Elizabeth S. Smoots, MD
9730 Third Avenue NE, Suite 202, Seattle, WA 98115

Patient Information

Patient Name: ____ Date: ____________________

Address: ______________________________ City: ____________________ State: _______ Zip: ____________

SSN: ______________________ Gender: O Female O Male Date of Birth: ____________________ Age:_____

Check appropriate box: O Partner O Single O Married O Divorced O Widowed O Separated

Phone: Home: ______________________ Work: ____________________ Cell: ____________________

Which of the above numbers is best for appointment reminders? __________ Email address: ______________________

For messages containing personal healthcare information, I give permission to leave such messages at the following phone number: ____________________________. Signature: ______________________________

Spouse/Partner or parent's name: ____________________________________ Phone: ____________________

Patient's or parent's employer: ____________________________________ Occupation: ____________________

Business Address: ______________________________ City: ______________ State: _____ Zip: __________

Person to contact in case of an emergency: ____________________________________ Phone: ____________

How did you first hear about Dr. Smoots? ____

Responsible Party

Name of person responsible for this account: ______________________________ Relationship: ________________

Address: ____Home Phone: ________________

Driver's license #: ____________________ Birthdate: _____________ Business Phone: ______________________

Employer: ____ Address: ____________________________________

Is this person currently a patient at our office? O Yes O No

Insurance Information

Subscriber name: ____________________________________ Relationship to patient: ____________________

Date of Birth: __________________________________ Social Security Number: __________________________

Insurance company: ____ Phone: ______________________

What is your deductible? ________________________ How much have you used? ________________________

Subscriber ID# __________________________________Group #____________________________________

Secondary Insurance:

Subscriber name: ____________________________________Relationship to patient: ______________________

Date of Birth: __________________________________ Social Security Number:__________________________

Insurance Company: ____

Subscriber ID# __________________________________Group # ____________________________________

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

X____________________________________ Date: ____________________

Signature of patient or parent if minor

Elizabeth S. Smoots, MD, LLC
9730 Third Avenue NE, Suite 202, Seattle, WA 98115
P: 206.525.5576 F: 206.525.5776

Treatment Authorization and Financial Agreement

Treatment Authorization: I authorize medical and health care treatment of ____ myself or ____ my minor child named____________________________ by Elizabeth S. Smoots, M.D. I certify that I am, or my minor child is, here to receive health care and for no other purpose.

Medical Records Release Authorization: I authorize Dr. Smoots to release my medical information to any physician or health practitioner to whom I am being referred for care. I also authorize any physician or health care provider I have seen, to release my medical records to Dr. Smoots.

Claim Management: I understand that it is my responsibility to know my plan benefits. Dr. Smoots may offer some assistance, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect. Dr. Smoots will respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information.

Notice as to Possible Non-Coverage of Services: I understand that my insurance company may not cover all of the services I may receive in this office. My insurance company may not pay for preventive services, for example, and in some cases may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, or other integrative medicine services. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics may also not be reimbursed.

Financial/Insurance Responsibility: I authorize Dr. Smoots to release to my insurance company or companies all and any information necessary to process my claims. I further authorize that payments be made directly to Dr. Smoots.

I understand and agree that I am fully responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account.

Cancellation Fee: A cancellation fee of $75 will be charged for missed appointments not canceled with a minimum of 24 hours notice.

Payment Policies: Co-pays must be paid at time of service. There is a $35 NSF fee on all returned checks. There is a minimum billing fee of 12% APR for account balances due beyond 30 days. Patients will be held responsible for non-payment by their insurance company; accounts unpaid by the insurance company greater than 90 days will be billed to the patient. Outstanding balances greater than 120 days will be turned over to a collection agency unless prior arrangements have been made with Dr. Smoots in writing.

No Guarantees. I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

I, the undersigned, have read, understand, and accept the information and conditions specified in this document.

Date:_________________________

______________________________ ________________________________
Patient/Guardian Name Printed

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: ______________________________________ Date of Birth: __________ Date: ___________

What are the concerns for which you are seeking care? (Primary concern first)

1. ____ Date of onset: _____________
2. ____ Date of onset: _____________
3. ____ Date of onset: _____________
4. ____ Date of onset: _____________

When, and for what concern, did you **last receive health care**? ________________________________

Do you have any known **contagious diseases** at this time? ÖYes ÖNo If yes, what?_____________

Other Medical Problems (include date of onset):

____ ____

____ ____

____ ____

____ ____

____ ____

Prescription and over-the-counter medications you are currently taking (include dosages):

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

Nutrients, herbs and dietary supplements you are currently taking (include dosages):

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

Allergies – Drugs:

____

____

____

____

Allergies – Foods and Other:

____

____

____

____

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Name: ______________________________________ Date of Birth: _________ Date: __________

Medical Conditions: Check any conditions you've ever had in the past. After the condition, write the date of onset.

___ ADD/ADHD
___ AIDS / HIV
___ Allergies
___ Anemia, type__________
___ Alcohol/drug problem
___ Anorexia / bulimia
___ Anxiety disorder
___ Arthritis, type_________
___ Asthma
___ Atrial fibrillation
___ Bipolar disorder
___ Bleeding disorder
___ Back pain
___ Cancer, type:
____
___ Cataracts
___ Cholesterol problem
___ Chronic fatigue syndrome
___ Coronary artery disease
___ Depression, type:
____
___ Diabetes, type_________
___ Emphysema
___ Epilepsy / seizure
___ Esophageal reflux
___ Fibromyalgia

___ Glaucoma
___ Goiter
___ Gout
___ Heart attack
___ Heart disease
___ Heart murmur
___ Hepatitis, type
___ High blood pressure
___ Irritable bowel syndrome
___ Jaundice
___ Kidney disorder
___ Kidney stones
___ Liver disease
___ Lung disease
___ Lupus
___ Mental illness
___ Migraines
___ Obsessive compulsive dis
___ Osteoporosis
___ Pancreatitis
___ Panic disorder
___ Periodontal disease
___ Pneumonia
___ Polio
___ Psoriasis
___ Psychiatric hospitalization

___ Rheumatic fever
___ Rheumatoid arthritis
___ Sinusitis, last date_________
___ Sjogrens syndrome
___ Sleep apnea
___ Stroke / TIA
___ Thyroid problem, type______
___ TMJ
___ Tuberculosis
___ Ulcerative colitis / Crohn's dis
___ Ulcers, type_______________
___ Urinary infection, last date___

Female conditions:

___ Endometriosis / uterine fibroid
___ Ovarian cysts /polycystic ovaries
___ Pelvic inflammatory disease
___ Sexually transmitted disease
___ Vaginitis, last date______

Male conditions:

___ Enlarged prostate
___ Prostatitis
___ Sexually transmitted disease

Other health problems:

____
____

List Hospitalizations, surgeries, x-rays or special studies you have had:

Year	Hospitalization or Procedure	Reason	Outcome

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Name: ______________________________________ Date of Birth: __________ Date: ___________

Social history: Describe yourself including your age, gender, job, school, who you live with, and how you spend your time. With whom do you have a supportive relationship? What in your life is most meaningful to you?

Health Habits

Substance or activity	How much?
Caffeine (coffee, tea, soft drinks)	No / Yes cups/day of coffee, cups/day tea, cups (8-oz)/day soft drinks
Cigarettes	No / Yes How much? Total years you've smoked? If past smoker: Quit date: packs/day x yrs
Are you interested in quitting?	NA (not applicable) / No / Yes
Chew Tobacco	No / Yes Amount If past user: Quit date: Used for yrs
Alcohol	No / Yes What kinds/how much/how often? If past use: Quit date: Why did you quit?
Drugs	No / Yes What do you use now? In the past?
Exercise	Type & frequency
Nutrition/Diet	Type
Tetanus vaccine	Date last received

Which of your blood relatives have had the following conditions? At what age did condition develop, if known?

Alcohol/Drugs __________________ Cancer _________________________ High blood pressure _____________

Allergies/asthma________________ Cholesterol dis________________ Kidney disease _________________

Alzheimer's dis__________________ Diabetes _______________________ Mental illness __________________

Anemia _________________________ Epilepsy ________________________ Osteoporosis ___________________

Arthritis ________________________ Heart disease ___________________ Stroke _________________________

Family History	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Medical disorders with age of onset							
If deceased, age and cause							

Name: ___________________________________ Date of Birth: _________ Date: __________

Review of Symptoms

Check any symptoms you've had **IN THE PAST THREE MONTHS.** Provide any additional requested information.

SKIN
___Rashes
___Eczema
___Acne
___Itching
___Fungal infections
___Hair loss
___Facial hair in female
___Dry skin / scalp
___Color change
___Lumps
___Slow healing sores / ulcers
___Flushing

NOSE AND SINUSES
___Stuffiness
___Hay fever
___Sinus problems
___Frequent colds
___Nose bleeds
___Loss of smell

EYES AND EARS
___Itchy eyes
___Watery eyes
___Dry eyes
___Swollen / painful eyes
___Red eyes
___Impaired vision / blurriness
___Floaters in vision
___Color blindness
___Double vision
___Hearing difficulty
___Ringing in ears
___Earaches / ear infection

MOUTH AND THROAT
___Sore throat
___Teeth grinding
___Sore tongue / lips
___Gum problems
___Hoarseness
___Gagging / choking
___Difficulty swallowing

IMMUNE
___Frequent infections
___Persistent swollen glands
___Slow wound healing

HEAD / NECK
___Headaches
___Migraines
___Faintness
___Dizziness
___Jaw pain
___Swollen glands
___Pain or stiffness

RESPIRATORY
___Chest congestion
___Wheezing / asthma
___Bronchitis
___ Pneumonia
___Emphysema
___Difficulty / pain breathing
___Shortness of breath
___Snoring excessively
___Cough ___Wet or ___Dry
___Coughing blood

CARDIOVASCULAR
___Angina / chest pain
___High / low blood pressure
___Murmurs
___Blood clots
___Irregular or rapid heart beat
___Palpitations / fluttering
___Swelling in ankles

CIRCULATION
___Easy bleeding or bruising
___Anemia
___Deep leg pain
___Varicose veins
___Cold hands / feet
___Fainting or collapse

MENTAL/EMOTIONAL
___Easily stressed
___Mood swings
___Anxiety or nervousness
___Considered / attempted suicide
___Depression
___Poor concentration
___Poor memory
___Panic
___Other

ENDOCRINE
___Heat or cold intolerance
___Excessive hunger
___Excessive thirst
___Low blood sugar
___Fatigue
___Other_______________

DIGESTION
___Trouble swallowing
___Heartburn / acid reflux
___Loss of appetite
___Nausea / vomiting
___Belching / passing gas
___Bloating of abdomen
___Diarrhea
___Constipation
___Pain or cramps in abdomen
___Mucous in stools
___Bloody stool / black tarry stool
___Hemorrhoids
___Itchy / burning anus
___Rectal pain
___Liver / gall bladder trouble
___Jaundice (yellow skin)
___Change in bowel habits
Bowel Movements: How often?______
Stools ___Hard ___Firm
___Soft ___ Loose
___Colonoscopy abnormal Date_____
Date of last colonoscopy _______
Normal / Abnormal

MUSCLES / JOINTS/ BONES
___Joint pain
___Muscle pain
___Muscle spasms / cramps
___Low back pain
___Sciatica

NEUROLOGIC
___Seizures
___Paralysis
___Muscle weakness
___Numbness or tingling
___Change in headaches
___Vertigo or dizziness
___Loss of balance

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Name: ___________________________________ Date of Birth: _________ Date: __________

Review of Symptoms

Check any symptoms you've had **IN THE PAST THREE MONTHS**. Provide any additional requested information.

GENERAL

___Poor sleep / insomnia
___Fatigue / low Energy
___Generally feel hot
___Generally feel cold
___Chills
___Fevers
___Unusual sweats
___Poor appetite
___Constant hunger
___Cravings, please specify___________
___Peculiar taste in mouth, describe_________
___Experience high stress
___Weight loss - unexpected

URINARY

___Pain on urination
___Frequent urination
___Urgent urination
___Blood in urine
___Urinary infections x _______
___Urination at night x _______
___Urine leakage
___Kidney stones

MALE ONLY

___Hernias
___Testicular masses
___Testicular pain
___Discharge or sores
___Difficulty in initiating urine stream
___Weak / diminished urinary stream
___Bladder not emptying completely
Are you sexually active? Yes No
Sexual partner: male / female / both
Contraceptive method: __________________
___Sexual dysfunction
___Can't maintain erection
___Erections less firm
___Premature ejaculation
___Lower sex interest / libido
Any other male difficulties?__________________
Prostate exam abnormal in past? No Yes Date_____
Date of last prostate exam_______________
Normal / Abnormal

FEMALE ONLY

___Pregnant or possibly pregnant
___PMS: days per month/severity_______________
___Menstrual cramps: # of days/severity_________
___Painful sex
___Low libido / loss of interest in sex
___Trouble conceiving / infertility
___Heavy or excessive flow or clots
___Irregular periods, describe________________
___Bleeding between periods
___Lack of periods
___Hot flashes or menopausal symptoms
___Spotting after menopause
___Vaginal dryness or pain
___Unusual vaginal discharge Color___________
___Vaginal irritation / odor
___Breast pain/tenderness
___Fibrocystic breasts
___Nipple discharge
___Breast Lumps
Any other feminine difficulties?_____________
Age at which menses began_________________
Age of last menses (if post-menopausal) ___________
Day 1 of period to Day 1 of next period ________days
Length of menstrual flow_______________________
Amount of flow, describe______________________
Last menstrual period, beginning date__________
Last period before that, beginning date__________
Are you sexually active? No Yes
Sexual partner: male / female / both
Want to discuss contraception options? No Yes
Contraceptive method _______________
Number of pregnancies _____________
Number of live births ______________
Number of miscarriages _____________
Number of abortions ________________
Pap smear abnormal in past? No Yes Date ______
Date of last Pap smear ______________
Normal / Abnormal
Mammogram abnormal in past? No Yes Date_____
Date of last mammogram ____________
Normal / Abnormal

Elizabeth S. Smoots, MD, (206) 525-5576

Name: ____ Date of Birth: __________ Date: ___________

Context of Care Overview

We would like to take this moment to welcome you to the medical practice of Elizabeth Smoots, MD. Whether you were referred by another practitioner for a one-time visit, or are looking for a longer-term comprehensive health solution, we look forward to our role in your care. Below are a few questions that really assist us in understanding "where you're coming from" and how we can best support your health.

1) How did you discover our clinic and how did you decide to see us now?

2) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

   0% **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** 100%

   What if anything stands between your current commitment and 100%?

3) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

4) What do you love most about your life at this time?

5) What behaviors or lifestyle habits do you currently engage in regularly that you would like to change? (Please list)

6) What potential challenges do you foresee in addressing lifestyle factors and recommendations, which we will be sharing with you?

7) What are your top three expectations of us?

Elizabeth S. Smoots, MD, (206) 525-5576

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Notice and Consent as to Nature of Integrative Medicine Services

I understand that care I receive from Dr. Smoots may be conventional or, at my option, may include non-conventional care. Non-conventional services are commonly referred to as complementary or alternative medicine (ACM or CAM), holistic care, or integrative medicine. This can include a variety of innovative medical treatments as well as nutritional and herbal consultation, prevention and wellness services, and mind-body approaches to care. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigational or experimental. I am seeking care from Dr. Smoots in order to benefit from her special training in integrative medicine and receive treatment and advice about such care.

***Nutritional and Herbal Guidance*:** Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will let Dr. Smoots and other physicians know what herbs I am taking. And I agree to notify Dr. Smoots if I experience any interactions or adverse experiences or reactions; if they are not serious I will notify her to ask for her assistance and if serious, I agree to seek emergency care first before notifying Dr. Smoots.

Recommendations could include fasting and other forms of detoxification. While this is generally safe, some people may experience a healing crisis, which may be a short period in which one's symptoms increase, or a period of a flu-like illness during which there could be some mild fever, chills, dizziness, loss of appetite, and so forth. Such an experience, while unpleasant, can signal that the body is effectively detoxifying or undergoing a healing effort.

***Mind/Body Medicine*:** Mind/body medicine is an emerging medical view intended to improve patient well-being by improving lifestyle, capacity to function in a meaningful and effective way, and reversing the impacts of stress. Because stress and emotional states may play an important role in my medical conditions, Dr. Smoots may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as meditation, guided imagery, muscle relaxation, or other stress management techniques.

Physical Medicine: Use of massage, stretching, hydrotherapy, electrical therapy, joint manipulation.

***Energy Medicine*:** Energy medicine is a controversial approach to healing that has a long traditional history across many cultures, and for which there is some evidence can have a healing benefit. In the approach the practitioner channels life energy for healing benefit; it is intended to affect the balance and flow of energy in a manner that might be thought of as similar to acupuncture, but without needles. It may be ineffective or it is possible that it could temporarily aggravate symptoms.

I understand that while these approaches can provide an important complement to my health care, I should ensure, by discussing my health needs with Dr. Smoots and my other physicians, that appropriate mainstream care is provided. I understand that Dr. Smoots will discuss potential therapies that she recommends, and I agree to accept the risks explained to me about these procedures by agreeing to undertake these treatments.

I have read and understand the nature of the services provided by Dr. Smoots. I represent that I am seeking treatment in order to further my own health and for no other reason. I agree to take a responsible role in improving my own health and discuss advice and suggestions of Dr. Smoots as presented in a treatment plan. I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments proposed by Dr. Smoots and I accept responsibility for less than satisfactory results. I am aware that I may withdraw this consent and discontinue following the recommendations at any time.

______________________________ ______________________________
Signature of Patient or Legal Guardian Witness

______________________________ ______________________________
Patient's Printed Name Date

Elizabeth S. Smoots, MD, LLC
9730 Third Avenue NE, Suite 202
Seattle, WA 98115-2023

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on___________________, today's date, and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Elizabeth Smoots MD. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *(0.10)* for each page and the staff time charged will be $ *(none)* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. Request a Complaint Form in writing from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Elizabeth S. Smoots, MD, LLC

Privacy Officer: Elizabeth S. Smoots, MD

Telephone: 206-525-5576 Fax: 206-525-5776

E-Mail: info@theemeraldcenter.com

Address: 9730 Third Avenue NE, Suite 202, Seattle, WA 98115-2023

Elizabeth S. Smoots, MD, LLC
9730 Third Avenue NE, Suite 202
Seattle, WA 98115-2023

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____
____
____

____ _______________
Employee/Practitioner signature *Date*