Soma
WELLNESS
A Center for Extraordinary Health

3333 Denali Street Suite 150
Anchorage, Ak 99503
Phone 907-563-SOMA (7662)
Fax 907-562-SOMA (7662)
www.SomaWellnessAk.com

As a new patient, and to help us understand any health issues you may have, please fill out the information below to the best of your ability. All information is confidential

Patient Name:_____ DOB:_____ Intake Date:_____

Chief Complaint: _____

Patient Medical History

Please check next to any you currently have and underline any you've had in the past.

☐ Measles	☐ Hemorrhoids	☐ Arthritis	☐ AIDS or HIV
☐ Mumps	☐ IBS / Diverticulitis	☐ Osteoporosis	☐ Infectious Mono / Epstein Barr Virus
☐ Chicken Pox	☐ Crohn's Disease	☐ Hives or Eczema	☐ Hepatitis A B C
☐ Diphtheria	☐ Ulcer	☐ Bladder Infections	☐ STD
☐ Smallpox	☐ Glaucoma	☐ Kidney Disease	☐ Blood/Plasma Transfusion
☐ Polio	☐ Epilepsy	☐ Thyroid Disease	☐ Anemia
☐ Rheumatic Fever	☐ Diabetes	☐ Hernia	☐ Bleeding Tendency
☐ Whooping Cough	☐ Cancer	☐ Back Trouble	☐ Bruising
☐ Tuberculosis	☐ Stroke	☐ Migraine Headaches	☐ Other Diseases (Please list)
☐ Pneumonia	☐ Heart Disease	☐ Head Injury	_____
☐ Bronchitis	☐ Mitral Valve Prolapse	☐ Fibromyalgia	_____
☐ Asthma	☐ High / Low Blood Pressure	☐ Chronic Fatigue	
☐ Respiratory Disease			Date of Last Physical Exam

Previous Hospitalizations / Surgeries / Serious Illnesses / Traumatic Events

Date

_____ _____
_____ _____
_____ _____
_____ _____

Medications (include herbs, supplements and over the counter items)

_____
_____
_____
_____

Allergies:_____

Patient Social History

Marital Status:	Alcohol use:	Caffeine use:	Smoking:	Exercise:	Sleep Habits:	Exposure to:
☐ Single ☐ Married ☐ Living w/partner ☐ Separated ☐ Divorced ☐ Widow	☐ Never ☐ Rarely ☐ Moderate ☐ Daily Amount/day:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily Amount/day:	☐ Never ☐ Previously, but quit:_____ ☐ Currently smoking ___ packs/day	☐ Rare ☐ Occasional ☐ Regularly ☐ Daily Type of exercise:	☐ 6-8 hours ☐ Insomnia ☐ Wake up too early ☐ Difficulty falling asleep ☐ Dreamer	☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise ☐ Vaccinations

Drug use: ☐ Never ☐ Type/frequency _____

Special Diet: ☐ Yes if so, type:_____

Family Medical History

	Age	Diseases	Date deceased, cause of death
Spouse	___	_____	_____
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____

Who do you see for Medical Doctors?_____

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Patient Name _____ Date _____

Please check all symptoms you currently have and underline any you've had in the past.

Constitutional Symptoms
☐ General health the past year
☐ Good ☐ Poor
☐ Recent weight change
_____
☐ Fever
☐ Fatigue / Poor Energy
☐ Sleep problems / snoring

Eyes
☐ Eye disease or injury
☐ Wear glasses or contacts
☐ Eye Surgery _____
☐ Blurred or double vision

Ear/Nose/Mouth/Throat
☐ Hearing loss or ringing of ears
☐ Ear pain or drainage
☐ Ear Infections
☐ Sinus Infections / Problems
☐ Nose bleeds
☐ Mouth sores
☐ Bleeding gums
☐ Bad breath or bad taste
☐ Sore throat or voice change
☐ Swollen glands in neck

Cardiovascular
☐ Last cholesterol screen
Date _____Total _____
LDL _____HDL _____
Triglycerides _____
☐ Heart trouble / attack
☐ Chest pain / angina
☐ Heart medications
☐ Blood thinner medications
☐ Heart Murmur
☐ High blood pressure
☐ Shortness of breath walking
☐ Pain in legs with walking
☐ Shortness of breath at rest
☐ Swelling of feet or ankles
☐ Varicose veins
☐ Cold Extremities

Respiratory
☐ Cough
☐ Shortness of breath
☐ Wheezing / Asthma
☐ Inhaler use
☐ Coughing up blood
☐ Tobacco use or exposure

Gastrointestinal
☐ Colon cancer screen
Date: _____
☐ Appetite ☐ Good
☐ Poor ☐ Excessive
☐ Change in appetite recently
☐ Nausea or vomiting
☐ Heartburn / Reflux
☐ Abdominal Pain
☐ Bloating
☐ Fatigue after eating
☐ Bowel movements:
#/day_____☐ Easy ☐ Hard
☐ Skip days of moving bowels
☐ Constipation
☐ Loose stool or diarrhea
☐ Painful bowel movements
☐ Change in bowel habits
☐ Rectal bleeding or blood in stool

Musculoskeletal / Pain
☐ Muscle aches or cramping
☐ Joint pain or stiffness
☐ Joint swelling
☐ Low Back Pain
☐ Neck Pain
☐ Difficulty Walking or Standing
☐ Osteoporosis - Bone Scan_____
☐ History of Injuries and Accidents
☐ Date:_____
☐ Date:_____

Neurological / Psychological
☐ Headaches
☐ Daily ☐ Weekly ☐ Rarely
☐ Migraines
☐ Sinus headaches
☐ Tension headaches
☐ Dizziness or Light headed
☐ Convulsions or seizures
☐ Tremors
☐ Paralysis
☐ Numbness or tingling
☐ Depression
☐ Anxiety / Nervousness
☐ Memory Loss / Confusion
☐ Abuse Survivor

Genitourinary
☐ Frequent urination
☐ Nighttime urination
☐ Urgency / burning / painful urination
☐ Blood in urine
☐ Change in urine stream
☐ Incontinence or dribbling
☐ Kidney stones
☐ Sexual difficulty
☐ Male: Testicle Pain
☐ Male: Last PSA_____
Prostate Check_____

Female:
Last Menstrual Period_____
Menses LMP _____
☐ Regular ☐ Irregular
☐ Menopausal
Length of Menses_____ # of days
Monthly Cycle_____# of days
PMS ☐ Irritability ☐ Fatigue
☐ Emotional
☐ Breast Tenderness/Swelling
☐ Other _____
☐ Vaginal discharge or itching
Pregnancies_____
Live Births_____
Menopause Symptoms:
☐ Hot flashes ☐ Night sweats
☐ Dryness
☐ Other_____
Date last Mammogram_____
☐ Normal ☐ Abnormal
Date last Pap Smear_____
☐ Normal ☐ Abnormal

Integumentary (Skin / Breast) / Immune System
☐ Rash, itching, hives
☐ Dry skin
☐ Eczema or Psoriasis
☐ Change in skin, hair or nails
☐ New or changing moles
☐ Breast pain or discharge
☐ Breast lump
☐ Allergies: ☐ Food ☐ Seasonal
☐ Environmental
☐ Immune Deficiency/Compromise

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Informed Consent

I consent to receive Acupuncture and other treatments that are within the scope of the practice of Acupuncture in the State of Alaska. I understand that licensed Acupuncturist's are not primary care providers. I understand that Acupuncture is able to treat a vast number of conditions but is not a substitute for regular medical exams by an MD, ND, DO, ANP or PA. If a serious health problem arises I will inform my acupuncturist as soon as possible.

Acupuncture has the effect to normalize the physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. Acupuncture is a safe method of treatment, utilizing only sterile, disposable needles. As with any procedure there can be side effects. Sometimes people experience euphoria, lightheadedness and dizziness. Occasionally there may be bruising from the acupuncture needles, gua sha or cupping. Your acupuncturist will explain all procedures to you prior to being performed. The herbs and nutritional supplements (from plant, mineral and animal sources) that may be recommended are traditionally considered to be safe in the practice of Oriental Medicine. If I have a history of serious allergic reaction to foods, insects or other substances, I will be sure that it is noted on the medical history form, and I will also verbally inform the practitioner. I understand that some herbs may be inappropriate during pregnancy. I will inform the acupuncturist if I am currently or become pregnant. Possible side effects of taking herbs are usually gastrointestinal in nature, nausea, diarrhea, more rarely, rashes, hives and tingling of the tongue. Stopping the herbal formula usually alleviates problems. Please, be sure to let the practitioner know if any adverse reaction or side effect develops.

I understand that methods of treatment may include, but are not limited to acupuncture and herbal medicine. Properly administered acupuncture and herbal medicine is safe and generally very effective. I understand that results are not guaranteed. I understand the office medical and administrative staff may review my medical records, but all my records will be kept confidential and will not be released without my written consent.

Printed Name of Patient **Date**

Signature of Patient or Guardian

Patient Notice of Billing Practice and Office Policy

Services provided by Soma Wellness are payable at time of service.
We accept: Cash, Mastercard, Visa, Discover credit cards and personal checks.
Insurance is billed as a courtesy for our patients (in most cases), this arrangement is accepted, after the deductible is met for the year. Your co-payment is due when services are provided.
Payment plan options are reviewed individually.

Private Insurance
Billing is a service provided to the client as a courtesy. We allow a 60-day grace period for your insurance to respond to our claims. If the insurance does not respond to our claims within 60 days, the full balance is due and payment is required. Most insurance policies do not cover herbal medicines and supplements. Our preference is ALWAYS to work with our patients directly, however, we reserve the right to forward any balances that remain unpaid to a collection service and you may be assessed additional fees that are in addition to your clinic charges. Should you have a question regarding a collection balance due, we will direct you to the collection service representative for resolution.

Cancellation and Missed Appointment Policy
Please notify the clinic at least 24 hours in advance if you are unable to make your appointment. If no notification is given within 24 hours you will be charged a no show fee of $75.00.
I have read the above and understand my financial responsibility to this organization. If I have additional questions, I will ask to speak to someone, prior to my appointment.

Patient or Guardian Signature **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR IDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

1. OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentially of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information.

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

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

2. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

3333 Denali Street Suite 150, Anchorage, Ak 99502
Phone 907-563-SOMA (7662), Fax 907-562-SOMA (7662)

3. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

✓ **Treatment:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you.

✓ **Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This 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.

✓ **Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

OPTIONAL:

✓ **Appointment Reminders/ Treatment Options:** Our practice may use and disclose your PHI to contact you and remind you of an appointment, and to inform you of potential treatment options or alternatives.

✓ **Health-Related Benefits and Services:** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

✓ **Release of Information to Family/Friends:** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the chiropractic office for treatment. In this example, the babysitter may have access to this child's protected health information.

✓ **Disclosure Required By Law:** We may use or disclose your protected health information to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

4. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use and disclose your protected health information:

✓ **Public Health Risks:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using have been recall
- Notifying appropriate government agency(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will on disclose this information if the patient agrees or we are required or authorized law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

✓ **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

✓ **Lawsuits and Similar Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a co or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful proces

✓ **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include:

- legal processes and otherwise required by law
- limited information requests for identification and location purposes
- pertaining to victims of a crime
- suspicion that death has occurred as a result of criminal conduct
- in the event that a crime occurs on the premises of our practice
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL:

✓ **Deceased Patients**: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may als disclose protected health information to a funeral director, as authorized by law, in c to permit the funeral director to carry out their duties. We may disclose such inform in reasonable anticipation of death.

✓ **Organ and Tissue Donation:** Protected health information may be used and disclo for cadaveric organ, eye or tissue donation purposes.

✓ **Serious Threats to Health or Safety:** Consistent with applicable federal and state l we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the hea safety of a person or the public. We may also disclose protected health informatio is necessary for law enforcement authorities to identify or apprehend an individual.

✓ **Food and Drug Administration**: We may disclose your protected health informati a person or company required by the Food and Drug Administration for the purpos quality, safety, or effectiveness of FDA-regulated products or activities including, report adverse events, product defects or problems, biologic product deviations, to

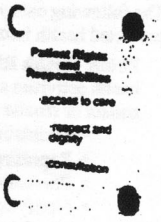
products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

- ✓ **Military Activity**: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.
- ✓ **National Security:** We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- ✓ **Inmates**: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
- ✓ **Workers' Compensation**: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

5. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

- ✓ **Confidential Communications: You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer at 563-7662.



- ✓ **Requesting Restrictions: 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 health care 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.**

We are not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. **You must make your request in writing to Privacy Officer c/o Soma Wellness Records Department, 3333 Denali Street Suite 150, Anchorage, Ak 99502 by submitting a request for Restriction to Protected Health Information. You must include:**

- **what information you want to limit**
- **whether you want to limit our use, disclosure or both**
- **To whom you want the limit to apply.**

- ✓ **Inspection and Copies: You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. 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 laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer at 563-7662 if you have questions about access to your medical record.

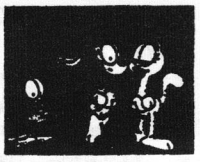
- ✓ **Amendment: You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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 such rebuttal. Please contact our Privacy Officer at 563-7662 if you have questions about amending your medical record.
- ✓ **Accounting of Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. In order to obtain accounting disclosures, you must submit your request in writing to Privacy Officer at 563-7662. All requests for an "accounting disclosure" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period.
- ✓ **Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice from us upon request.** You must submit in writing to Privacy Officer at 563-7662 in order to inspect and /or obtain a copy of your medical and billing records. Our practice may charge a fee associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
- ✓ **Right to File Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights by us. You must file a complaint with us in writing by contacting our Privacy Officer at (907) 563-7662 or 3333 Denali Street Suite 150, Anchorage, Ak 99502. We will not retaliate against you for filing a complaint.
- ✓ **Right to Provide an Authorization for Other Uses and Disclosures:** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

6. Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to agree or Object:

We may use and disclose your protected health information in the following instances:

- Agree or object to the use or disclosure of all or part of your protected health information.
- Your physician may, using professional judgment, determine whether the disclosure is in your best interest, unless you object.

- ✓ **Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information 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. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.



Again, if you have any questions regarding this notice or our health information privacy policies.
Please contact Privacy Officer at 907-563-7662.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you again soon!

_____

Patient Signature Date

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PATIENT: _____ DOB: _____ Age: _____
Last Name First Name Initial

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City _____ State: _____ Zip: _____

E-Mail Address: _____ Social Security # _____

Occupation: _____

Employer _____

Sex: M F Marital Status: Single Married Partner Widow/er Separated Divorced

Partner's Name: _____

Responsible Party: _____ DOB: _____ SS# _____

Employer: _____ Home Phone: _____

Address: _____ Work Phone: _____

Primary Insurance: _____

Address: _____

Subscriber Name: _____ DOB: _____ SS# _____

Subscriber ID #: _____ Group #: _____

Secondary Insurance: _____

Address: _____

Subscriber Name: _____ DOB: _____ SS# _____

Subscriber ID #: _____ Group #: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Address: _____

Referred By: Friend/Co-worker _____ Relative _____ Other _____

Health Care Provider _____ Yellow Pages (which one) _____

Release, Assignment and Statement of Responsibility

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to the provider(s). I understand that I may revoke this consent at anytime in writing to this office. I further understand that I am responsible for payment for all products and services rendered to me or any patient for which I am the guarantor of payment.

X Date

Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge and agree that I have reviewed a copy of Soma Wellness Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

X Date