CONFIDENTIAL CONTACT FORM **DATE: ________________**

Full Legal Name: ______________________________ / ________________________ / ____________
Last Name First Name Middle Initial

Preferred Name: ________________ Age: _______ Date of Birth: _______________ SS#: ____________

Address ____ / ________________ / ______/ ____________
street #/PO Box city state zip code

Telephone: (H) _____________________ (W) _____________________ (M) ______________________

E-mail Address: ____ Gender: Female_____ Male: _____

Occupation _______________________________________ (circle) Full Time /Part Time /Student /Retired

Emergency Contact Name: ____________________________________ Relationship: _________________

Emergency Contact Number: (H) _________________ (W) _________________ (M) __________________

How did you hear about our clinic? ____

Has any other family member already been a patient at the clinic? ________________________________

COMMUNICATION

What is the best way to communicate with you between office visits? E-mail / Home ph. / Work ph. / Cell ph.

Is there any place you do NOT want us to leave a message? _____________________________________

May our practitioner(s) discuss your private medical information with you via e-mail*? **Yes** **No**

May we send you educational/promotional materials such as newsletters via e-mail? **Yes** **No**

NOTE: Please be aware that email is not a secure communication, and that discussion of your medical care will become part of your medical record.

INSURANCE

Insurance? Yes / No Insurance Name: ____________________________ Phone #: __________________
Policy/ID Number: ____ Group Number: __________________

Secondary Insurance? Yes / No Insurance Name: __________________________ Phone #: ____________
Policy/ID Number: ____ Group Number: __________________

MEDICAL RELEASE: I hereby authorize the release of medical information necessary to process my insurance claim and any future insurance claims, without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
AUTHORIZATION OF PAYMENT: I authorize payment of medical benefits directly to Northwest Natural Medicine LLC.

I am responsible for all charges of all services provided. In the event that my insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

Signature: ____ Date:______________________

Patient Name: ______________________________ **Date of Birth:** ______________ **Date:** ____________

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) What do you know about our approach?

2) What three expectations do you have from this visit to our clinic?

a)____

b)____

c)____

What expectations do you have of me personally as your physician?

3) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that we will be sharing with you?

4) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

5) What is your present commitment at addressing the underlying cause of your health concerns? (please circle)

10 20 30 40 50 60 70 80 90 100%

Are you currently receiving healthcare? Y N

If yes, where and from whom:____

If no, when and where did you last receive medical or health care? _____________________

What was the reason? ____

What are your most important health problems? List as many as you can in order of importance:

1) ____

2) ____

3) ____

Do you have any known contagious diseases at this time? Y N

If yes, what? ____

Patient Name: ________________________________ **Date of Birth:** ________________ **Date:** _______________

Family History Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma/Hay fever/Hives			

Any other relevant family history? ____

Childhood Illnesses Please circle whether you had any of these as a child:

Scarlet fever Diphtheria Rheumatic fever Mumps Measles German measles

Hospitalization, Surgery, Imaging What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

___________________________year: _________ _____________________________ year: _________

___________________________year: _________ _ _____________________________ year: _________

Allergies Are you hypersensitive or allergic to...

Any drugs? ____

Any foods? ____

Any environmental or chemicals? ____

Current Medications Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list **any** prescription medications, over-the-counter medications, vitamins or other supplements you are taking?

1)____ 4) ____

2)____ 5) ____

3)____ 6) ____

General

Height: ___________________ Weight:__________________ lbs. Weight 1 year ago: __________lbs.

Maximum Weight: ____________________ When: ____

When during the day is your energy: Best? _____________________ Worst? ____________________

Typical Food Intake

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Patient Name: ______________________________ **Date of Birth:** _______________ **Date:** _____________

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Habits

Main interests and hobbies: ____

Do you exercise? Y N

If yes, what kind? ______________________ How often? ______________________

Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	How many hours? ______	
Any major traumas?	Y N P	Read?	Y N
Use recreational drugs?	Y N P	How many hours? ______	
Been treated for drug dependence?	Y N P		
Use alcoholic beverages?	Y N P	Do you eat 3 meals a day?	Y N
Treated for alcoholism?	Y N P	Do you go on diets often?	Y N
Do you use tobacco?	Y N P	Do you eat out often?	Y N
Smoked previously?	Y N P	Do you drink coffee?	Y N P
How many years? ______________		Drink black/green tea?	Y N P
How many packs per day? __________		Do you drink cola/other sodas?	Y N P
		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what? ______________________

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems?	Y N P	Depression?	Y N P
Mood Swings?	Y N P	Anxiety or nervousness?	Y N P
Considered/Attempted suicide?	Y N P	Tension?	Y N P
Poor concentration?	Y N P	Memory problems?	Y N P

Immune

Reactions to immunizations?	Y N P	Reactions to vaccinations?	Y N P
Chronic Fatigue Syndrome?	Y N P	Chronic infections?	Y N P
Chronically swollen glands?	Y N P	Slow wound healing?	Y N P

Endocrine

Hypothyroid?	Y N P	Heat or cold intolerance?	Y N P
Hypoglycemia?	Y N P	Diabetes?	Y N P
Excessive thirst?	Y N P	Excessive hunger?	Y N P
Fatigue?	Y N P	Seasonal depression?	Y N P

Neurologic

Seizures?	Y N P	Paralysis?	Y N P
Muscle weakness?	Y N P	Numbness or tingling?	Y N P
Loss of memory?	Y N P	Easily stressed?	Y N P
Vertigo or dizziness?	Y N P	Loss of balance?	Y N P

Skin

Rashes?	Y N P	Eczema, Hives?	Y N P
Acne, Boils?	Y N P	Itching?	Y N P
Color Change?	Y N P	Perpetual Hair Loss?	Y N P
Lumps?	Y N P	Night Sweats?	Y N P

Patient Name: ______________________________ Date of Birth: ______________ Date: ____________

Y=a condition you have now **N=**Never had **P=**Significant problem in the past

Head

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems	Y N P

Eyes

Spots in Eyes?	Y N P	Cataracts?	Y N P
Impaired vision?	Y N P	Glasses or contacts?	Y N P
Blurriness?	Y N P	Eye pain/strain?	Y N P
Color blindness?	Y N P	Tearing or dryness?	Y N P
Double Vision?	Y N P	Glaucoma?	Y N P

Ears

Impaired hearing?	Y N P	Ringing?	Y N P
Earaches?	Y N P	Dizziness?	Y N P

Nose and Sinuses

Frequent colds?	Y N P	Nose Bleeds?	Y N P
Stuffiness?	Y N P	Hay fever?	Y N P
Sinus problems?	Y N P	Loss of smell?	Y N P

Mouth and Throat

Frequent sore throat?	Y N P	Copious saliva?	Y N P
Teeth grinding?	Y N P	Sore tongue/lips?	Y N P
Gum problems?	Y N P	Hoarseness?	Y N P
Dental cavities?	Y N P	Jaw clicks?	Y N P

Neck

Lumps?	Y N P	Swollen glands?	Y N P
Goiter?	Y N P	Pain or stiffness?	Y N P

Respiratory

Cough?	Y N P	Sputum?	Y N P
Spitting up blood?	Y N P	Wheezing	Y N P
Asthma?	Y N P	Bronchitis?	Y N P
Pneumonia?	Y N P	Pleurisy?	Y N P
Emphysema?	Y N P	Difficulty breathing?	Y N P
Pain on breathing?	Y N P	Shortness of breath?	Y N P
Shortness of breath at night?	Y N P	“ “ “ lying down?	Y N P
Tuberculosis?	Y N P		

Cardiovascular

Heart disease?	Y N P	Angina?	Y N P
High/Low Blood Pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic Fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Gastrointestinal

Trouble swallowing?	Y N P	Heartburn?	Y N P
Change in thirst?	Y N P	Abdominal pain or cramps?	Y N P
Change in appetite?	Y N P	Belching or passing gas?	Y N P
Nausea/vomiting	Y N P	Constipation?	Y N P
Ulcer?	Y N P	Diarrhea?	Y N P

Patient Name: ________________________________ **Date of Birth:** _______________ **Date:** _____________

Y=a condition you have now **N**=Never had **P**=Significant problem in the past

Jaundice (yellow skin)?	Y N P	Bowel Movements: How often? _______	
Gall Bladder disease?	Y N P	Is this a recent change?	Y N
Liver Disease?	Y N P	Black stools?	Y N P
Hemorrhoids?	Y N P	Blood in stool?	Y N P

Urinary

Pain on urination?	Y N P	Increased frequency?	Y N P
Frequency at night?	Y N P	Inability to hold urine?	Y N P
Frequent infections?	Y N P	Kidney stones?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Arthritis?	Y N P
Broken bones?	Y N P	Weakness?	Y N P
Muscle spasms or cramps?	Y N P	Sciatica?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet?	Y N P
Varicose veins?	Y N P	Thrombophlebitis?	Y N P

Male Reproduction

Hernias?	Y N P	Testicular masses?	Y N P
Testicular pain?	Y N P	Prostate disease?	Y N P
Venereal disease?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N	Chlamydia?	Y N P
Sexual orientation:		Gonorrhea?	Y N P
Impotence?	Y N P	Condyloma?	Y N P
Premature ejaculation?	Y N P	Herpes?	Y N P
Birth control? Type?		Syphilis?	Y N P

Female Reproduction / Breasts

Are you pregnant?	Y N		
Age of first menses?	_____________	Date of last annual exam/ PAP	_____________
Age of last menses? (if menopausal)	_____________	Are cycles regular?	Y N
Length of cycle?	________days	Bleeding between cycles?	Y N P
Duration of menses?	days	Pain during intercourse?	Y N P
Painful menses?	Y N P	Clotting?	Y N P
Heavy or excessive flow?	Y N P	Discharge?	Y N P
PMS?	Y N P	Birth control?	Y N P
If yes, what are your symptoms?		What type? ________________________	
		Number of pregnancies: ______________	
		Number of live births: _______________	
Endometriosis?	Y N P	Number of miscarriages: _____________	
Ovarian cysts?	Y N P	Number of abortions: ________________	
Difficulty conceiving?	Y N P	Menopausal symptoms?	Y N P
Cervical Dysplasia?	Y N P	Abnormal PAP?	Y N P
Sexual difficulties?	Y N P	Chlamydia?	Y N P
Gonorrhea?	Y N P	Condyloma?	Y N P
Herpes?	Y N P	Syphilis?	Y N P
Are you sexually active?	Y N	Sexual orientation: _________________	
Do you do breast self-exams?	Y N P	Breast lumps?	Y N P
Breast pain/tenderness?	Y N P	Nipple discharge?	Y N P

Thank you for your time and effort. We look forward to providing you with the best possible care

Naturopathic Medicine
Informed Consent for Treatment

I, ____________________________, hereby authorize Dr. Jesse I Buttler or other licensed doctors of naturopathic medicine, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:
Common diagnostic procedures: e.g., venipuncture, UA, Pap smears, radiography, laboratory
Minor office procedures: e.g., ear cleansing
Naturopathic physical medicine: e.g. craniosacral technique, muscle energy stretching, therapeutic massage techniques, heat and cold therapies, electric stimulation, manual therapies and other related treatments
Medical use of nutrition: therapeutic nutrition, nutritional supplementation, intramuscular vitamin injections, IV therapy
Western Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, gels, or suppositories
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses
Lifestyle counseling: promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work, spiritual awareness, and social activities
Psychological counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential benefits: restoration of health and the body's maximal capacity, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: allergic reactions to prescribed herbs and supplements; side effects of natural medicines; inconvenience of lifestyle changes; injury from injections, venipuncture, or physical medicine; aggravation of pre-existing conditions.
Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

______________________________	______________________________	____________
Printed Name of Patient	Signature	Date
______________________________	______________________________	____________
Printed Name of Legal Guardian	Signature	Date

Payment Policies

1) Payment is expected in full at the time that services are rendered. Payment is expected in full at the time supplements or other products are purchased. We accept Visa, MasterCard, debit cards, cash and checks. There will be a $30 fee for every returned check.

2) Insurance: If your insurance policy is qualified and proven to cover our care, we will agree to bill your insurance company directly. This is with the understanding that your insurance policy is a contract between you and your insurance company - we cannot guarantee payment of your claims. If your insurance company pays only a portion of your bill or rejects your claim, you are still financially responsible for the remainder of the claim unless we are contracted with your insurance plan.

3) Appointments by phone must be paid at the time of the visit. You will be asked for your credit/debit card number prior to the visit and will be charged for the visit as well as any supplements and shipping costs at that time.

Office Policies

1) Please call 24 hours in advance to cancel or change an appointment. A missed appointment fee of $50 will be assessed for appointments cancelled with less than 24 hours notice.

2) I give permission to the physicians and staff of Northwest Natural Medicine, LCC to contact me via telephone and email given the contact information that I provided on my intake forms. I understand if I am not available, a message with information about my appointment or my medical condition will be left.

3) Return Policy on Supplements: Unopened and unused pre-packaged supplements can be returned for their full value. Individualized supplements that are formulated by Northwest Natural Medicine, LLC cannot be returned.

4) Please refrain from using your cell phone in the clinic unless it is an emergency. Thank you.

I have read and understand the above-stated policies of Northwest Natural Medicine, LLC and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

______________________________	________________________________	________________
Printed Name of Patient	Signature	Date
______________________________	________________________________	________________
Printed Name of Legal Guardian	Signature	Date

HIPAA Notice of Privacy Practices

Please review this notice carefully. It describes how medical information about you may be used *and disclosed and how you can get access to this information.*

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 use 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. As another example, 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 or 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 registration 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.

Use required by law: 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 requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and 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.

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

Your Rights

The 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 physician believes it is 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 communications from us by alternative means or at an alternative location.

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 such 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.

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 electronically.

Complaints: You may complain to us or to 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 HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on January 2, 2008.

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 ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature Below is only an acknowledgment that you have received this Notice of our Privacy Practices:

______________________	______________________	____________
Printed Name of Patient	Signature	Date
Printed Name of Legal Guardian	Signature	Date

Informed Consent and Request for
Classical Chinese Medicine Treatment and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Gibran K. Ramos, Licensed Acupuncturist, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, ________________________, hereby request and consent to examination and treatment with Classical Chinese Medicine (CCM) and Acupuncture with Gibran K. Ramos, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for him, hereafter called *allied health care provider*.

I understand that I have the right to ask questions and discuss to my satisfaction with Gibran K. Ramos, and/ or with the *allied health care provider* providing backup the following:

1. my suspected diagnosis(es) or condition(s)
2. the nature, purpose, goals and potential benefits of the proposed care
3. the inherent risks, complications, potential hazards or side effects of treatment or procedure
4. the probability or likelihood of success
5. reasonable available alternatives to the proposed treatment procedure
6. potential consequences if treatment or advice is not followed and/ or nothing is done
7. any other questions or concerns regarding medical procedures, course of treatment, and/or care.

I understand that Classical Chinese medicine and Acupuncture evaluation and treatment may include, but not be limited to:

- Physical exam (general, including palpation of pulse, observation of the tongue, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (burning of herbal material in the form of a loosely compacted herb or stick directly on the skin or indirectly above the skin)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Tuina (ancient Chinese massage)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements)
- Herbs which may be taken internally or used externally. (use of herbal formulas or single herbs in the form of teas, powders, pills, capsules, tinctures which may contain alcohol, pastes, plasters, washes or suppositories. Formulas or Herbs may include shells, minerals and animal materials)
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)

<u>Potential benefits</u> of care, treatment or procedure provided by Gibran K. Ramos, and/ or with the *allied health care providers*: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

<u>Potential risks</u> of care, treatment or procedure provided by Gibran K. Ramos, and/ or with the *allied health care providers*: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, spontaneous miscarriage; allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical medicine (cupping, tuina/massage); aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert Gibran K. Ramos, and/ or with the *allied health care provider*s if they have **confirmed or suspect pregnancy** as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor and any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider, Gibran K. Ramos and/or the *allied health care providers*, of these conditions.

Please INITIAL the following:

_______ I understand that Gibran K. Ramos is not licensed to prescribe any pharmaceuticals or controlled substances. Appropriate referrals will be provided to manage my prescriptive medication needs.

_______ I understand that the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years.

_______ I understand that Gibran K. Ramos not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies and not to treat mental conditions or mental illnesses.

I do not expect Gibran K. Ramos, and/or any *allied health care provider* to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Gibran K. Ramos, and/or any *allied health care provider* explain and answer any questions regarding therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read, or that it has been read to me, this entire consent form (page 1 and 2). I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment with Gibran K. Ramos and/or any *allied health care provider* at Northwest Natural Medicine.

______________________________	______________________________	_______________
Printed Name of Patient	Signature of Patient	Date

______________________________	______________________________	_______________
Printed Name of Legal Guardian	Signature of Guardian	Date