

# Utah Natural Medicine

242 S 400 East, Suite A; Salt Lake City, UT 84111 • Tel. 801-363-UTAH (8824)

## PATIENT INFORMATION

Today's Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_ Patient Social Security Number: \_\_\_\_\_

Home Phone: (    )    -                      Cell Phone: (    )    -                      Work Phone: (    )    -

Fax: (    )    -                      Email: \_\_\_\_\_

Can we send general information such as a newsletter to you by email? \_\_\_\_Yes\_\_\_\_No

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Residential Address

Mailing Address (if different)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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Check One: \_\_\_\_Minor\_\_\_\_Single \_\_\_\_Married \_\_\_\_Divorced\_\_\_\_Widowed\_\_\_\_Separated

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How Did You Hear about the Clinic: \_\_\_\_ Yellow Pages \_\_\_\_Advertisement  
\_\_\_\_Publication/Book \_\_\_\_Acquaintance \_\_\_\_Internet

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IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (    )    -                      Cell Phone: (    )    -                      Work Phone: (    )    -

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Complete if Patient is a Minor

Father: \_\_\_\_\_ Home Phone: (    )    -                      Work Phone: (    )    -

Mother: \_\_\_\_\_ Home Phone: (    )    -                      Work Phone: (    )    -

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FINANCIALLY RESPONSIBLE PERSON

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Retired?: \_\_\_\_\_

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## PATIENT INTAKE

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please list in order of importance your chief medical complaints or problems:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Current Prescription Medications with dose:

_____	_____
_____	_____
_____	_____

### Recent [within past 6 months] Prescription Medications no longer taking:

_____	_____
_____	_____
_____	_____

### Current Non-Prescription Substances [Nutritional, herbal, over-the-counter meds.] with dose:

_____	_____
_____	_____
_____	_____

*If additional space is needed, please use the end of this form or backside.*

### Diet: Circle the foods you eat on a regular basis.

Tofu	Luncheon meats	Eggs	Fresh vegetables	Coffee/Tea
Beef	Milk: cow's, soy,	Frozen foods	Dark leafy	Herbal tea
Chicken	rice, almond	Fast foods	greens	Alcohol
Turkey	Cheese	Organic foods	Pasta	Sodas
Fish	Butter	Nuts & Seeds	Rice	Filtered water
Tuna fish	Margarine	Flax/Fish oil	Whole grains	Diet foods/plans
Pork		Fresh fruit	White flour	Artificial
			Refined sugar	sweetener

What describes your diet best? \_\_\_ Omnivore (animal and plant based) \_\_\_ Vegetarian

\_\_\_ Vegan \_\_\_ Low Fat \_\_\_ Low Salt \_\_\_ Low Carbohydrate

Specific restrictions: \_\_\_ Wheat or gluten \_\_\_ Dairy \_\_\_ Soy \_\_\_ Gluten \_\_\_ other? \_\_\_\_\_

Servings of fruits per day? \_\_\_\_\_ Servings of vegetables per day? \_\_\_\_\_

### Family Medical History: Have any family members had any of the following (please indicate mother, father, brother, aunt, grandfather, etc. and whether on paternal or maternal side):

Diabetes _____	High blood pressure _____	Heart disease _____
Cancer _____	Bleeding disorder _____	Epilepsy _____
Asthma _____	Thyroid disorder _____	Gout _____
Birth defects _____	Kidney disease _____	Mental illness _____
Heart attack _____	Stroke _____	Tuberculosis _____
Emphysema _____	Alcoholism _____	Substance abuse _____
Osteoporosis _____	Auto-Immune disease _____	Arthritis _____

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Your Medical History**

Current Weight:\_\_\_\_\_ Max. Weight:\_\_\_\_\_ Significant weight change in past six months?:\_\_\_\_\_

Please list major illnesses you have ever had: \_\_\_\_\_

Please list any major surgeries and/or hospitalizations you have ever had, include date: \_\_\_\_\_

Do you have any allergies to Medications? \_\_No \_\_Yes, please list: \_\_\_\_\_

Do you have any food allergies? \_\_No \_\_Yes, please list: \_\_\_\_\_

Do you have Seasonal/Environmental allergies? \_\_No \_\_Yes, please list: \_\_\_\_\_

Have you ever been diagnosed/treated for psychological or emotional conditions? \_\_No \_\_Yes please specify with dates: \_\_\_\_\_

How would you rate your General Health? Excellent Good Fair Poor

**Review of Systems:** Please circle any of the following conditions/symptoms you have had in the past year:

- |  |  |  |   |
|--|--|--|---|
| <p><b>•Skin:</b><br/>Rashes<br/>Itching<br/>Burning<br/>Warts<br/>Hair Loss<br/>Skin cancer<br/>Dry skin<br/>Brittle nails<br/>Discoloration<br/>Eczema<br/>Psoriasis<br/>Swellings or bumps</p> <p><b>•Head, Eyes, Ears, Nose, Throat:</b><br/>Headaches<br/>Blurred vision<br/>Partial/full loss vision<br/>Eye pain<br/>Chronic sinusitis<br/>Mouth sores<br/>Change/loss of taste<br/>Thrush<br/>Chronic cough<br/>Chronic sore throat</p> | <p><b>•Cardiovascular:</b><br/>Angina<br/>Heart attack<br/>Stroke<br/>Valve disease<br/>Chest pain<br/>Palpitations<br/>Fainting<br/>Swollen Feet/ankles<br/>Varicose veins</p> <p><b>•Pulmonary:</b><br/>Breathing difficulty<br/>Shortness of breath<br/>Asthma<br/>Coughing up blood</p> <p><b>•Gastrointestinal:</b><br/>Abdominal pain<br/>Chronic constipation<br/>Chronic diarrhea<br/>Nausea<br/>Vomiting<br/>Jaundice<br/>Dark/bloody stools<br/>Abnormal colonoscopy</p> | <p><b>•Genitourinary:</b><br/>Pain/burning urination<br/>Blood in urine<br/>Frequent urination<br/>Urgent need to urinate<br/>Kidney stones<br/>Flank or kidney pain<br/>Sexually transmitted diseases<br/>Problems with sexual function</p> <p><b>•Musculoskeletal:</b><br/>Loss of muscle strength<br/>Joint/muscle pain<br/>Chronic back pain<br/>Sciatica<br/>Stiff joints<br/>Fingers blue when cold</p> <p><b>•Endocrine:</b><br/>Heat/cold intolerance<br/>Excessive thirst</p> | <p><b>•CNS:</b><br/>Changes in memory<br/>Inability to concentrate<br/>Loss of coordination<br/>Tingling/numbness<br/>Sleep disturbance<br/>Strong emotion change<br/>Mood swings</p> <p><b>•Women:</b><br/>Hot flashes<br/>Vaginal itching/dryness<br/>Unusual pelvic exam<br/>Unusual breast exam<br/>Do self breast exam</p> <p><b>•Men:</b><br/>Prostate enlarged or infected<br/>Penile Pus/drainage<br/>Swelling in groin<br/>Nodule in testicle<br/>Painful/tender groin<br/>Do self testicular exam</p> |
|--|--|--|---|

**For Women Only:**

Age onset of menses: \_\_\_\_ History of irregular menses? \_\_\_\_ History of contraceptive use? \_\_\_\_  
# of pregnancies \_\_\_\_ # of miscarriage \_\_\_\_ # of children \_\_\_\_  
Age onset of menopause \_\_\_\_

Patient Name:

Date of Birth:

**Chemical Exposure:**

Did your mother take any drugs, alcohol, medications, or tobacco during her pregnancy with you? \_\_\_ Are you exposed to second hand smoke? \_\_\_ Do you use tobacco products? \_\_\_ If so, how many cigarettes/day? \_\_\_\_\_ Past smoker? \_\_\_ Yes \_\_\_ No If so, dates? \_\_\_\_\_ Do you take antacids regularly? \_\_\_ Do you use recreational drugs? \_\_\_ Any current or past addictions: \_\_\_ Yes \_\_\_ No If so, please explain \_\_\_\_\_ Are you exposed to chemicals/fumes at work/home/hobby? \_\_\_ Are you sensitive to strong odors? \_\_\_ Past exposure to pesticides? \_\_\_ solvents? \_\_\_ heavy metals? \_\_\_ radioactivity? other known chemicals? \_\_\_ If so, please explain: \_\_\_\_\_ Do you use any of the following? \_\_\_ natural cleaning products \_\_\_ air fresheners \_\_\_ organic lawn care \_\_\_ scented candles Do you use any of the following? \_\_\_ acrylic nails \_\_\_ perfumes/cologne \_\_\_ artificially scented products Do you have silver fillings/amalgams? \_\_\_ How many? \_\_\_

**Health Maintenance:**

Date of last full general checkup/ physical: \_\_\_\_\_ If abnormal, please explain: \_\_\_\_\_

Date of last skin/dermatologic checkup: \_\_\_\_\_ If abnormal, please explain: \_\_\_\_\_

Have you had a colonoscopy? \_\_\_ Yes \_\_\_ No Dates: \_\_\_\_\_

If abnormal, please explain: \_\_\_\_\_

Date of last vision test: \_\_\_\_\_ If abnormal, please explain: \_\_\_\_\_

Date of last ophthalmologic exam? \_\_\_\_\_ If abnormal, please explain: \_\_\_\_\_

Do you have regular dental exams? \_\_\_ Yes \_\_\_ No. If yes, how often? \_\_\_\_\_

**Safety:**

Do you wear a seat belt? \_\_\_ Yes \_\_\_ No

Do you use a cell phone while driving? \_\_\_ Yes \_\_\_ No Do you text while driving? \_\_\_ Yes \_\_\_ No

Do you have a smoke detector in your home? \_\_\_ Yes \_\_\_ No

Do you have a carbon monoxide detector in your home? \_\_\_ Yes \_\_\_ No

Do you have a fire extinguisher in your home? \_\_\_ Yes \_\_\_ No

**Stress:**

Circle your usual level of stress. (1 = lowest) 1 2 3 4 5 6 7 8 9 10 For how long? \_\_\_\_\_

**Health goals:** Please circle all that apply.

Have more energy/vitality

Have more endurance

Sleep better

Eat better

Have less pain

Get sick less often

Have more libido/sex drive

Have less dependency on certain medication

Lose weight

Improve posture

Increase activity level

Have stronger bones

Have stronger muscles

Improve flexibility

Reduce stress

Have less brain fog

Balance moods

Gain motivation

Reduce risk of disease and cancer

Have better relationships

Have a healthier life longer

**Willingness to change:** Please circle: (0 = not willing, 10 = I'll do almost anything!)

0 1 2 3 4 5 6 7 8 9 10

Patient Name:

Date of Birth:

UTAH NATURAL MEDICINE DIET AND LIFESTYLE DIARY							
Date	Time	Food & Liquids consumed	Any Symptoms (1 to 10) 1 = least 10 = most problematic	Feelings: emotion, energy, and stress level	Bowel movement, urination, gas, bloating	Exercise/ Activity level	Sleep – include naps

Please follow these guidelines as best as possible:

1. Make 6 copies of this page and fill it out for 4 weekdays and 2 weekend days and bring completed diary to first appointment.
2. Be honest! Try not to change your diet and lifestyle habits during this time so we can make a fair assessment of what you're doing currently.
3. Include the amount of food you eat and brand name as applicable. Also include ingredients of the food as best you can (e.g. instead of salad, please write 1 ½ cups romaine lettuce, 1 medium tomato, ½ carrot, ½ ounce turkey, 2 Tbsp ranch dressing).
4. Include symptoms, if any, that you experience (e.g. headache, pain, joint stiffness, rash, cramping).
5. Note when you have a bowel movement and if it was difficult to pass or loose. Note any changes (e.g. color) or abnormalities (e.g. blood).
6. Note under the exercise column your activity level (e.g. if you sit in the office all day or gardened for 7 hours, please list this).
7. List your naps, if any, and the time you fall asleep and awaken. If you're up in the night, other than briefly to urinate or otherwise, please specify time and reason, if known (e.g. mind racing, stress, hot flashes, restless legs, pain).

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## Financial Agreement

### Insurance Information

Many insurance companies, flex plans, and health savings accounts will cover visits with us as Out of Network Providers. For all patients with health insurance and those without insurance, we ask that you pay for your visit at the time of service. We can provide a receipt/ "superbill", including necessary codes and information for reimbursement for those who wish to submit for having seen an Out of Network Provider.

Most insurance companies cover the standard lab tests, blood work, or imaging tests that we order, but we cannot guarantee coverage for them. For patients who choose to pay out of pocket, we offer onsite blood draws at reduced rates. Some specialized testing we offer such as food allergy tests or heavy metal testing is typically not covered by insurance.

**Medicare and Medicaid are not contracted with Utah Natural Medicine and visits for patients with these insurance plans will NOT be covered.**

### Rates

Please call our office for specific rates for services we offer. The doctor fee schedule is posted on our website under Patient Information for your reference. We do not accept checks, but do accept Visa and Mastercard. Visits with the doctors include physician consult, physical exam, and a comprehensive treatment plan. New patient visits are usually 90 minutes and return visits are usually 15-45 minutes long. If you would like to book a specific amount of time, please let the receptionist know when you make the appointment.

### Cancellation/Re-scheduling and No-Show Policy

We have a less than 48 hour cancellation/rescheduling fee policy for new patients and a less than 24 hour cancellation/re-scheduling fee policy for return patients. Please be aware that the doctors do not overbook or double book their appointments and their time is reserved exclusively for you. In order to accommodate those on the waiting list, we appreciate ample notification when rescheduling and for cancellations. **We will hold your first appointment with a \$150 deposit by credit card. This deposit is non-refundable in the event you cancel or reschedule less than 48 hours before your scheduled appointment or do not appear for your appointment. Return patients are charged a fee of \$60 for either a less than 24 hours cancellation or not appearing for their appointment.**

**FINANCIAL TERMS:** I, the undersigned, certify that I have read the above and agree to follow the parameters of this agreement. I understand that I am financially responsible for all charges whether or not they are paid for by insurance and will pay at the time of service. *For Medicare and Medicaid patients only:* I have been informed that the services I am requesting are not covered by Medicaid, Medicare, or Medicare Supplemental insurance. I am aware that I cannot submit these bills to Medicare/Medicaid for reimbursement and I will be financially responsible for these services, including but not limited to: nutritional counseling, treatments for wellness, and any labwork associated with these services.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/Representative's Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

## UTAH NATURAL MEDICINE

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### INFORMED CONSENT FOR MEDICAL TREATMENT AND PROCEDURES

This document is a binding agreement (the “Agreement”) between Utah Natural Medicine (“the Doctor” “UNM”) and the individual whose name and signature appears below (“I” “the Patient”) or the legal guardian thereof. In consideration of the health care services provided to the Patient by Utah Natural Medicine at the present and at all times in the future, I agree as follows (agreement is indicated by placing Patient initials on the lines following each section and by signing in the space provided at the bottom of the page):

1. **Consent For Treatment:** I, \_\_\_\_\_, the undersigned, do hereby authorize and give consent to UNM to provide health care, medical treatment and procedures to the Patient which may include but is not limited to the following:
  - a) General Diagnostic Procedures: Including, but not limited to, venipuncture (phlebotomy), x-rays, ultra sound, blood & urine lab work, pap smears, and physical exams.
  - b) Prescriptions: Including, but not limited to, pharmaceutical drugs, nutritional supplements, homeopathic remedies, plant, mineral, and animal materials/products for internal or external use. These products may contain diluents, solvents, or carrier mediums such as alcohol in tinctures.
  - c) Lifestyle & Dietary Counseling: Including, but not limited to diet regimens, exercise plans, nutritional supplements, psychological and emotional counseling, and advice concerning sleep hygiene, stress reduction, and balance of life activities.
  - d) Office Procedures and Treatments: Including, but not limited to, intramuscular injections (e.g. nutritional substances, vaccines, local anesthetics, homeopathic medicines, dextrose and other prescriptive medicines), intradermals and subcutaneous injections, intravenous therapy, mesotherapy, prolotherapy, scar infiltration, acupuncture, trigger point injections, nerve blocks, joint injections, dressing of wounds, ear cleansing (lavage), cryotherapy and minor surgery.
  - e) Physical Therapies: Including, but not limited to, massage, neuro-muscular technique, muscle energy stretching, craniosacral therapy, visceral manipulation, cupping & Gua Sha (Chinese techniques involving manual instruments for scraping & suction to increase circulation), as well as manipulation of extremities and spine.
  - f) Thermal and Electrical Therapies: Including, but not limited to, ultrasound, high & low volt muscle stimulation, interferential, transcutaneous electrical stimulation, microcurrent stimulation, diathermy, infrared and ultraviolet therapies, hydrotherapies (hydrocolators, hyperthermia, contrast baths) and moxabustion.

I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. I acknowledge that UNM has not made any guarantees or promises as to the outcome, the safety or the efficacy of the Treatments. (Initial)\_\_\_\_\_

2. **Experimental Nature of Treatment.** I acknowledge and agree that the Treatments may consist in whole or in part of experimental procedures and methods, on which no governmental (including the U.S. Food and Drug Administration [FDA]), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. I acknowledge that the safety record of the Treatments may be based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. I have been informed that the treatments MAY alter, address or decrease my symptoms or complaints, but also may have NO effect. (Initial)\_\_\_\_\_

3. **Potential Risks, Side Effects, Complications.** I agree and acknowledge that there are certain unavoidable risks, side effects, and complications to the Treatments including, but not limited to infection, swelling, allergic reaction, increased pain, aggravation of existing conditions, bleeding,

scarring, scar or wound enlargement, keloid formation, blistering, burns, itching, discoloration, temporary or permanent alteration in sensation, permanent skin contour irregularities at the site of Treatments, need for additional surgery or treatment, internal or external leaking of fluids, pneumothorax (air on the outside of lung), paralysis, dizziness, loss of consciousness, serious or debilitating injury, and death. (Initial)\_\_\_\_\_

4. **Information I Have Provided to UNM.** I hereby verify that I have provided UNM with a complete list of all prescription and non-prescription medications and substances I am currently or have recently been taking; and I agree to update such list whenever a change is made. I have also provided a list of all known allergies including medications, dietary/nutritional substances, and plant and animal substances. I have also provided a list of all medical, surgical and/or psychological conditions I currently have, and any such major conditions I have had in the past. I covenant that all the information I have provided including but not limited to the information required by this Section 4, is true, accurate, complete and up-to-date to the best of my, the Patient's, knowledge. (Initial)\_\_\_\_\_

5. **Assumption of Risk.** I hereby verify that I have not been legally adjudged as incompetent. Furthermore, I attest that I am fully capable of understanding the risks and benefits of the above mentioned procedures and treatments, that I have carefully read and understand fully the terms of the Agreement, and after having adequate time to ask any questions about this Agreement or the Treatments that I have, I am willing to assume any and all risks associated with the Treatments including without limitation those described in this Agreement. I also acknowledge that no explanation or description of Treatment can ever fully explain every possible risk, side effect or complication that may or could arise from Treatment, but that by initialing and signing this Agreement, I nevertheless, acknowledge my, the Patient's, willingness to assume such risks and that my, the Patient's, consent to Treatment is willing, voluntary and informed. I furthermore acknowledge and understand that IT IS MY RIGHT TO DETERMINE THE EXTENT OF THE TREATMENT AND THAT I MAY DECLINE TREATMENT AT ANY TIME BEFORE OR DURING TREATMENT. (Initial) \_\_\_\_\_

6. **Miscellaneous.** I agree that this Agreement constitutes the entire agreement between UNM and the Patient regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by the Patient. This Agreement shall be binding on the Patient, their successors, heirs, legal representatives and assigns. This Agreement shall be governed by the laws of the state of Utah without regard to any choice of law principal. (Initial)\_\_\_\_\_

BY SIGNING THIS AGREEMENT, I INDICATE THAT I HAVE READ , UNDERSTAND AND AGREE TO ITS TERMS, THAT I AM THE PATIENT, GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE OR GUARDIAN, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT ITS TERMS.

**Witness**

**Patient/Legal Guardian**

**Interpreter**  
(If necessary)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name & Title of Witness

\_\_\_\_\_  
Print Name if not the Patient

\_\_\_\_\_  
Name/Title of Interpreter

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relation, if signed by other than patient

## **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!***

Utah Natural Medicine (UNM) respects your privacy and understands that your medical information is personal and sensitive; and we are required by law to keep medical information that identifies you private. This notice explains how we use and disclose your personal information, the choices and rights you have about how your information may be used and disclosed, and our obligations to protect the privacy of your personal health information. When you receive care at UNM we may use your health information for treating you, billing for services, and conducting normal business (“health care operations”). We reserve the right to change our privacy practices and to make such changes apply to all protected health information we maintain.

### **HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

Your personal health information may be used in the following ways:

- To the extent that we are required to by law.
- For Treatment: to plan, provide, and coordinate you health care services within UNM and with other health care providers.
- To obtain payment for health care services we have provided to you from insurance companies, yourself, or other third-party. We may contact your insurance company to verify your coverage.
- For health care operations.
- To our business associates to provide the service we have contracted them to do in your behalf. We require all business associates to also safeguard your information in accordance with the law.
- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases or injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and products under the jurisdiction of the U.S. FDA; and problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- To a health oversight agency charged with overseeing the health care system as authorized by law.
- For law enforcement purposes to law enforcement officials in compliance with and as limited by applicable law.
- To organ procurement organizations for organ, eye, or tissue donation purposes.
- For research purposes when such research has been approved by an institutional review board that has reviewed the research to ensure the privacy of your personal health information, or as otherwise allowed by law.
- To certain government agencies charged with special government functions as limited by applicable law.

- To prevent or lessen a serious threat to any person's or the public's health or safety. In all cases, disclosures will only be made in accordance with applicable law.
- For workman's compensation.
- Unless you object, we may contact you to provide appointment reminders or information about treatment, health benefits or services that may interest you.
- We may also use your information to notify a family member, close friend, or another person responsible for your care, provided that you have the opportunity to object. If you are unable to object, we may disclose this information as necessary if we determine it is in your best interest based upon our professional judgment.

**YOUR INDIVIDUAL RIGHTS**

You have the following rights with regard to your personal health information:

- Upon request, to access and obtain a copy of your health information maintained by UNM (a processing fee may apply).
- Request, in writing, restrictions on how we use and share your health information. We will consider all requests of restrictions carefully but are NOT required to agree to any restrictions.
- Request that we use a specific contact information to communicate with you.
- Request, in writing, an accounting of certain disclosures of your health information made by UNM. The accounting may include the date, a brief description of the information disclosed, and the person or entity that received the disclosure, and a brief statement of the reason for the disclosure. Your request must state the period of time desired for the accounting, which must be within six years prior to your request and exclude dates prior to April 14, 2003.
- If you feel your rights have been violated, you may file a formal complaint with UNM and/or a written complaint with the Office of Civil Rights of the U.S. Dept. of Health and Human Services. We will investigate all complaints and will not penalize or treat you any differently for filing a complaint.

**I hereby acknowledge that I have read and understand Utah Natural Medicine's "Notice of Privacy Practices" and have received and/or been offered a signed copy of them.**

Name of Patient or Guardian: \_\_\_\_\_  
(Printed)

Signature of above Person: \_\_\_\_\_  
(Date)

Witness: \_\_\_\_\_  
(Signature) (Date)