Welcome

Dr. Matthew Zorn, N.D.
1235 SE Division, Suite 205
Portland, OR 97202
(503) 449-4179

Please Print

Patient Information

Name ____ Date ___________
Date of Birth _____________________
Street Address____
City ___________________________ State ______________________ Zip _______

Home Phone ________________________ Cell Phone ________________________
Employer ___________________________ Business Phone ____________________
Email Address____
Sex: □ Male □ Female Height_____________ Weight ________________

Are you □ Married □ Single □ Domestic Partnership □ Divorced
□ Separated □ Widowed
Spouses Name: ___________________________ # of Children ___________________
Emergency Contact Name __________________________ Relationship _____________
Contact Phone __________________________

Do you have any special needs? ____

What are your health concerns? ____
____
____
____
____
____

Who is your primary care provider? ____
____
Please list any allergies you may have ____
____
Please list any medications you are currently taking ______________________________
____
____
Please list any supplements you are currently taking ______________________________
____
____

Personal History

As a child, did you have any of the following diseases?

□ Scarlet fever □ Rheumatic fever □ Diphtheria □ Mumps □ Measles □ German measles
□ Other ____

List hospitalizations and surgeries you have had with corresponding dates.
____
____
____

Have you ever been in an auto accident? ____________ When? ___________________

List other injuries including falls and other traumas and when they occurred:
____
____
____

Have you been diagnosed with any diseases or disorders and when? _________________
____
____

List immunizations you received ____
____

Pregnant or pregnancy plans?____

Review of Symptoms

Weight _______ Weight 1 yr. ago _______ Max. Weight ______ When ______

Y= a condition you have now N= never had P= a condition you have had in past

Symptom		Symptom	
Fatigue	Y P N	Head Injury	Y P N
Weakness	Y P N	Impaired Vision	Y P N
Skin Rashes	Y P N	Corrected Vision	Y P N
Eczema	Y P N	Eye Pain	Y P N
Hives	Y P N	Tearing/Dryness	Y P N
Acne	Y P N	Double Vision	Y P N
Itching	Y P N	Glaucoma	Y P N
Color Change	Y P N	Cataracts	Y P N
Lumps	Y P N	Constipation	Y P N
Night Sweats	Y P N	Liver Disease	Y P N
Headaches	Y P N	Eye Floaters	Y P N
Frequent Colds	Y P N	Impaired Hearing	Y P N
Sinusitis	Y P N	Ear Ringing	Y P N

Condition		Condition	
Postnasal Drip	Y P N	Earaches	Y P N
Dizziness	Y P N	Pain on Urination	Y P N
Nose Bleeds	Y P N	Urinary Frequency	Y P N
Sore Mouth/Gums	Y P N	Inability to Hold Urine	Y P N
Hoarseness	Y P N	Gall Bladder Disease	Y P N
Cavities	Y P N	Blood in Urine	Y P N
Change in Taste	Y P N	Joint Pain/Stiffness	Y P N
Goiter	Y P N	Angina	Y P N
Neck Pain	Y P N	High Blood Pressure	Y P N
Cough	Y P N	Heart Murmur	Y P N
Sputum	Y P N	Palpitations	Y P N
Spit up Blood	Y P N	Edema	Y P N
Wheezing	Y P N	Difficulty Swallowing	Y P N
Asthma	Y P N	Heartburn	Y P N
Bronchitis	Y P N	Change in Thirst/Appetite	Y P N
Pneumonia	Y P N	Nausea	Y P N
Pleurisy	Y P N	Vomiting	Y P N
Emphysema	Y P N	Diarrhea	Y P N
Difficulty Breathing	Y P N	Change in Bowel Movements	Y P N
Shortness of Breath	Y P N	Blood in Stool	Y P N
Tuberculosis	Y P N	Gas/Bloating	Y P N
Heart Disease	Y P N	Broken Bones	Y P N
Jaundice	Y P N	Muscle Spasms	Y P N
Indigestion	Y P N	Deep Leg Pain	Y P N
Hemorrhoids	Y P N	Cold Hands and Feet	Y P N
Abdominal Pain	Y P N	Varicose Veins	Y P N
Anal Discomfort	Y P N	Mood Swings	Y P N
Peptic Ulcer	Y P N	Eating Disorder	Y P N
Kidney Disease	Y P N	Memory Loss	Y P N
Frequent Kidney Infection	Y P N	Drug/Alcohol Abuse	Y P N
Kidney Stones	Y P N	Difficulty Sleeping	Y P N
Arthritis	Y P N	Phobia	Y P N
Thrombophlebitis	Y P N	Blue/Blanched Skin	Y P N
Coordination Difficulties	Y P N	Fainting	Y P N
Speech Difficulties	Y P N	Seizures	Y P N
Excessive Thirst	Y P N	Paralysis	Y P N
Excessive Hunger	Y P N	Muscle Weakness	Y P N
Blood Sugar Dysregulation	Y P N	Numbness/Tingling	Y P N
Anemia	Y P N	Anxiety	Y P N
Easy Bleeding	Y P N	Thyroid Problem	Y P N
Blood Transfusion	Y P N	Temperature Intolerance	Y P N
Depression	Y P N		

Females			
Age menses began	________	Number of miscarriages	________
Age menses ended	________	Number of abortions	________
Average cycle length	________	Vaginal Dryness	Y P N
Average bleeding length	________	Vaginal Discharge/Sores	Y P N
Spotting	Y P N	Number of pregnancies	________
Irregular Cycles	Y P N	Number of live births	________
Pain with Intercourse	Y P N	Menopausal Symptoms	Y P N
Painful Menses	Y P N	**Males**	
Birth Control	Y P N	Hernias	Y P N
Sexual Difficulties	Y P N	Testicular Masses	Y P N
Breast Lumps	Y P N	Testicular Pain	Y P N
Breast Pain	Y P N	Sexual Difficulties	Y P N
Nipple Discharge	Y P N	STD	Y P N
STD	Y P N	Penile Discharge/Sores	Y P N
PMS Symptoms	Y P N	Prostate Disease	Y P N

Are there any additional health concerns or questions you have?

____

____

____

Instructions for Homeopathic Intake Form

Please answer the questions on the following pages as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your problem or main complaint, however, each one may help determine which homeopathic remedy is best suited for you. **All information in this questionnaire is kept confidential.**

The questionnaire is designed to be user friendly. You can answer many of the questions by placing a circle around the appropriate number. For example:

Which weather conditions are you most troubled by?
Circling a number closer to the clear end means that you are more troubled by clear weather.
Circling a number closer to the cloudy end means that you are troubled by cloudy weather.

Cloudy Clear
1 2 3 4 5 6 7 8 9 10

Some questions will ask you to rate how much you are troubled by a single particular symptom or how much of this quality characterizes you in general. Circling number “1” means that you are troubled very little while marking “10” means that you are troubled a lot. For example:

Do you worry about any of the following?

Circling closer to “10” means that you worry about your health a lot. Circling closer to “1” means that you do not worry about your health.

1 2 3 4 5 6 7 8 9 10 Health

Some questions ask you to circle the answer you think best fits you. For example:

What are your feelings toward disease?

Optimistic
Doubtful of Recovery
Fearful
Despair of Recovery

Name:______________________________

Date:_________________

The following general symptoms pertain to you as a whole person.

Which weather conditions are you most troubled by?

Cloudy — Clear
1 2 3 4 5 6 7 89 10

Wet — Dry
1 2 3 4 5 6 7 8 9 10

Damp cold — Snow (Dry Cold)
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Storms

1 2 3 4 5 6 7 8 9 10 Wind

1 2 3 4 5 6 7 8 9 10 Fog

1 2 3 4 5 6 7 8 9 10 Hot Sun

Circle which seasons cause you the most trouble?

Winter Spring
Fall Summer

Are you worse being in the:

Mountains — At the seashore
1 2 3 4 5 6 7 8 9 10

Are you generally sensitive to and/or troubled by:

1 2 3 4 5 6 7 8 9 10 Bright Light

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Open Air

1 2 3 4 5 6 7 8 9 10 Stuffy Rooms

1 2 3 4 5 6 7 8 9 10 Tight Clothing

1 2 3 4 5 6 7 8 9 10 Noise

1 2 3 4 5 6 7 8 9 10 Odors

1 2 3 4 5 6 7 8 9 10 Drafts

Are you generally chilly or warm?

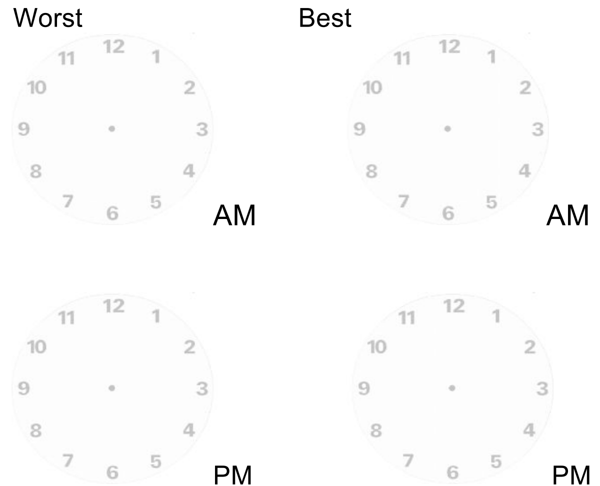
Chilly — Warm
1 2 3 4 5 6 7 8 9 10

Which are you generally most sensitive to, warm or cold?

Cold — Warm
1 2 3 4 5 6 7 8 9 10

What times of day are you generally worst (mood, energy, symptoms, etc.) What times are you best?

Worst Best



Symptoms during sleep. Circle which you have.

Tooth Grinding
Restlessness
Talking
Perspiration
Frequent Urination
Excess Heat or Cold
Laughing
Snoring
Nightmares
Recurring Dreams
Sleepwalking

Circle what you prefer. Do you sleep:

Without Covers
Partly Covered
Fully Covered (Not including Head)
Fully Covered (Including Head)
With Arms or Legs Out of the Covers
Without Clothing
With a Fan or Air Blowing on You
With the Window open

What position do you sleep in most often?

Right Side On Back
Left Side On Abdomen

How much do you perspire?

Never 1 2 3 4 5 6 7 8 9 10 All the Time

Do you have difficulty waking?

Never 1 2 3 4 5 6 7 8 9 10 All the Time

Do you wake unrefreshed?

Never 1 2 3 4 5 6 7 8 9 10 All the Time

Food Desires and Aversions:

In the following questions you are asked how much you desire or are averse to a particular food or taste. Please answer from the point of view of your natural desires, not your knowledge of nutrition. For example, you may never eat fatty meat because this is known to increase cholesterol, however you do love the taste of fat. Answer the question that you like fat. If you strongly desire or crave a food or taste, mark 10. If you detest a food or taste, mark 1.

Tastes:

1 2 3 4 5 6 7 8 9 10 Sweet

1 2 3 4 5 6 7 8 9 10 Sour

1 2 3 4 5 6 7 8 9 10 Salty

1 2 3 4 5 6 7 8 9 10 Bitter

1 2 3 4 5 6 7 8 9 10 Spicy (hot)

1 2 3 4 5 6 7 8 9 10 Smoked

1 2 3 4 5 6 7 8 9 10 Juicy

1 2 3 4 5 6 7 8 9 10 Refreshing

1 2 3 4 5 6 7 8 9 10 Pungent

Foods:

1 2 3 4 5 6 7 8 9 10 Alcohol

1 2 3 4 5 6 7 8 9 10 Apples

1 2 3 4 5 6 7 8 9 10 Bacon

1 2 3 4 5 6 7 8 9 10 Bread alone

1 2 3 4 5 6 7 8 9 10 Bread with butter

1 2 3 4 5 6 7 8 9 10 Butter alone

1 2 3 4 5 6 7 8 9 10 Cheese

1 2 3 4 5 6 7 8 9 10 Chocolate

1 2 3 4 5 6 7 8 9 10 Coffee

1 2 3 4 5 6 7 8 9 10 Pastries

1 2 3 4 5 6 7 8 9 10 Eggs

1 2 3 4 5 6 7 8 9 10 Fat (meat, chicken, pork, etc.)

1 2 3 4 5 6 7 8 9 10 Fish

1 2 3 4 5 6 7 8 9 10 Fruit

1 2 3 4 5 6 7 8 9 10 Fruit (sour)

1 2 3 4 5 6 7 8 9 10 Grain products (pasta, bread, cereal, etc.)

1 2 3 4 5 6 7 8 9 10 Ham

1 2 3 4 5 6 7 8 9 10 Ice

1 2 3 4 5 6 7 8 9 10 Ice cream

1 2 3 4 5 6 7 8 9 10 Indigestible things (chalk, clay, paper, etc.)

1 2 3 4 5 6 7 8 9 10 Lemonade

1 2 3 4 5 6 7 8 9 10 Meat

1 2 3 4 5 6 7 8 9 10 Milk

1 2 3 4 5 6 7 8 9 10 Nut butters

1 2 3 4 5 6 7 8 9 10 Oysters

1 2 3 4 5 6 7 8 9 10 Pickles

1 2 3 4 5 6 7 8 9 10 Vegetables

1 2 3 4 5 6 7 8 9 10 Vinegar

Temperature of food. Which do you prefer?

Warm Food 1 2 3 4 5 6 7 8 9 10 Cold Food

Warm Drinks 1 2 3 4 5 6 7 8 9 10 Cold Drinks

Do you notice any specific tastes in your mouth (e.g., metallic, bitter, foul, etc.)?

How thirsty are you generally?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

Mental and Emotional State:

How strong in general are the following emotional symptoms? The most mark 10. The least mark 1.

1 2 3 4 5 6 7 8 9 10 Anxiety (worry and fear)

Do you worry about any of the following? 10 means the most, 1 the least.

1 2 3 4 5 6 7 8 9 10 Creative Activities

1 2 3 4 5 6 7 8 9 10 Emotions

1 2 3 4 5 6 7 8 9 10 Financial Security

1 2 3 4 5 6 7 8 9 10 Health

1 2 3 4 5 6 7 8 9 10 Mental Functioning

1 2 3 4 5 6 7 8 9 10 Morals/past Indiscretions

1 2 3 4 5 6 7 8 9 10 Others (family and close friends) well being

1 2 3 4 5 6 7 8 9 10 Religion

1 2 3 4 5 6 7 8 9 10 Social Life

1 2 3 4 5 6 7 8 9 10 Social Position

1 2 3 4 5 6 7 8 9 10 The Future

1 2 3 4 5 6 7 8 9 10 Work

1 2 3 4 5 6 7 8 9 10 Irresolution (Not being able to decide or stick to a decision)

1 2 3 4 5 6 7 8 9 10 Capriciousness (Willfulness, changeable and erratic desires that are difficult to satisfy)

1 2 3 4 5 6 7 8 9 10 Selfishness

Frightened Easily 1 2 3 4 5 6 7 8 9 10 Never Afraid

Answer as honestly as you can about your personality traits.

Stingy 1 2 3 4 5 6 7 8 9 10 Overly generous

Thrifty 1 2 3 4 5 6 7 8 9 10 Extravagant

Hurried, impatient 1 2 3 4 5 6 7 8 9 10 Slow

Messy 1 2 3 4 5 6 7 8 9 10 Fastidious

Calm 1 2 3 4 5 6 7 8 9 10 Restlessness

Indolence (Lazy) 1 2 3 4 5 6 7 8 9 10 Always busy

Shyness/Timid/Bashful 1 2 3 4 5 6 7 8 9 10 Outgoing

Anger 1 2 3 4 5 6 7 8 9 10 Mildness

Lack of moral sense 1 2 3 4 5 6 7 8 9 10 Guilty

No Religious feeling 1 2 3 4 5 6 7 8 9 10 Highly Religious Feeling

Obstinate (stubborn) 1 2 3 4 5 6 7 8 9 10 Yielding

Heedless/Reckless 1 2 3 4 5 6 7 8 9 10 Cowardice

Social/Antisocial. In regard to being with other people or in company?

Aversion 1 2 3 4 5 6 7 8 9 10 Desire for

Circle the expression that best describes your feelings about the following issues.

Significant past emotionally traumatic events:

Resolved Grief
Dwells on Past
Inconsolable
Remorse
Guilt

Feeling towards people close to you:

Loving
Affectionate
Indifferent
Resentment
Hatred

Feeling toward disease/condition:

Optimistic
Doubtful of recovery
Discouraged
Fearful
Despair of recovery

Feeling toward life

Love life
Indifferent
Bored
Weary of life
Loathing of life
Desires death
Suicidal thoughts
Suicidal disposition

Feeling toward spouse/lover:

Loving
Affectionate
Dissatisfaction
Disappointed
Indifferent
Resentment
Hatred

How much do you have the following symptoms? 10 a lot, 1 hardly ever.

1 2 3 4 5 6 7 8 9 10 Irritability

1 2 3 4 5 6 7 8 9 10 Jealousy

1 2 3 4 5 6 7 8 9 10 Mood

Alternating Moods — Even Moods
1 2 3 4 5 6 7 8 9 10

Circle which best expresses your general mood.

Morose
Sad
Apathy/Indifferent
Excitement
Exhilaration

How do you experience sympathy or consolation?

Like — Dislike
1 2 3 4 5 6 7 8 9 10

Better from — Worse from
1 2 3 4 5 6 7 8 9 10

How talkative are you in general?

Aversion to talking — Talkative
1 2 3 4 5 6 7 8 9 10

Not trusting — Trusting
1 2 3 4 5 6 7 8 9 10

Gullible — Suspicious
1 2 3 4 5 6 7 8 9 10

How often and easily do you weep?

Never — Often
1 2 3 4 5 6 7 8 9 10

How often do you experience clairvoyance?

Never — Often
1 2 3 4 5 6 7 8 9 10

How is your level of self-confidence?

Lack of confidence — Pride/Haughty
1 2 3 4 5 6 7 8 9 10

How impulsive are you?

Never — Often
1 2 3 4 5 6 7 8 9 10

How afraid are you of the following? 1, never. 10, very afraid.

1 2 3 4 5 6 7 8 9 10 Animals

1 2 3 4 5 6 7 8 9 10 Being alone

1 2 3 4 5 6 7 8 9 10 Death

1 2 3 4 5 6 7 8 9 10 Relative's Death

1 2 3 4 5 6 7 8 9 10 Impending Disease

1 2 3 4 5 6 7 8 9 10 Downward Motion

1 2 3 4 5 6 7 8 9 10 Evil

1 2 3 4 5 6 7 8 9 10 Failure

1 2 3 4 5 6 7 8 9 10 Falling

1 2 3 4 5 6 7 8 9 10 Ghosts

1 2 3 4 5 6 7 8 9 10 Heights

1 2 3 4 5 6 7 8 9 10 Insanity

1 2 3 4 5 6 7 8 9 10 Misfortune (bad luck)

1 2 3 4 5 6 7 8 9 10 Of a Crowd

1 2 3 4 5 6 7 8 9 10 People

1 2 3 4 5 6 7 8 9 10 Robbers/ Intruders

1 2 3 4 5 6 7 8 9 10 Snakes

1 2 3 4 5 6 7 8 9 10 Spiders

1 2 3 4 5 6 7 8 9 10 Strangers

1 2 3 4 5 6 7 8 9 10 Having a Stroke

1 2 3 4 5 6 7 8 9 10 That something will happen

1 2 3 4 5 6 7 8 9 10 Darkness

1 2 3 4 5 6 7 8 9 10 Thunderstorms

1 2 3 4 5 6 7 8 9 10 Water

1 2 3 4 5 6 7 8 9 10 Wind

Are you forgetful of any of the following?
(1 not at all, 10 a lot)

1 2 3 4 5 6 7 8 9 10 Dates

1 2 3 4 5 6 7 8 9 10 Names

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Of what someone else just said to you

1 2 3 4 5 6 7 8 9 10 Of what you just said

1 2 3 4 5 6 7 8 9 10 Of words

How often do you make mistakes with the following?

1 2 3 4 5 6 7 8 9 10 Numbers

1 2 3 4 5 6 7 8 9 10 Words (reading)

1 2 3 4 5 6 7 8 9 10 Words (speaking)

1 2 3 4 5 6 7 8 9 10 Words (writing)

How sensitive are you to any of the following?

1 2 3 4 5 6 7 8 9 10 Beauty

1 2 3 4 5 6 7 8 9 10 Criticism

1 2 3 4 5 6 7 8 9 10 Cruel Stories

1 2 3 4 5 6 7 8 9 10 Frightening things

1 2 3 4 5 6 7 8 9 10 Being made fun of

1 2 3 4 5 6 7 8 9 10 Music

1 2 3 4 5 6 7 8 9 10 Reprimand

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 The suffering of others

How do you handle conflict usually?

Quarrelsome Yielding
1 2 3 4 5 6 7 8 9 10

How are you in regard to authority?

Bossy/Dictatorial Yielding/Fawning
1 2 3 4 5 6 7 8 9 10

How critical are you of others?

Not at All — All the Time
1 2 3 4 5 6 7 8 9 10

How critical are you of yourself?

Not at All — All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach (find fault, scold, or blame) others?

Not at All — All the Time
1 2 3 4 5 6 7 8 9 10

How often do you reproach yourself?

Not at All — All the Time
1 2 3 4 5 6 7 8 9 10

How honest are you?

Always Lie — Always honest
1 2 3 4 5 6 7 8 9 10

How often do you have the following behaviors?

1 2 3 4 5 6 7 8 9 10 Abusive

1 2 3 4 5 6 7 8 9 10 Biting

1 2 3 4 5 6 7 8 9 10 Breaks Things

1 2 3 4 5 6 7 8 9 10 Contrary (Opposite to what is logically expected)

1 2 3 4 5 6 7 8 9 10 Cursing

1 2 3 4 5 6 7 8 9 10 Disobedience

1 2 3 4 5 6 7 8 9 10 Insolent (insult, boldly rude)

1 2 3 4 5 6 7 8 9 10 Rage

1 2 3 4 5 6 7 8 9 10 Rudeness

1 2 3 4 5 6 7 8 9 10 Striking others

1 2 3 4 5 6 7 8 9 10 Striking self

1 2 3 4 5 6 7 8 9 10 Violence

Please circle the best approximation of your sexual desire. Please circle the level of your desire and not your actual frequency.

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

How often do you actually have sex?

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

How often do you masturbate?

Never
1x/year
1x/3 mo.
1x/mo.
2x/mo.
1x/wk.
2x/wk.
4x/wk.
1x/day
2x/day
4x/day

What worries or concerns do you have about your sexual life?

Not enough desire — Too much desire
1 2 3 4 5 6 7 8 9 10

Not enough sex — Too much sex
1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10 Lack of enjoyment

1 2 3 4 5 6 7 8 9 10 Difficulty reaching orgasm

1 2 3 4 5 6 7 8 9 10	Impotence
1 2 3 4 5 6 7 8 9 10	Troubling fantasies or thoughts
1 2 3 4 5 6 7 8 9 10	Sexual confidence
1 2 3 4 5 6 7 8 9 10	Unusual sexual practices or desires

Dr. Matthew Zorn Informed Consent for Treatment

I, ___________________________________, hereby authorize Dr. ______________________________ to use the following to facilitate my diagnosis and treatment:
Common diagnostic procedures: (ex. blood draw, laboratory)
Use of nutrition: (Therapeutic nutrition, nutritional supplements and intramuscular vitamin injections)
Homeopathic Medicines: (Homeopathically prepared substances given orally)
Botanical medicine: (Teas, alcohol and glycerin extracts, solid extracts, capsules, tablets, creams,
ointments and suppositories)
Prescription medications: (Antivirals, antibiotics, antifungal, hormonal, or other prescription medications)
Physical medicine: (Massage therapy, muscle energy stretching, trigger point release, manipulation,
hydrotherapy, or similar hands-on therapies)
Lifestyle counseling and hygiene: (Diet therapy, promotion of wellness including recommendations for exercise, sleep and stress.)

I recognize the potential risks and benefits of these procedures as described below:
Potential benefits: Restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
Potential risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipunctures or procedures, tenderness/soreness or bruising from physical treatments.
Notice to all pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy.

Welcome

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 myself, my representative, or unless law requires. I understand that I may look at my medical record and can request a copy of my record by my paying the appropriate fee. I understand that my medical record will be kept no more than ten years after the date of my last treatment. I understand that the doctor will answer any questions that I might have.

With this knowledge, I voluntarily consent to the above procedures. I realize that neither the doctor nor any personnel has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition by signing this agreement.

Print Name____

Signature____ Date______________

Signature of Patient Representative or Guardian__________________________________

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Matthew Zorn. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Matthew Zorn reserves the right to change the privacy practices that are describes in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. (*Please circle*)

ANY MEMBER OF THE IMMEDIATE FAMILY Y / N

____

SPOUSE: Y / N

____

OTHER (please Specify) Y / N

____

Name of Patient or Personal Representative ____

Signature of Patient or Personal Representative ____

Statement of Privacy Practices - Dr. Matthew Zorn

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and the state of Washington. This personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality care, implement payment activities, conduct normal practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, ECT. Dr. Matthew Zorn retains full ownership of all documentation collected, and reserves the right to duplicate it for treatment purposes. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail/answering machine messages, postcards, newsletters and special events.

Patient Rights

You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for used other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Name of Patient or Personal Representative ____

Signature of Patient or Personal Representative ____________________________________