

Laurelhurst Integrative Health, LLC
HormoneSynergy® Inc.
Kathryn Retzler, ND
2705 E. Burnside, Suite 206
Portland, OR 97214
Office 503-230-7990 Fax 503-230-1887

Patient Handbook

Welcome to Laurelhurst Integrative Health, LLC. We look forward to getting to know you and providing you the highest quality health care. The purpose of this Patient Handbook is to answer your questions and communicate our office policies. Our goal is to make sure you receive exceptional, thorough care, and to provide care at the lowest possible cost. _____ **(please initial at the end of each section)**

Initial Appointments

Please read, initial, and sign this new patient handbook and complete all new patient forms **prior** to your first appointment. If you have not done so, please arrive **at least** thirty (30) minutes prior to your appointment time to complete any necessary paperwork. Initial consultations are scheduled for a minimum of 30 minutes in the office; all of your time is spent personally with Dr. Retzler. Dr. Retzler does not double book appointments, nor will you spend time with nurses or other assistants. Any paperwork not completed by the beginning of your appointment will be completed during your appointment time and your initial consult with Dr. Retzler may be shortened or rescheduled. If you have not completed all paperwork before your appointment time and need to be rescheduled, you will be charged for the appointment time. _____

Laboratory Testing

You're welcome to bring past lab results to your appointment, or send a release of records form (obtained from our office) to your previous physician to have lab work sent directly to us. Dr. Retzler does not order pre-appointment lab testing for non-established patients. Dr. Retzler orders appropriate lab testing (based on your health history, current symptoms, family history, physical exam, etc.) during the first appointment. You will either have your blood drawn at our office and sent out to a lab, or we will send you with a form that you can take with you to another lab. If you don't have insurance and have to pay out-of-pocket for lab work, we've negotiated lower fees with LabCorp as a courtesy to you. LabCorp is only willing to charge these significantly lower fees if they bill our office directly (rather than billing the patient). If you use this option, you are required to pay all lab fees to this office at the time your blood is drawn. Any additional fees due to lab tests added after your blood draw are your responsibility. Dr. Retzler does not make any profit from lab testing and assumes a liability and added cost in providing this service to you. Therefore there will be no exceptions in pre-payment for lab work sent to LabCorp at this reduced fee for out-of-pocket (non-insured) patients. _____

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Late Appointments

Our patients are our number one priority and we ask that you also make us your priority by being on time to all appointments. **Please leave your destination in plenty of time to allow for traffic issues, parking, or other obstacles that may prevent you from being on time to your appointment.** In addition, please arrive 15 minutes early to address any administrative needs. If you are late for an appointment, this time will come from your allotted time. For example, if you are 10 minutes late to a 30 minute appointment, you will be charged for the entire 30 minute appointment time allocated to you, even if your actual face time with Dr. Retzler is 20 minutes. If Dr. Retzler is running late due to an unforeseen patient need or emergency, our office staff will notify you if at all possible and you will still receive your full allotted time. Please understand that this policy has been put in to place so we can afford to provide you exceptional care, and so that other patients aren't made to wait if you are late. Because Dr. Retzler does not double book appointments, a late or missed appointment means a revenue loss for our clinic which would require either an increase in fees, or shortened appointment times to accommodate more patients. _____

Cancellations, Missed Appointments, & Rescheduling

At any given time we have a waiting list of patients who would like to see Dr. Retzler sooner than their scheduled appointment. We are typically booked at least 4 weeks in advance and require existing patients to give a minimum of one (1) business day (24-hours) notice to cancel or reschedule appointments. New patients must give at least two (2) business days (48-hours) notice. In order to avoid having to increase our fees, or shorten appointments and squeeze in more patients, each patient is required to pay for any appointment missed, late, or cancelled without notice, regardless of weather, a busy transit system, parking, or any other reason. If an appointment is cancelled or rescheduled without required notice, our staff will attempt to fill this appointment. If the appointment does not get filled, you will be charged for this missed/cancelled appointment, and you will not be rescheduled until this fee is paid. Please note that our office staff attempts to remind you by phone the day before your appointment; however, we do not guarantee reminder calls and it is your responsibility to remember your appointment time and date. Please sign here indicating that you have read and agree to this policy:

Signature

Date

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New Patient Security Deposit

Unfortunately it has become necessary for our office to secure first time appointments with a credit card number or personal check. Our major source of revenue is the patient's appointment fee. Unlike the standard of care model, Dr. Retzler has chosen to only see a limited number of patients in her office per day in order to spend more time with each patient to thoroughly address individual health care needs and goals. In addition, we choose not to charge high fees as seen in other clinics offering similar treatment, and we make no profit on lab testing. Due to these choices, we must collect payment for every appointment in order to maintain affordable rates.

If you are a new patient, you are required to provide a credit card number with expiration date **which will NOT be charged** unless you cancel with less than 48 hours notice, or miss your first appointment. All cancellations or rescheduling requests must be made by phone to our office; messages on our answering machine will be accepted.

If you are a new patient, please read and sign below: I, the cardholder named below, authorize Laurelhurst Integrative Health, LLC to use the credit card information provided or to cash my personal check in the event of cancellation without 48 hours notice, or in the event that I, the patient so named below, do not appear at the office of Laurelhurst Integrative Health on the time date of my scheduled appointment.

Signature

Date

Phone calls

Your health and well-being are very important to us. If you have questions or concerns, and you don't want to wait until your scheduled appointment to have them addressed, please feel free to contact our office directly by email or phone. Complications, changes in symptoms, side effects, and instructions are all important to Dr. Retzler. Our office staff will forward these questions/concerns to her and will get back to you as soon as possible. However, if you believe it's necessary to speak to Dr. Retzler personally, please understand that you will be charged for phone consults. _____

Email

In order to provide the best and most accurate care possible, Dr. Retzler makes it a policy to avoid email communications with patients. You will be better served by discussing your situation in person or by contacting our office staff by phone or email.

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However, non-medical related issues in email communication with our staff in regard to booking appointments, general information, feedback, etc. will be addressed on a daily schedule. In general, emails are convenient and effective, but if you have not heard back from our office staff within 48 hours, please call us. Our email address is info@hormonesynergy.com _____

Lab results

No lab results will be sent to any patient before a follow up appointment since Dr. Retzler needs to be present when interpreting lab results. Dr. Retzler may decide to send you a copy of your lab results with a note explaining them; however, she may also need to see you in person based on these results. _____

Insurance Policy

Our office does not bill any insurance companies nor is Dr. Retzler contracted with any insurance panels. Unfortunately, insurance companies dictate the time allowed for patient visits and often the type of treatment. In addition, Dr. Retzler's unique and successful approach to hormone balance and optimal aging often falls outside the "standard of care" approach as put forth by the insurance industry to limit their costs and increase their profits. Insurance billing costs and restrictions would prevent Dr. Retzler from providing you the thorough, individualized care that you and other patients deserve.

As a courtesy to you, we will provide you with an insurance claim form and appropriate diagnosis and procedure codes to attempt reimbursement on your own. Many patients do successfully get reimbursed for some or all of their treatment, depending upon their insurance plan. Also, any required lab testing as well as prescriptions is often covered by insurance companies.

If your insurance company requests chart notes or any other information, the fee for handling these issues is \$25. If Dr. Retzler is required to fill out any forms or participate with your insurance company in any way, you will be charged a minimum of \$50. _____

Medicinary sales:

Laurelhurst Integrative Health, LLC has an extensive medicinary of pharmaceutical-quality supplements which are often recommended and/or prescribed. Dr. Retzler has compiled this medicinary over the years based on clinical experience and on the quality and effectiveness of each item. Dr. Retzler does make a small profit from the sale of medicinary items, which is adequate compensation for the time it takes to research products, as well as the investment cost of keeping such an extensive medicinary on hand. Lloyd Center pharmacy and Pharmaca are two integrative pharmacies that carry

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most of the supplements dispensed by this office. In addition, some recommended supplements are available on the Internet from people who sell them at a reduced cost. **Dr. Retzler makes supplement recommendations based solely on medical need.** If you feel uncomfortable or believe this is a conflict of interest, please feel free to talk to her about it, or to purchase supplements at another location. _____

Patient Rights and Patient Responsibilities

Patient Rights: As a patient, you have the right to:

- Be treated as an individual with considerate, respectful, and compassionate care regardless of your age, race, gender, gender expression, religion, national origin, sexual orientation, political ideology, physical disability, or mental disability.
- Be provided by Dr. Retzler with information about your diagnosis, treatment, and expected result.
- Receive information on the planned course of treatment, including an explanation about procedures and costs, as well as on the risks, benefits, available research, and alternatives of your treatment.
- Take an active role in your health care, to make decisions about your plan of care before and during treatment.
- Not participate in a research study related to your treatment. You may decline to participate in or withdraw from a research study at any time. Your refusal to participate will not affect your treatment in any way.
- Have all communications and records pertaining to your care treated as confidential. You have the right to review or obtain a copy of your medical record according to patient policies of Laurelhurst Integrative Health, LLC, and to have your information explained as needed by Dr. Retzler.
- Receive a summarized list of charges for each visit, purchase, or procedure.
- Question the accuracy of your bills and obtain information about those charges.

Patient Responsibilities: As a patient, you are expected to:

- Provide complete and accurate information about your health, including conditions and illnesses including prior history of cancer and other serious diagnoses, hospitalizations, medications, natural products and vitamins, and items pertaining to your health.
- Provide complete and accurate information including your legal full name, address, home telephone number, date of birth, and to notify us when this information changes.

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- Follow the therapy as agreed upon in your appointment, indicated on your Treatment Plan, ***and accept all consequences from not complying with recommended therapy.***
- Express any concern to Dr. Retzler about your ability to comply with a proposed course of treatment.
- Ask questions when you do not understand your diagnosis or treatment.
- Provide us with the knowledge that you no longer require or desire therapy or treatment.
- Assist us in providing the best care possible by informing us when you have a grievance or issue with your health care, Dr. Retzler, our office staff, or your care.
- Be considerate of the rights of other patients and to our office staff, ***and to arrive promptly for your appointments.***
- Notify the office according to our cancellation or reschedule policy.
- Make payment for services at the time of appointment for procedures and products as outlined in the Patient Policies for our office.
- Understand that although Dr. Retzler's treatments are effective in the vast majority of patients, there can be no guarantee that it will be effective in your condition and ***that following your treatment plan as well as dietary and lifestyle recommendations as provided by Dr. Retzler will greatly affect your outcome.***

By signing on the line below, I acknowledge that I have read and agree to the policies as stated above in the Patient Handbook and that it is my responsibility to address any concerns or questions regarding these policies to the office manager.

Signature

Date

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient Name _____
SSN _____ Male Female Birth date _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Check appropriate box: Minor Single Married Divorced Widowed Separated
Patient's or parent's employer _____ Work Phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____ Work Phone _____
If patient is a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Email _____

Is it ok if we add you to our private newsletter list and send you information about upcoming clinic events and health-related topics? (email addresses are NOT be shared with anyone else)

- Yes
 No

Insurance Information This office does not bill insurance companies. Insurance information will enable us to make sure any lab work performed in the office is billed to your insurance. This does not guarantee coverage for lab work and we assume no liability for the cost of required lab tests.

Name of Insured _____ Relationship to Patient _____
Birth date _____ SSN _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional insurance? Yes No If yes, complete the following:

Name of Insured _____ Relationship to Patient _____
Birth date _____ SSN _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____
SIGNATURE

DATE

HEALTH HISTORY

Patient Name _____ Birth date _____ Patient Number _____

To help us meet your healthcare needs, please fill out **both** sides of this form completely, in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date _____
 Place of birth _____
 Highest level in school _____
 Occupation _____
 Previous occupations _____
 Marital status _____
 Hobbies _____
 Exercise/recreation _____
 Habits:
 Smoking (type & amount per day) _____
 If former smoker, date quit _____
 Alcohol (type & amount per week) _____
 Caffeine (type & amount per day) _____
 Street drugs (type & amount per day) _____
 Usual weight _____
 Date of last dental exam _____
 Please list all allergies (foods, drugs, environment)

When was your last physical exam _____
 Name of doctor _____
 Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: None

 Please list all medicines you are currently taking (include nonprescription drugs): None

 Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): None

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Past Medical History

Have you ever had the following: (Circle "no" or "yes"; leave blank if uncertain)

Measles no yes	Migraine headaches no yes	Hives or eczema no yes
Mumps no yes	Tuberculosis no yes	AIDS or HIV+ no yes
Chickenpox no yes	Diabetes no yes	Infectious mono no yes
Whooping cough no yes	Cancer no yes	Bronchitis no yes
Scarlet fever no yes	Polio no yes	Mitral Valve Prolapse no yes
Diphtheria no yes	Glaucoma no yes	Stroke no yes
Smallpox no yes	Hernia no yes	Hepatitis no yes
Pneumonia no yes	Blood or plasma no yes	Ulcer no yes
Rheumatic fever no yes	transfusions	Kidney disease no yes
Heart disease no yes	Back trouble no yes	Thyroid disease no yes
Arthritis no yes	High or low blood no yes	Bleeding tendency no yes
Venereal disease no yes	pressure	Any other disease no yes
Anemia no yes	Hemorrhoids no yes	(please list) _____
Bladder Infections no yes	Date of last chest x-ray _____	_____
Epilepsy no yes	Asthma no yes	_____

Family History

Has a blood relative had any of the following: (Circle "no" or "yes"; leave blank if uncertain)

Cancer no yes	Relationship _____	Stroke no yes	Relationship _____
Tuberculosis no yes	_____	Epilepsy no yes	_____
Diabetes no yes	_____	Allergies no yes	_____
Heart disease no yes	_____	Anemia no yes	_____
High blood pressure no yes	_____	Bleeding tendency no yes	_____

Family History (cont.) (Circle "no" or "yes"; leave blank if uncertain)

	Relationship	Present age or age at death	If living, health (good, fair, poor) If deceased, cause of death
Asthma.....	no yes _____	Father _____	
Chronic lung disease	no yes _____	Mother _____	
Drug or alcohol problem.....	no yes _____	Siblings _____	
Mental illness	no yes _____		
Leukemia	no yes _____		
Migraine headaches.....	no yes _____		
Obesity.....	no yes _____		
Thyroid disease.....	no yes _____	Spouse _____	
Ulcer	no yes _____	Children _____	
Depression.....	no yes _____		
High cholesterol	no yes _____		
Kidney disease.....	no yes _____		
Glaucoma	no yes _____		
Gout.....	no yes _____		

Do you have now, or have you recently experienced: (Circle "no" or "yes"; leave blank if uncertain)

Weakness or paralysis.....	no yes	Bloody sputum	no yes	Joint pain or stiffness.....	no yes
Tire easily or weakness.....	no yes	Wheezing	no yes	Swollen joints	no yes
Recent weight changes.....	no yes	Chest pain or discomfort	no yes	Muscle cramps or spasms.....	no yes
Change in appetite.....	no yes	Purple fingers or lips	no yes	Sleeplessness	no yes
Sensitivity to cold or heat	no yes	Swelling of hands, feet, ankles.....	no yes	Seizures	no yes
Persistent fever	no yes	Difficulty in breathing.....	no yes	Depression	no yes
Night sweats or hot flashes	no yes	Palpitations or heart fluttering.....	no yes	Memory loss	no yes
Skin rash.....	no yes	Leg cramps: walking, at night.....	no yes	Poor coordination	no yes
Skin trouble or changes	no yes	Enlarged veins	no yes	Dizziness or fainting spells	no yes
Change in nails or hair	no yes	Difficulty swallowing	no yes	Living will or advance directive	no yes
Headaches.....	no yes	Heartburn	no yes	Men only:	
Easy bleeding or bruising.....	no yes	Frequent belching	no yes	Discharge from penis.....	no yes
Double vision	no yes	Abdominal cramping	no yes	Pain or lump in testicles.....	no yes
Blurred vision	no yes	Nausea.....	no yes	Impotence.....	no yes
Eye pain.....	no yes	Vomiting	no yes	Women only:	
Infected eyes	no yes	Vomited or coughed up blood	no yes	Age period began.....	_____
Contacts or glasses	no yes	Chronic diarrhea.....	no yes	How many days do periods last.....	_____
Last eye exam date.....	_____	Chronic constipation.....	no yes	How many days between periods.....	_____
Ringing in ears.....	no yes	Rectal bleeding	no yes	Is the flow heavy.....	no yes
Discharge from ears.....	no yes	Black, tarry stools.....	no yes	Bleed/spot between periods	no yes
Ear pain	no yes	Dark urine	no yes	Pain or cramps	no yes
Decrease in hearing.....	no yes	Yellow jaundice	no yes	Date last period began.....	_____
Frequent nosebleeds	no yes	Frequent urination (day).....	no yes	Date of last pelvic exam.....	_____
Frequent colds	no yes	Frequent urination (night).....	no yes	Date of last mammogram.....	_____
Sinus trouble.....	no yes	Increase in thirst.....	no yes	Any itching in vaginal area.....	no yes
Loss of smell.....	no yes	Painful urination	no yes	Pain with intercourse	no yes
Persistent hoarseness	no yes	Leakage of urine	no yes	Type of birth control used.....	_____
Sore throat.....	no yes	Difficulty starting urine.....	no yes	Number of pregnancies.....	_____
Sore tongue or gums	no yes	Blood in urine	no yes	Number full-term births.....	_____
Breast lump or discharge	no yes	Lack of sex drive	no yes	Number of pre-term births.....	_____
Chronic or frequent cough.....	no yes	Hemorrhoids.....	no yes		
Shortness of breath.....	no yes	Backaches	no yes		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform any necessary healthcare services I (my child) may need.

Patient signature, or parent if patient is a minor: _____ Date: _____

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Fee Schedule

Note: fees are based on complexity of decision making as well as time.

New patient office visit, intermediate (approx. 60 min)	240.00
New patient office visit, brief (approx. 45 min)	190.00
New patient consultation (approx. 30 min)	140.00
New patient consultation (approx. 15 min)	95.00
Return office visit, routine (approx. 60 min)	205.00
Return office visit, short (approx. 45 min)	155.00
Return office visit, brief (approx. 30 min)	105.00
Return office visit, brief (approx. 15 min)	60.00
Annual exam including Pap smear	185.00
I.V. Nutrients	125.00-225.00
Injections	17.00
Blood Draw Fee	25.00
Lab Handling Fee (for LabCorp, non-insurance patients)	25.00
Sharps Disposal Fee	5.00

Subcutaneous Pellet office and insertion fees

New patient office visit & pellet insertion (must have all required lab work)
\$275.00 women/\$285.00 men

Established Patient - Pellet insertion \$195 women/\$205 men

Subcutaneous pellets \$30 -\$40 per pellet depending on dosage.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Retzler. In addition, I understand that I will be billed for phone consultations, except those regarding questions about prescribed treatments and conditions already being treated by Dr. Retzler.

I understand that I am responsible for all lab work costs that may or may not be covered by my insurance plan. **I also understand that I will be charged for follow-up appointments cancelled without 24 hours notice, or 48 hours notice for new patients.**

Signed _____ Date _____

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

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

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. In addition, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and 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.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registrations desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration (FDA) requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates. Required uses and disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician

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or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for 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 rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please speak with your physician.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____