** for never had

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Skin** | | | | **Ears** | | | | **Neck** | | | |
| Rashes | Y | P | N | Impaired hearing | Y | P | N | Swollen glands | Y | P | N |
| Eczema, hives | Y | P | N | Ringing | Y | P | N | Lumps/Goiter | Y | P | N |
| Acne, boils | Y | P | N | Earache | Y | P | N | Pain or stiffness | Y | P | N |
| Itching | Y | P | N | Dizziness | Y | P | N | | | | |
| Color change | Y | P | N | | | | | **Chest** | | | |
| Lumps | Y | P | N | **Nose and Sinuses** | | | | Asthma | Y | P | N |
| Night sweats | Y | P | N | Frequent colds | Y | P | N | Bronchitis | Y | P | N |
| | | | | Nose bleeds | Y | P | N | Pneumonia | Y | P | N |
| **Head** | | | | Stuffiness | Y | P | N | Emphysema | Y | P | N |
| Headache | Y | P | N | Allergies/Hay fever | Y | P | N | Difficulty breathing | Y | P | N |
| Head injury | Y | P | N | Sinus problems | Y | P | N | Pain on breathing | Y | P | N |
| | | | | | | | | Tuberculosis | Y | P | N |
| **Eyes** | | | | **Mouth and Throat** | | | | | | | |
| Impaired vision | Y | P | N | Frequent sore throat | Y | P | N | **Cardiovascular** | | | |
| Glasses/contacts | Y | P | N | Sore tongue | Y | P | N | Heart disease | Y | P | N |
| Eye pain | Y | P | N | Gum problems | Y | P | N | High blood pressure | Y | P | N |
| Tearing, dryness | Y | P | N | Hoarseness | Y | P | N | Murmurs | Y | P | N |
| Double vision | Y | P | N | Dental cavities | Y | P | N | Rheumatic fever | Y | P | N |
| Glaucoma | Y | P | N | | | | | Chest pain | Y | P | N |
| Cataracts | Y | P | N | | | | | Swelling in ankles | Y | P | N |
| | | | | | | | | Palpitations | Y | P | N |

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**Respiratory**

| | | | |
|---|---|---|---|
| Cough | Y | P | N |
| Sputum | Y | P | N |
| Spitting up blood | Y | P | N |
| Wheezing | Y | P | N |

**Urinary**

| | | | |
|---|---|---|---|
| Pain on urination | Y | P | N |
| Increased frequency | Y | P | N |
| Frequency at night | Y | P | N |
| Kidney stones | Y | P | N |
| Inability to urinate | Y | P | N |
| Weak urine stream | Y | P | N |

**Gastrointestinal**

How often do you have a bowel movement? _____

| | | | |
|---|---|---|---|
| Is this a change? | Y | P | N |
| Trouble swallowing | Y | P | N |
| Heartburn | Y | P | N |
| Change in thirst | Y | P | N |
| Change in appetite | Y | P | N |
| Nausea /vomiting | Y | P | N |
| Vomiting blood | Y | P | N |
| Gas/bloating/belching | Y | P | N |
| Liver disease | Y | P | N |
| Gall bladder disease | Y | P | N |
| Ulcer | Y | P | N |
| Hemorrhoids | Y | P | N |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Joint pain/stiffness | Y | P | N |
| Arthritis | Y | P | N |
| Broken bones | Y | P | N |
| Muscle spasms | Y | P | N |

**Peripheral vascular**

| | | | |
|---|---|---|---|
| Deep leg pain | Y | P | N |
| Cold hands/feet | Y | P | N |
| Varicose veins | Y | P | N |

**Blood**

| | | | |
|---|---|---|---|
| Anemia | Y | P | N |
| Easy bleeding/bruises | Y | P | N |

**Neurological**

| | | | |
|---|---|---|---|
| Fainting | Y | P | N |
| Seizures | Y | P | N |
| Muscle weakness | Y | P | N |
| Numbness/Tingling | Y | P | N |
| Loss of memory | Y | P | N |

**Emotional**

| | | | |
|---|---|---|---|
| Depression | Y | P | N |
| Mood swings | Y | P | N |
| Anxiety | Y | P | N |
| Tension | Y | P | N |

**Social**

| | | | |
|---|---|---|---|
| Use rec. drugs | Y | P | N |
| Use alcohol | Y | P | N |
| Drinks per week: _____ | | | |
| Use tobacco | Y | P | N |
| In what quantity: _____ | | | |

**Endocrine**

| | | | |
|---|---|---|---|
| Diabetes | Y | P | N |
| Hypothyroid | Y | P | N |
| Heat/cold intolerance | Y | P | N |
| Excessive thirst | Y | P | N |
| Excessive hunger | Y | P | N |

**Breast**

| | | | |
|---|---|---|---|
| Self exams | Y | P | N |
| Lumps | Y | P | N |
| Tenderness/Pain | Y | P | N |
| Nipple discharge | Y | P | N |

**Female reproductive**

| | | | |
|---|---|---|---|
| # Days of bleeding | _____ | | |
| Length of cycles | _____ | | |
| Bleed between periods | Y | P | N |
| Irregular cycles | Y | P | N |
| Painful menses | Y | P | N |
| Excessive flow | Y | P | N |
| Pain with intercourse | Y | P | N |
| Birth control | Y | P | N |
| What type? _____ | | | |
| # of Pregnancies | _____ | | |
| # of miscarriages | _____ | | |
| # of abortions | _____ | | |
| Difficulty conceiving | Y | P | N |
| Menopause symptoms | Y | P | N |
| Sexually active | Y | P | N |
| Sexual difficulties | Y | P | N |
| Venereal diseases | Y | P | N |
| Sexual preference: | | | |
| Heterosexual | _____ | | |
| Bisexual | _____ | | |
| Homosexual | _____ | | |

**Male reproductive**

| | | | |
|---|---|---|---|
| Hernias | Y | P | N |
| Testicular masses | Y | P | N |
| Sexually active | Y | P | N |
| Sexual difficulties | Y | P | N |
| Prostate disease | Y | P | N |
| Venereal disease | Y | P | N |
| Discharge | Y | P | N |
| Sores | Y | P | N |
| Sexual preference: | | | |
| Heterosexual | _____ | | |
| Bisexual | _____ | | |
| Homosexual | _____ | | |

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# Belief Statement Questionnaire

Dear Patient, please rate how you feel about the statement, from 0 to 10, with 0 = Totally Disagree and 10 = Totally Agree.

Note: You may mark anywhere between 0 – 10, to designate how much toward one or the other you feel.

| | Statement 'A' | Statement 'B' |
|---|---|---|
| #1 | I am blessed and whole<br>0 1 2 3 4 5 6 7 8 9 10 | My needs must be fulfilled by others<br>0 1 2 3 4 5 6 7 8 9 10 |
| #2 | I trust the choices I make<br>0 1 2 3 4 5 6 7 8 9 10 | I question the choices I make<br>0 1 2 3 4 5 6 7 8 9 10 |
| #3 | I am taking responsibility and forgiving myself and others<br>0 1 2 3 4 5 6 7 8 9 10 | I blame myself and others for what happens<br>0 1 2 3 4 5 6 7 8 9 10 |
| #4 | I am relaxing, doing my best and appreciate the results<br>0 1 2 3 4 5 6 7 8 9 10 | I worry about my performance and results<br>0 1 2 3 4 5 6 7 8 9 10 |
| #5 | I am living my life with spirit<br>0 1 2 3 4 5 6 7 8 9 10 | I lack connection with spirit<br>0 1 2 3 4 5 6 7 8 9 10 |
| #6 | I am in control of my life<br>0 1 2 3 4 5 6 7 8 9 10 | Outside influences or events control my life<br>0 1 2 3 4 5 6 7 8 9 10 |
| #7 | I am embracing change<br>0 1 2 3 4 5 6 7 8 9 10 | I want things to stay the way they are<br>0 1 2 3 4 5 6 7 8 9 10 |
| #8 | I am joyfully releasing all anger and frustration<br>0 1 2 3 4 5 6 7 8 9 10 | I hold onto past pain and emotion<br>0 1 2 3 4 5 6 7 8 9 10 |
| #9 | I love myself and am whole complete and balanced<br>0 1 2 3 4 5 6 7 8 9 10 | I hold back loving myself unconditionally<br>0 1 2 3 4 5 6 7 8 9 10 |
| #10 | I am protected by Divine Law<br>0 1 2 3 4 5 6 7 8 9 10 | I feel vulnerable and alone<br>0 1 2 3 4 5 6 7 8 9 10 |

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# INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize the doctor's of the Portland Clinic of Holistic Health to perform the following specific procedures as necessary to facilitate my diagnosis and treatment(s). I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Common diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.
Minor office procedures: eg., dressing a wound, ear cleaning, incision repair, laceration repair, wart removal, skin biopsy,etc
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrition.
Botanical medicine: substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
Homeopathic medicine: the use of diluted quantities of naturally occurring elements to gently stimulate the body's healing responses, given orally, topically, or by injection.
Lifestyle counseling/ Psychological counseling: promotion of wellness including recommendations for exercise, sleep, contraception, and stress reduction.
Lab tests and procedures: including referral for x-ray, MRI, or other imaging.
Naturopathic manipulation: specific manipulation of muscles, joints (including cranial bones), or soft tissue.
Acupuncture and trigger point needling, including injections such as prolotherapy, neural therapy, homeopathic injections.
Prescription of pharmaceuticals or bio-identical hormones.

I understand the treatment by a naturopathic doctor is intrinsically different from treatment by a conventional medical doctor. While naturopathic medicine is intrinsically safer than other systems of medicine, there are potential risks in what we do as well. The care we provide may or may not be directed at a specific disease or disorder. It may be preventative in nature, designed to improve overall health and well-being, and restore your body's innate healing ability. We will always strive to provide full disclosure of all information relevant to your health care. I understand that in providing treatments my physician is relying on the information that I am providing to them about myself and my health. I agree that the information I provide will be true and accurate and that I will disclose to the physician everything needed for treatment. If I have any reactions, I will advise my physician immediately.

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

Potential risks: allergic reactions to prescribed herbs or supplement, side effects of natural medications, healing reaction as defined below, inconvenience of lifestyle changes, injury from injections, venipuncture, or procedures.

Healing reaction: natural healing may occasionally generate a " healing reaction". Generally this will occur as a flu-like state with fever or a worsening of symptoms for a few days. It can also be different than this and may require expert attention and guidance.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy.

With this knowledge, I voluntarily consent to the above procedures and that I realize that no guarantees have been given to me by the doctor's or staff of the Portland Clinic of Holistic Health regarding cure or improvement of my condition.

Privacy Notice: The Portland Clinic of Holistic Health is required by law to respect your privacy by following HIPPA guidelines. By signing I acknowledge I have received and reviewed the attached privacy policy.

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name:_____ Patient Name if Guardian:_____

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# FEES & FINANCIAL AGREEMENT

You have come to us for results. Like many before you, this has been a long journey and, more often than not, you have tried other medical solutions with little or no relief. We don't treat symptoms with drugs that simply mask your underlying causes. We do treat the underlying causes of your illness. We practice medicine differently from the typical medical model. First of all, we take considerable time with you. Most of our appointments are reserved for almost an hour. This is so we can thoroughly evaluate your concerns and talk with you about your healing plan. We dedicate our time with you for a full understanding of your condition and concerns.

Because we operate entirely different from typical medical office, we have found most insurance programs do not adequately compensate us for the time we take with all of our patients. Consequently, we do not bill insurance plans, but with some exceptions. These include care associated with insurance covered motor vehicle accidents and for annual well woman exams. Certain routine lab testing is also billed to your insurance plan. We will provide a bill at each visit that is formatted so it can be submitted to insurance companies directly (we recommend faxing or sending a copy). Some insurance plans may reimburse you for our care. It is up to you to submit our bill to your insurance carrier if you so choose and we encourage you to do so. In any event, complete payment for our services is due on the date of your visit.

Here is a brief limited example of current common customary fees for routine services:

| | |
|---|---|
| Typical intake to become a clinic patient is a 2 visit process: Visit 1 is evaluation and testing- a 45 minute visit that evaluates your food intolerance, Bolen blood analysis, Iris diagnosis, infection screening, physical examination, and a full case history followed by Visit 2 report and treatment plan - a 45 minute detailed report of findings and individualized plan of treatment. | $395.00 |
| General returning patient office visit (45 minutes) | $185 |
| Bio Thermal Therapy treatments (45-90 minutes) | $90.00 - 128 |
| Joint Injection Therapies (15-45 minutes) | $186 -370.00 + Medication |
| IV Therapies | $45.00 - 200.00 + IV Medication |
| Acupuncture Treatments | $69.00 - 128 |
| Nutritional Consultation – 30 minute visit to develop a detailed diet plan | $117.00 |
| Well Woman Visit | $180.50 + lab fees* |

* Fees for medical services not listed are available upon request. Laboratory fees not included in above fee schedule.

Dispensary Policy: We use a variety of nutritional concentrates, homeopathic medicines, botanical medicines, etc. These items must be paid for at the time they are dispensed. Once these products leave our office we cannot bear responsibility for their storage or their use. Therefore, if we were to accept returns on these products, we would not be able to vouch with confidence as to their handling. **For this reason, for the health and safety of you and all of our patients, we simply CANNOT accept returns on any products.**

Cancellation policy and missed appointment fees: We will be establishing a course of treatment for you. A certain number of treatments in a set amount of time is required for the results we both desire. If that is not possible, be sure to make up the missed appointment within one week. Because our appointments are limited and we schedule on a first come basis, other patients suffer when someone cancels abruptly, does not show up or frequently reschedules the same appointment over 3 times. **I understand I will be billed $50.00 for any appointment cancelled/missed with less than 24 hours notice and rescheduled over 3 times for the same appointment.**

I understand that I am wholly and personally responsible for payment on date of service. The Portland Clinic of Holistic Health is not a participant in Medicare or insurance plans. I realize that I may request the attending physician's statement of diagnosis or services provided to me, which I may submit to my insurance company for reimbursement of the treatment cost, as may be provided by my plan. The Portland Clinic of Holistic Health does not guarantee that I will receive reimbursement from my insurance carrier. I understand that the Portland Clinic of Holistic Health, at its option, may charge me interest on unpaid balances. Unpaid balances 30 days past due will be charged and interest of 8%. We reserved the right to terminate our services for any client with unpaid past due balances. In the event this occurs the Portland Clinic of Holistic Health will continue providing medical care on an urgent care for up to 30 days or until care with another physician is established.

I have read and agree to the financial terms and cancellation policy above.

Signature of patient or legal guardian: _____ Date_____

Printed Name:_____ Patient Name if guardian:_____

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# NOTICE OF PRIVACY PRACTICES

This clinic is required by law to provide you with this notice so that you will understand how we may use or share your information from your Designated Record Set/Protected Health Information.
If you have any questions about this notice, please ask a Patient Care Coordinator.

This notice describes your privacy rights as they relate to information from your health records and explains the circumstances under which information from your health records may be shared with others. If you do not understand the information in this notice, please ask for further explanation.

## Uses of Protected Health Information

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the way we are permitted to use and disclose information will fall into one of the categories.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the 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 or your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
- **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, and training of medical students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by your first name in the waiting room when your provider is ready to see you.

## Other allowable uses of your Protected Health Information:

- **Business Associates** – when services are contracted, we may disclose your health information to that they can perform the job we have asked them to do and pay for services rendered. To protect your health information, however, we require the business associate to sign an agreement to safeguard your information.
- **Treatment Alternatives** – we may use and disclose your health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health Related Benefits and Reminders** – we may contact you to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to you.
- **Individuals Involved in Your Care or Payment of Your Care** – unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for you care.
- **As Required by Law** – We will disclose health information about your when required to do so by federal, state, local law or military authorities.
- **To Avert a Serious Threat to Health or Safety** – we may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

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**Uses of Protected Health Information**

The clinic will not use or disclose your health information without your authorization except for the purposes described in this information sheet or in accordance with existing laws. You may authorize the use or disclosure of your health information for other purposes. If you choose to do so, you may revoke the authorization at any time. You must submit your authorization in writing to the Clinic Manager.

**Limiting Disclosure of Your Protected Health Information**

You have the right to limit the disclosure of your protected health information if you choose not to use any health insurance or third party payments as payment for services, in which case, you may only limit disclosure if you have advised the provider prior to the delivery of services and have paid for the health care services yourself. You may also request that we limit the health information we disclose to someone who is involved in your care or the payment for your care.

**Right to Inspect, Copy and/or to Amend**

With some exceptions you have the right to review and request a copy of your health information. (We may charge a fee for the costs associated with your request). If you feel that health information in your record is incorrect or incomplete you may ask to amend the information.
You must submit your request to Inspect, Copy and/or Amend in writing to the Clinic Manager. In addition, you must provide a reason for your request. We may deny requests if they are not in writing and do not include a reason to support the request.

**Right to Request Alternate Communications**

You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example you may ask that we only contact you via mail. The clinic has policies in place to safeguard and prevent the improper uses and disclosures of protected health information through various forms of communication.
You must submit your request for alternate communications in writing to the Clinic Manager. We will accommodate all reasonable requests.

**Right to Request a Paper Copy of This Notice**

You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this notice at any time.
You may also obtain a copy of this Notice at our website at www.HolisticHealthPC.com

**Changes to this Notice**

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective e for health information we already have about you as well as any information we receive in the future. We will post a copy of the Notice in the clinic and on the website.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic contact the Clinic Manager. You must submit your complaint in writing to the Clinic Manager. You will not be penalized for filing a complaint.

I hereby acknowledge that have I received a copy of the Portland Clinic of Holistic Health's NOTICE OF PRIVACY PRACTICES.

_____ _____
Signature Date

**For clinic use only**

_____

_____ _____
Clinic staff signature Date