Recapture your Life

West Valley Naturopathic Center

Dear New Patient,
We are very excited to welcome you to West Valley Naturopathic Center. Within this letter you will find the following: our policies, a website for the new patient forms, the physical address of our office, and a map of ouroffice location.

At the time of scheduling, we take a $25 ***NON-REFUNDABLE*** deposit that gets deducted off of the total cost of your visit. If you should need to reschedule your appointment, it must be before 24 business hours of your scheduled appointment time. The initial deposit will be held for the rescheduled appointment up to 3 months. If your appointment is not rescheduled within 3 months of the initial deposit payment, another $25 deposit is requiredto reschedule.

The new patient forms can be found on our website at www.wvncaz.com/forms. We require the new patient forms to be filled out and submitted at least 48 hours prior to your scheduled appointment time. If we do not receive the new patient forms in the allotted time frame, we will have to reschedule your initial appointment. Our office blocksout an hour time slot solely dedicated to your appointment and we do not double book patients. Having your new patient forms before the visit helps ensure the doctors are able to stay on schedule with your appointment and the patients after you.

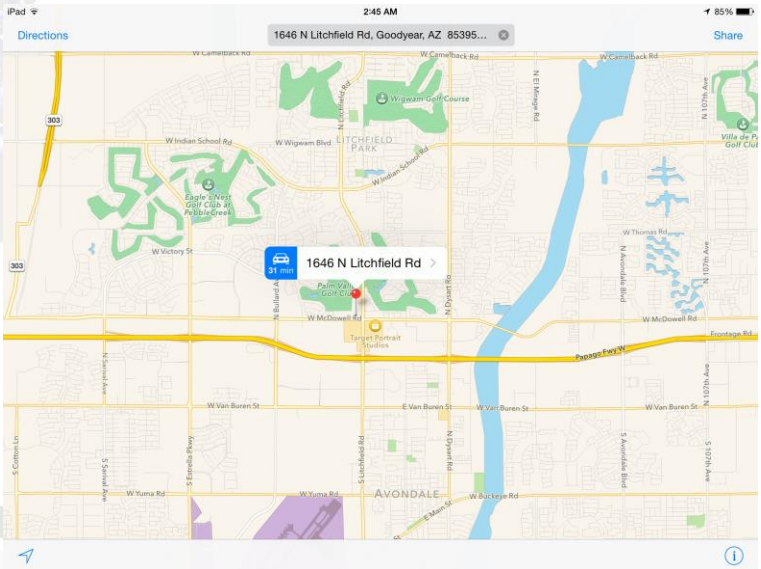
Our office is a cash pay office and your service fee is based on the amount of time spent with the doctor only. Ifyour initial 60 minute consult was to go over the allotted time, an additional charge will be applied.

You will receive text reminders 48 hours before your scheduled appointment time as a reminder. You will also be given a call by our front office staff to confirm your appointment.

Items to bring with you to your initial visit: recent labs, recent imaging, health insurance card, drivers license, list ofcurrent supplements and medications, and any other pertinent medical records.

We are at your service to assist you on your journey to optimizing your health and wellness. Please do not hesitate to contact us directly if you have any additionalquestions or concerns. We look forward to meeting youand we are truly excited that you have chosen our officeto facilitate your health care needs.

In health,
The WVNC team



(T) 623.643.9598. (W) www.wvncaz.com. (E) admin@wvncaz.com
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Authorization to Disclose Protected Health Information

Authorization for use or disclosure of protected health information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and164)

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I authorize West Valley Naturopathic Center to use and disclose my healthcare information to:

Individual/Facility/Provider Name: _____

Self: _____ (place check mark here)

Phone: _____

Address: _____

This authorization shall be in force and effect until _____(date), at which time this authorization expires.

This authorization for release of information covers the period of healthcare from

_____ to _____ or ____ all past, present and future periods

You must initial each of the following individually for the information to be released:

_____ HIV/AIDS _____ Mental HealthRecords

_____ Drug/alcohol diagnosis and treatment. _____ Genetic Testing

Federal Regulation requires a description of how much information and what kind of information

you would like disclosed: _____

I understand that I have the right to the following:

- Revoke this authorization by sending written notice to this office. I understand that a revocation is not effective to the extend that any person or entity has already acted in reliance of my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and insurer has a legal right to contest a claim
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization and a a result of authorization
- Inspect a copy of Patient Health Information being used or disclosed under Federal Law
- Refuse to sign this authorization
- Receive a copy of this authorization
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on wether I sign this authorization
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law

_____ _____

Signature of patient or personal representative **Date**

_____

Printed name of personal representative