NOURISH NATURAL HEALTH CLINIC

Shannon R. May, N.D., L.Ac
Naturopathic Doctor and Acupuncturist

Adult Intake Packet

Welcome to Nourish Natural Health Clinic, LLC. In order to provide you with the best possible care, we ask you to complete this form in its entirety. It will be greatly appreciated if you can either mail (with sufficient time), fax, email, or drop this form off at the clinic prior to your appointment so that Dr. May can review your health history ahead of time. Otherwise, just bring it with you to your appointment. Thank you!

Personal Information

Name _____Date_____
Address _____
City_____State _____ Zip code _____
Phone (hm)_____ (wk) _____ (cell) _____
Preferred number for messages and appointment reminders?_____
E-mail _____Social Security # _____
Age _____ Date of birth _____ Birth Gender: F M NG Identified Gender: F M NG
☐ Married ☐ Partnership ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Live with: ☐ Spouse or partner ☐ Parents ☐ Children ☐ Friends ☐ Alone
Occupation _____ Hours per week _____ Retired _____ Years _____
Employer _____
What is your ethnic heritage and/or cultural upbringing?_____
Have you seen a Naturopathic Physician or Acupuncturist before? Yes_____ No_____
Which one?_____
How did you hear about this clinic?_____
May we thank them for the referral? Yes_____ No _____
Has any other family member already been a patient at the clinic?_____
_____
Emergency Contact: _____
Relationship _____ Phone _____
Duluth is a small town. In an effort to maintain confidentiality, please let me know if you would like to be addressed upon meeting in public: _____ or remain anonymous:_____

Insurance Information

Insurance Company:_____ Phone #: _____
Name of Policy Holder: _____ DOB: _____
Policy ID #: _____ Group #: _____

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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 help me understand your needs and how to help you reach your health goals. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this clinic?

What do you know about our approach?

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

What long term expectations do you have from working with our clinic?

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

3) 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%

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

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

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

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

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Current Health History

Do you have a Primary Care Provider? Y / N

If yes, please give their name, location, and phone number:_____

_____

Are you currently receiving other forms of healthcare (massage, physical therapy, etc)? Y / N

If yes, for what 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)_____
4)_____
5)_____
6)_____
7)_____

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

If yes, what?_____

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/Hayfever/Hives	Allergies	Osteoporosis	Eczema
IBD	Alcoholism		

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
Chicken pox	Mononucleosis	

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Immunizations

Polio	Y N	Diptheria	Y N
Tetanus	Y N	Pertussis	Y N
Measles/Mumps/Rubella	Y N	Other: _____	

Hospitalization, Surgery, Imaging

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

_____year:_____ _____year:_____
_____year: _____ _____year:_____
_____year: _____ _____year:_____

Allergies

Are you hypersensitive or allergic to...
Any drugs?_____
Any foods?_____
Any environmentals or chemicals?_____

Exposures

Have you had daily or prolonged exposure to any toxic chemicals, paints, lead, mercury? Y N
If **yes**, what type and when? _____
Second hand smoke? Y N If yes, for how long? _____

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)_____ 5)_____
2)_____ 6)_____
3)_____ 7)_____
4)_____ 8)_____

General

Height:_____ Weight:_____ lbs. Weight 1 year ago:_____ lbs.

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Maximum Weight:_____ When:_____
When during the day is your energy the best?_____ worst?_____

Typical Food Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
To drink:_____

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/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?_____

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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
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			

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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	Hayfever?	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
Jaundice (yellow skin)?	Y N P	Bowel Movements: How often?_____	

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Gall Bladder disease?	Y N P	Is this a change?_____	
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

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:_____	

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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

Is there anything else you would like to add or comment on?

Thank you for taking the time to help me better understand your whole health. We look forward to providing you with the best possible care.
~Dr. Shannon May

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Informed Consent and Request for Naturopathic Medical Care, 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 Dr. Shannon R. May, ND, L.Ac, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I,_____ , hereby request and consent to examination and treatment with Naturopathic Medicine and Chinese Medicine by Dr. Shannon R. May, ND, L.Ac, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Shannon R. May, ND, L.Ac, and/ or with the allied health care provider providing backup:

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

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and therapeutic adjustment (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic adjustment of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and cranio-sacral therapy)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

The scope of practice of acupuncture is outlined below. I understand that Chinese medicine and Acupuncture evaluation and treatment may include, but are not limited to:

- 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 (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- 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)
- Gua sha (rubbing on an area of the body with a blunt or round instrument)

- Dietary advice (based on traditional Chinese medicine theory)
- Herbs (use of patented herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials)

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies; allergic reaction to prescribed herbs, supplements, prescription medications; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.
Potential benefits: 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.
Notice to pregnant women: All female patients must alert the provider 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, Dr. Shannon R. May, ND, L.Ac,, of these conditions. Please Initial:

____I understand that Dr. Shannon R. May, ND, L.Ac, is not licensed to prescribe any controlled substances.

____I understand that Dr. Shannon R. May, ND, L.Ac will provide the appropriate referrals to manage any prescription med needs.

____I understand 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 Dr. Shannon R. May, ND, L.Ac is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect Dr. Shannon R. May, ND, L.Ac, 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 Dr. May explain 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 this form or that it has been read to me. 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 condi¬tion and any future conditions for which I seek treatment

Printed Name of Patient_____ Signature of Patient_____
Printed Name of Guardian_____ Signature of Guardian_____
Date Signed_____

Please fill out both sides of this page.

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Notice of Privacy Practices
Nourish Natural Health Clinic, LLC

Nourish Natural Health Clinic, LLC refers to Dr. Shannon R. May, her student preceptors and her contracted employees.

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. We are legally obligated to provide this information to you. It is subject to change and updated versions are always available from Dr. May.

Nourish Natural Health Clinic, LLC is the private medical practice of Dr. Shannon R. May. The majority of the time Dr. May is the only person with access to your medical information; however, there are a few instances in which she may share pertinent information about you for the purposes of treatment, payment or health care operations. She may disclose your health information to other health professionals, their staff or students who may consult on your treatment or the coordination of your health care.

Nourish Natural Health Clinic, LLC also uses and discloses your health information for billing and payment collection from you, an insurance company, or someone else for health care services you receive from us. We may also tell your insurance company about your proposed treatment to determine whether your plan will pay for the treatment.

We may use and disclose your health information in order to run the necessary administrative, educational, quality assurance, and business functions of Nourish Natural Health Clinic, LLC. Data about effectiveness of treatments and what services we should offer may be gathered from patient's health information. We may also use and disclose your health information to contact you regarding treatment options, products or services and for appointment reminders.

Other potential instances in which your health information could be disclosed without your explicit permission include legal obligations at the federal, state or local level to disclose to specified parties for purposes including subpoenas/ court orders, public health risks, governmental agency oversight of health care, threats to health or safety, disaster relief, na¬tional security, for identification of deceased persons, or for the purpose of organ or tissue transplantation. Military command or government authority may acquire information about veterans or members of the military. Correctional institutions may acquire information about inmates for the purpose of providing health care and safety. Information about employees can be disclosed to employers regarding worker's compensation type programs.

With some rare exceptions, you have the right to access and get a copy of any data regarding your health information from Nourish Natural Health Clinic, LLC. In the exceptional cases in which we are permitted to withhold information from you, you may ask that the denial be reviewed. You have the right to amend your health information. We will amend the information, except if it a) is not information that we created, (unless the source of the information is no longer available to make the amendment), b) is not part of the health information that we keep c) is of a type that you would not be permitted to inspect and copy; d) is already accurate and complete.

Dr. May and all associates of Nourish Natural Health Clinic, LLC seek to maintain confidentiality regarding your health information. We are happy to discuss your concerns about these matters and consider further restricting use and disclosure of your health information.

Signature_____ Date Signed_____

Printed Name Relationship to Patient_____

Please fill out both sides of this page.

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NOURISH NATURAL HEALTH CLINIC
FEE SCHEDULE

Payment is required at the time of service, unless previous arrangements have been made. We accept cash, checks, VISA, or Mastercard for payment.

New Patient Office Visit: Acupuncture or Naturopathic *(approximately 1 ½ hours)*	**$180**
Routine Return Naturopathic Visit *(approximately 45 minutes – 1 hour)*	**$75**
Routine Return Acupuncture Visit *(approximately 30 – 45 min)*	**$60**
New Patient Acute Visit *(approximately 30 - 45 min)*	**$120**
Return Patient Acute Visit *(approximately 15 – 30 min)*	**$45**
Well Woman Exam including Pap smear (external lab fees not included)	(new) **$150** (return) **$120**
Adult Screening Physical	(new) **$120** (return) **$95**
Well Child Exam	(new) **$100** (return) **$80**
Home visit	**$20 in addition to typical office visit**

(While I do not make a regular habit of coming to see patients at their homes, I certainly will do so if the gravity of the situation merits.)

Phone/Skype Consults **(Same as Routine Return Visits)**	**$75**

Phone calls and email messages regarding questions about your current treatment plan, and taking less than 10 minutes of time, are not charged.
Any laboratory fees, imaging fees or natural supplement items that may be recommended are not included in the office visit fee.

Insurance Reimbursement:

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Currently, insurance companies and HMO's in Minnesota do not cover naturopathic services. Flex Spending programs may allow for naturopathic health care deductions. Check with your plan administrators. We recommend that everyone ask their insurance providers to allow coverage for natural healthcare expenses. However, insurance billing for certain lab work is possible with some insurance companies.

Cancellation Policy:
If you need to change or cancel your appointment, please give us at least 24 hours notice. Appointments that are either missed or cancelled with less than 24 hours notice (excluding emergencies) will be charged a $35 fee.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. May. I also understand that I will be billed for phone or Skype consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated, and lasting less than 10 minutes of time.

In addition, I understand that lab work may or may not be covered by my insurance plan and that I am responsible for payment of lab work ordered if my insurance company does not cover it. I also understand that I will be charged $35 for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: _____ Date: _____

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E-Mail Authorization and Consent Agreement Between Nourish Natural Health Clinic Clinician and Patient

I have been advised that:
E-mail is never, ever appropriate for urgent or emergency problems.
E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
All e-mail correspondence will become a part of my medical record at Nourish Natural Health Clinic, LLC. It is extremely important to include my name on each and every e-mail sent to Nourish Natural Health Clinic, LLC and/or Dr. May.
Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow-up by telephone or in person if I do not receive a response within a week.
I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and healthcare, and I understand the issues and concerns inherent in this use.
I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my healthcare and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.
I designate that all e-mail correspondence coming from me or to me should be sent to the following Internet e-mail address: _____

E-mail address:_____

Signature:_____ Date:_____

Name:_____ DOB:_____

Printed Name of Clinician:_____

Signature of Clinician:_____