



**Dr. Mulyukova, ND, EAMP**  
**Tel: 425-273-4273 / Fax: 1-855-764-4359**  
**[www.tacomaturalhealth.com](http://www.tacomaturalhealth.com)**

2211 Pacific Ave  
Tacoma, WA 98402

6210 75<sup>th</sup> St.W, Ste A100  
Lakewood, WA 98499

**Welcome!**

Dr. Mulyukova, ND, EAMP, LAc. is happy to provide integrative and individualized guidance toward your optimal health.

The following forms are included in this packet:

Notice of Privacy Practices, Acknowledgement , HIPAA Rights, Payment Agreement, Informed Consent

**Your Visit:** Dr. Mulyukova is currently seeing patients by appointment at these locations:

1. 2211 Pacific Ave, Tacoma, WA 98402
2. 6210 75th St W, Suite A100, Lakewood, WA 98499

The first visit typically averages from 60-75 minutes depending on complexity. This visit includes an interview and a physical exam to determine a diagnosis and individualized treatment plan. First visit fee is \$250. Follow up visits are typically scheduled for 30-45 minutes depending on complexity and range between \$125 and \$150.

There is a credit / debit card service fee of 3.00%.

Telephone / Skype Consultations available for established patients under special circumstances instead of an office visit - \$45 per 15 minutes.

*No charge if patient is calling at Dr. Mulyukova's request or for clarification of on-going therapy.*

Lab & Dispensary Fees

Due to the individualized nature of your treatment, there is no standard set of tests run on every patient. Lab fees vary depending on treatment/labs ordered. Fees for lab work are due at the time of sample collection, and all pricing is available prior to service.



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### 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 read it carefully.

The following is the privacy policy ("Privacy Policy") of Dr. Mulyukova and Optimum Natural Medicine, LLC ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

#### **Your personal health information**

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

#### **Uses or Disclosures of Your Personal Health Information**

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

#### **Without Your Consent**

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for

those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

#### **As Required By Law**

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

#### **All Other Situations With Your Specific Authorization**

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or

disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

#### **Miscellaneous Activities Notice**

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

#### **Your Rights With Respect to Your Personal Health Information**

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

#### **Right To Request Restrictions On Use Or Disclosure**

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: (a) to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

#### **Right To Receive Confidential Communications**

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

#### **Right To Inspect And Copy Your Personal Health Information**

Your designated record set is a group of records we maintain that includes: Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information

maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

#### **Right To Amend Your Personal Health Information**

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Dr. Mulyukova.

#### **Right To Receive An Accounting Of Disclosures Of Your Personal Health Information**

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately

preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Dr. Mulyukova.

#### **Complaints**

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Dr. Mulyukova. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

#### **Amendments to this Privacy Policy**

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

#### **On-going Access to Privacy Policy**

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Dr. Mulyukova. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Dr. Mulyukova at 425-273-4273.



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### Notice of Privacy Practices Acknowledgement

*Please Fill Out and Return*

I received a copy of the Notice of Privacy Practice, and I have been provided an opportunity to review it.

Name \_\_\_\_\_

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

Signature \_\_\_\_\_

Date \_\_\_\_\_



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**Your Health Information Privacy Rights / HIPAA Rights**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- To obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

- Do not phone me at home. Use this alternate phone number: \_\_\_\_\_
- Do not phone me at work. Use this alternate phone number: \_\_\_\_\_
- Do not leave messages on my answering machine.
- Do not contact me by email.

Send mail, including my bills, to this alternate address:

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor) \_\_\_\_\_ Date: \_\_\_\_\_





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### Payment Policy

Thank you for choosing Dr. Mulyukova, ND, EAMP, LAc. as your health care provider. I am committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Returned checks will be subject to \$20.00 NSF fee.

**3. Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit. Dr. Mulyukova may prescribe supplements, which may be purchased at office or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the above-stated policies of Dr. Mulyukova 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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### Informed Consent

I, \_\_\_\_\_, acknowledge that I am accepting treatment from Dr. Mulyukova, ND, EAMP, LAc. This may include all modalities allowed under the scope of practice of naturopathic physician licensed in the State of Washington and East Asian Medical Practitioner and Acupuncturist licensed in the State of Washington.

**Methods, Procedures and Therapeutic Approaches:** Dr. Mulyukova, ND, EAMP, LAc. may perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, treat or otherwise address your health concerns: **General Diagnostic Procedures** (including but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments); **Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions; Herbs/Natural Medicines and Pharmaceutical Medications** not including scheduled drugs with the exception of Testosterone and codeine. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical crèmes, pastes, plasters washes; suppositories, injections or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

**Dietary Advice and Therapeutic Nutrition** (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)

**Soft Tissue and Osseous Manipulation** (use of massage, neuro-muscular techniques, muscle energy stretching, as well as manipulations of the extremities and spine including traction and craniosacral therapy).

**East Asian Medicine and Acupuncture**, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping, gua-sha (dermal friction technique); infra-red; sonopuncture, laserpuncture; point injection therapy; dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and Tuina, which is a method of East Asian bodywork, characterized by the kneading,

pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and superficial heat and cold therapies. I understand that the herbs may need to be consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify Dr. Mulyukova, ND, EAMP, LAc. of any unanticipated or unpleasant effects associated with the consumption or application of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, and needle sickness. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify Dr. Mulyukova, ND, EAMP, LAc. if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify Dr. Mulyukova, ND, EAMP, LAc. if I am or become pregnant.

***Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema must inform practitioners prior to any treatment.***

I do not expect the Dr. Oksana Mulyukova, ND, EAMP, LAc. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above mentioned doctor to exercise judgment during the course of treatment which she thinks best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I understand that although naturopaths are primary care providers in the State of Washington, they have some restrictions to their scope of practice, such as limitations in prescriptive authority and lack of hospital privileges, and that in some situations, I may need to be referred to other appropriate providers or settings including hospitals, other primary providers, urgent care facilities, or specialists to obtain necessary or recommended medical care. ***Potential Risks:*** Pain, discomfort, blistering, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, allergic reactions to prescribed herbs, supplements or pharmaceuticals; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

***Potential benefits:*** Restoration of health and the body's optimal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

***Notice to Pregnant Women or Breastfeeding:*** All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy or during breast feeding.

I understand that I may ask questions regarding my treatment before signing this form and

that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Mulyukova, ND, EAMP, LAc. regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

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Patient Signature

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Date

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Parent/Guardian Signature

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Date