

Theresa Martez, ND, LMT  
Sudikshya Baskota, ND  
Stacy Bowker, ND  
Jennifer Read, ND, LAc



Rebekah Oldenkamp, ND  
Charleen VanHorn, Lac  
Theresa Free, FNP  
Nitin Thapa, ND

110 Cedar Avenue, Suite 101, Snohomish, WA 98290 Phone: 360-282-4014 Fax: 360-282-4017

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### Acknowledgement of Receipt:

### Notice of Privacy Practices:

- I have been offered a copy of the Notice of Privacy Practices for the Practitioner that I am seeing. For future reference, I may access a copy at the front desk or on the website.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

### Acknowledgement of Confidentiality:

- **Voicemail (please check one circle):**

I hereby give permission for Cedar Avenue Integrative Medicine to leave the following on my voicemail:

- Detailed medical information
- Limited medical information (please specify with your provider)
- Billing and appointment information

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

- **I allow and authorize the following people to discuss and participate in my medical care (participate in visits and treatment plans):**

\_\_\_\_\_, Relationship: \_\_\_\_\_

\_\_\_\_\_, Relationship: \_\_\_\_\_

- **Email (please check one circle):**

I hereby give permission for Cedar Avenue Integrative Medicine to leave the following on my email:

- Detailed medical information
- Limited medical information (please specify with your provider)
- Billing and appointment information

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

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