Corina B. Going, ND
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. Please review carefully and complete.

I, _____, hereby acknowledge that Dr. Going's office has provided me with access to a copy of its Notice of Privacy Practices describing 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 253-341-9410.

initial
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.

initial
I authorize Dr. Corina Going and/or staff to contact me in the following manner *(check one or all applicable)*:
Telephone
Email
OK to leave a message with call back name and number only.
OK to leave a detailed email, voice, or text message
to discuss health concerns via telemedicine using a video platform.

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

Phone: _____ Email: _____ Patient/Guardian Initials: [ ]

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

initial
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)	Email

You may change your information on 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.

I verify that the information on this form is true and accurate to the best of my knowledge.

Person Completing form: _____ Date: _____

Relationship to Patient: _____

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_____