Patient Registration MRN_____

Patient Information

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (MyChart)

Ethnicity
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, procedures and medical services deemed advisable by the practitioner and staff of the Spokane Wellness Center to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I fully understand this agreement and consent will continue until cancelled by me in writing.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of Prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

Family History – continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient			
Occupation		Employer	
Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:	

For Pediatric Patient					
Patient Reside with:	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other:
	Secondary	☐ Mother	☐ Father	☐ Other:	
Mother's Occupation			Father's Occupation		
Parents Relationship ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed			Childcare ☐ Mother ☐ Grandparent ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare		
Tobacco Exposure: ☐ Yes ☐ No Smokers at home: ☐ Yes ☐ No			Patient is current smoker? ☐ Yes ☐ No		

NOTICE OF PRIVACY PRACTICES

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

Spokane Wellness Center is required by Federal and Florida law to maintain a record of the care and services you receive. We understand that this information about you and your health is personal, and we are committed to protecting the privacy and security of your health information.

This NOTICE OF PRIVACY PRACTICES (the "Notice") describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, as well as other purposes that are permitted or required by law. It also describes your rights to access and control your protected heath information. "Protected Health Information" (PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice applies to all your PHI maintained by Spokane Wellness Center, whether the PHI is created by your treating Spokane Wellness Center provider, by your referring provider, by a nurse, or by others working at/or with Spokane Wellness Center provider, Spokane Wellness Center is required by law to abide by the terms of this Notice In this regard, we are required by law to:

- Make sure that your PHI is private;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of this Notice as currently in effect.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice at any time, and we reserve the right to make the changed Notice effective for all health information that we maintain at the time of the revision. If we revise the terms of this Notice, we will post a revised notice at all Spokane Wellness Center offices. We will also make paper copies of the revised Notice available upon request.

HOW TO CONTACT Spokane Wellness Center

If you would like further information regarding your rights or regarding the uses and disclosures of your health information, you may contact our Privacy Officer at 509-904-1644 at Spokane Wellness Center, 3324 S Grand BLVD, Spokane, WA 99203

THIS NOTICE IS EFFECTIVE AS OF March 1, 2018.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI):

You have the following rights with respect to your protected health information:

Right to Request Restrictions: You may request that we restrict or limit the PHI we use or disclose about you for treatment, payment, or health care operations, or you may request a limit on the PHI we disclose to others who are involved in your care (i.e., a non- Spokane Wellness Center provider, a laboratory) or in the payment of your care. We are not required to agree to your request; but if we do, we will honor it. Even if we agree to your request, your restrictions might not be applied in certain situations. For example, in an emergency, we may use or disclose the PHI, without any restriction, to provide

emergency treatment to you. To request a restriction or limitation, your request must be made in writing and submitted to the Administrator or designee.

Right to Request Confidential Communications: You have the right to receive communications from us in a confidential manner, and you may request that we communicate with you about your PHI in a certain way (e.g., only by mail, only on your cell phone) or at a certain location (e.g., only at work, only at home). Your request for confidential communications must be made in writing to the Administrator and must specify how and where you wish to be contacted. We will accommodate reasonable requests.

Right to Inspect and Copy: Generally, you may review and obtain a copy of your PHI in a designated record set. This right is subject to certain specific exceptions. Your request must be made in writing to the Administrator. We may charge a reasonable fee to cover our copying, mailing, and any other supplies associated with your request. We will notify you of the fee and you may choose to withdraw or modify your request at that time, before any costs are incurred. We reserve the right to withhold the requested information until payment of the reasonable fee is received.

Right to Amend: You may ask us to amend your PHI if you believe that any of the information is incorrect or incomplete. You have the right to request an amendment for as long as the PHI is maintained by Spokane Wellness Center. We may deny your request for certain specific reasons. For example, we may deny your request if you ask us to amend information that was not created by us; is not part of the PHI maintained by Spokane Wellness Center; is not the type of PHI that you would be permitted to inspect and copy; if we determine that the information is correct and complete, or if you fail to explain the reason(s) for your request in writing, your request to amend your PHI must be made in writing to the Administrator and must specify the reason (s) that support your request. If we deny your request, we will provide you with a written explanation for the denial and information regarding appeal right you may have at that point.

Right to an Accounting of Disclosures: You have the right to request a written list of certain disclosures of your PHI made by Spokane Wellness Center. We are not required to account for disclosures made for treatment, payment, healthcare operations (as described below), disclosures that you authorized, and certain other specific disclosure types. Your request must state the time period which the accounting is to cover. This period may not be longer than six (6) years and may not include dates before March 1, 2018. Your request for an accounting of disclosures must be made in writing to the Administrator. The first accounting you request within a twelve (12) month period will be free of charge. For additional accounting requests during that twelve-month period, we may charge a reasonable fee to cover court costs of providing the accounting. We will notify you of the fee and you may choose to withdraw or modify your request at that time, before any costs are incurred. We reserve the right to withhold the requested accounting until payment of the reasonable fee is received.

Right to a Copy of This Notice: You may request a paper copy of this Notice of Privacy Practices at any time.

Complaints: You have the right to complain to us, and the Secretary of the U.S. Department of Health and Human Services, if you believe your privacy rights have been violated. If you choose to file a complaint, you will not be retaliated against in any way. You must submit all complaints in writing to: Spokane Wellness Center, Attention: Privacy Officer, 3324 S Grand BLVD, Spokane, WA 99203

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. Your PHI may be used and disclosed by your provider, by nurses, technicians, or health care team members, by our office staff, and by others outside of our office that are involved in your care and treatment. When required, we will obtain your authorization before disclosing any of your PHI, and we will use reasonable efforts to share only minimally necessary PHI with others.

Treatment: We may use and disclose your PHI to provide, coordinate, and manage your health care and many related services. For example:

- Your protected health information may be provided to a provider to whom you have been referred, to other providers who may be treating you, or to a hospital or ambulatory surgery center that is involved in your care, to ensure that the provider, hospital, or ambulatory surgery center has the necessary information to diagnose and /or treat you.
- We may disclose your PHI from time to time to another provider or health care provider (e.g., a specialist, imaging center or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or plan of treatment.
- We may disclose your PHI to a pharmacy when calling in a prescription.

Payment: Your PHI may be used and disclosed by the business office to process your payment for the health care services provided to you. For example:

- Before you receive scheduled services, we may share information with your health plan in order to verify eligibility, to ask whether coverage is provided by your plan or policy, to obtain required pre-certification, or to obtain prior approval of payment.
- After you receive services, we may share information with your health plan to support our claim for payment, to review services provided to you for medical necessity, and for utilization review activities.

Health Care Operations: We may use or disclose, as needed, your PHI in order to support the business activities and operations of Spokane Wellness Center. These activities include, but are not limited to reviewing the quality of the care you received, quality assessment activities, employee review activities, training of healthcare students, licensing and marketing activities, compliance with applicable laws, and conducting or arranging for other business activities. For example:

- We review the quality, efficiency and cost of care that we provide to you and our other patients in order to find more efficient and effective ways to provide service, to develop ways to assist our health care providers and staff in deciding what additional services Spokane Wellness Center should offer, and to evaluate whether new treatments are effective.
- We may share your PHI with third party “business associates” who perform various activities for Spokane Wellness Center (e.g., accountants, lawyers, transcription, copy, billing, and collection services). Whenever an arrangement between Spokane Wellness Center and a business associate involves the use or disclosure of your PHI, we will have a written contract with the business associate that contains terms that will protect the privacy of your PHI.

Disclosure to Department of Health and Human Services: We may disclose your PHI when required by the U.S. Department of Health and Human Services, the Washington Department of Health or Agency for Health Care Administration, or their agents, as part of an investigation or determination of our compliance with relevant laws.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and / or legal proceedings.

Abuse or Neglect: We may disclose your PHI, in accordance with applicable federal, state and local law, when it concerns abuse, neglect, or violence to you.

Law enforcement and Legal Proceedings: As required by law, we may disclose your PHI for law enforcement purposes or other specialized government functions. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts, as required by law have been made to tell you about the request or to obtain an order protecting the requested information.

Coroners, Medical Examiners and Funeral Directors: We may disclose your PHI to a coroner, medical examiner or a funeral director.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Organ Donation: We may disclose your PHI to an organ donation and procurement organization.

Medical Education: We may use and disclose PHI about you in the teaching of medical students and/ or providers in training (residents) who receive a portion of their medical education from observing, assisting, or participating in the care of patients within Spokane Wellness Center.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release PHI about you. We may also release information about foreign military agency.

Research: Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. We also may disclose your PHI to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, as long as the health information they review does not leave Spokane Wellness Center's offices. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

Public Health and Safety: We may use or disclose your PHI for public health activities, including but not limited to the reporting of disease, injury, vital events, conducting of public health surveillance, investigation and intervention, child abuse or neglect, and for activities related to quality and safety of FDA-regulated products or activities. We may use or disclose your PHI to prevent or lessen a serious threat to the health or safety of another person or to the public, or for national security and intelligence activities authorized by law.

Notification of Family and Friends: We may disclose your PHI to family members, other relatives, or other person(s) you identify if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We also may disclose PHI to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your PHI to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. We may disclose your PHI to others who may be involved in your health care, to notify a family member, or another person responsible for your care of your location, general condition or death. 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 also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies or x-rays. We also may disclose your PHI to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.
We may disclose such information, as necessary, based on our professional judgment to respond to the emergency circumstances.

Appointment Reminders: We may use or disclose your PHI, as necessary, to contact you to provide appointment reminders or to reschedule your appointment. We may leave brief messages about your appointment on your answering machine or voice mail and / or may contact you by postcard.

Alternative Treatment Information: Spokane Wellness Center is always interested in improving health care and lowering costs for groups of people who have similar health problems, and to help manage and coordinate the care for these groups of people. We may use your PHI to identify groups of people with similar health problems, to provide them with information about treatment alternatives or other health-related benefits and services that we believe may be of interest to them. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, or we may send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer in writing to request that these materials not be sent to you.

ANY OTHER USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUIRES YOU WRITTEN AUTHORIZATION

We will not use or disclose your health information for any other purpose without your written authorization. Once you give written authorization, you may cancel your authorization in writing at any time. If you cancel your authorization, we will not disclose protected health information about you after we receive your cancellation, except for disclosures made or processed, before we received your cancellation.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I,_____, understand that as part of my health care, Spokane Wellness Center originates and maintains paper and / or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Spokane Wellness Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Spokane Wellness Center reserves the right to change its notice and practices. Should Spokane Wellness Center change its notice, a copy of any revised notice will be sent to the address I have provided by either U.S. Mail or, if I agree, by email.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I understand that as part of Spokane Wellness Center treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and____Accept_____Decline the terms of this consent.

_____

Patient's Signature Date

PATIENT PRIVACY QUESTIONNAIRE (HIPAA)

NAME: _____

Names and contact numbers of persons, if any, we may contact in an emergency.

_____

_____

If you would like correspondence from our office sent to an address other than your home please specify.

_____

_____

Are there any special instructions how correspondence may be sent to you?

_____

_____

Please provide an e-mail address we could send correspondence to: _____

List the telephone numbers where we may call you. If you do not want to be called at a certain number do not list that number. Please remember that cell phones, voice mail, and answering machines are not completely private.

Home phone: _____

May we leave a message on the answering machine? YES___NO _____

If someone answers your home phone may we leave a message with that person? YES NO _____

Cell phone: _____

May we leave a message on voice mail? YES____NO _____

Work phone: _____

May we leave a message on voice mail? YES____NO _____

Which of the above phone numbers should we call to confirm your appointment time? _____

SIGNATURE: _____ DATE: _____

PATIENT'S ACCOUNT NUMBER: _____

Note: This signed Privacy Questionnaire will remain in your file and will be considered current.
If there are any changes you must notify our office and complete another form.

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I,_____DOB _____

SS#_____, authorize Bradley Hilliard-Lythgoe, ARNP, his associates and/or staff of Spokane Wellness Center to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify and/or cancel my appointments and/or to tender payment for services on my behalf.

NAME: _____

NAME: _____

NAME: _____

NAME: _____

_____ _____

Signature Date

_____ _____

Witness Date