Corina B. Going, ND, PLLC

Naturopathic Physician ◆ Classical Homeopath

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by the person legally responsible for the patient's medical decisions pertaining to the treatment situation.

I, _____, hereby acknowledge that Dr. Going's office has provided me with access to a copy of its Notice of Privacy Practices that describes how medical and/or psychological information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints that I may contact the office at 253-983-8507.

Please indicate your preferences by initialing in the brackets below and supplying information where needed:

[ ] I understand that I am entitled to receive updates upon request if Dr. Going's office amends or changes its Notice of Privacy Practices in a material way.

[ ] I authorize Dr. Corina Going and/or staff to contact me in the following manner *(check one or all applicable)*:

___ Telephone number: _____

___ OK to leave a detailed message.

___ OK to leave a message with call back name and number only.

[ ] I authorize Dr. Corina Going and/or staff to leave voice mail messages concerning my health information (I.E. lab results, appointment instructions, etc.) at the following number:

Phone: _____ Patient/Guardian Initials: _____

This office **CAN NOT** release your account balance/appointment time/health infomation to anyone but you unless they are listed on this form. If you wish to designate someone to receive that information please indicate below:

[ ] I authorize Dr. Corina Going and/or staff to release communications that may include health, billing and/or appointment information to:

_____ _____ _____

(Name) (Relationship to Patient) (Phone Number)

You may request changes to this form, however changes must be in writing and a new form completed. This form remains in effect unless written notice is given by me.

_____ _____

(Signature of Patient or Parent/Guardian) (Relationship to Patient)

_____

(Date)

THIS SECTION IS TO BE COMPLETED BY DR. GOING'S OFFICE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM THE PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this written Acknowledgement.

[ ] Other (specify): _____

Name and Title of employee_____Date_____