

David A. Tucker, MSAOM, L.Ac, L.M.P.

4500 9th Ave NE, Suite 300

Seattle, WA 98105

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by David A. Tucker, L.Ac., L.M.P. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by David A. Tucker, L.Ac., L.M.P. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. David A. Tucker, L.Ac., L.M.P. is not required to agree to the restrictions that I may request. However, if he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time except to the extent that David A. Tucker, L.Ac., L.M.P. has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review David A. Tucker, L.Ac., L.M.P. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations under David A. Tucker, L.Ac., L.M.P. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and David A. Tucker, L.Ac., L.M.P. with respect to my identifiable health information.

David A. Tucker, L.Ac., L.M.P. reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

Signature of Patient or Authorized Representative

Date

Printed Name and Relationship



David A. Tucker, MSAOM, L.Ac, LMP

4500 9th Ave NE, Suite 300

Seattle, WA 98105

-PATIENT CONFIDENTIAL INFORMATION

1. Name First Middle Last
2. Address Street City State Zip
3. Home Phone: _____ 4. Business Phone: _____
Cell Phone: _____ Extension: _____
5. Fax Number: _____ 6. Email: _____
7. Age 8. Date of Birth 9. Sex 10. Marital: M S D W
11. Occupation 12. Employer _____

Employer's Address _____
Street City State Zip

BRIEF CASE HISTORY

13. Chief Complaint _____
14. Complaint result of: Auto Accident Injury Job Related Other
15. Date of accident/Injury/Other / /
16. Have you seen any other doctor about this condition? If yes, when? _____
17. Spouse's name _____ Occupation _____
Employer Address Phone _____
18. Nearest relative not living with you _____
Address _____ Phone _____
Street City State Zip
19. In an emergency, call: Name Street City Phone
FOR FEMALES: Are you pregnant? IF YES, HOW LONG? _____
FOR MINORS: List both parents' names and addresses _____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? Cash Check Credit Card Health Insurance

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED _____ PATIENT'S SIGNATURE _____
(parent's signature if patient is minor)

Referred by _____

The Zen of Healing
David A. Tucker, L.Ac., L.M.P. - Informed Consent
4500 9th Ave NE, Suite 300
Seattle, WA 98105

I, the undersigned, hereby authorize David A. Tucker to perform the following procedures:

- **Acupuncture:** The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
- **Moxibustion:** The direct or indirect warming of specific points using the herb mugwort (*artemesia vulgaris*)
- **Chinese Herbs:** Recommendation of patent, granular, and/or loose herbs from the Chinese Materia Medica
- **Electroacupuncture:** Using very small amounts of electricity to stimulate specific acupuncture points.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Liniments, Oils, Plasters:** Herbal formulas applied topically to the skin.
- **Dietary Advice:** Suggestions for nutrition and herbal food products.

I recognize the potential benefits and risks of these procedures, including but not limited to:

Potential Benefits: Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.

Potential Risks: Discomfort, pain, bruising, burning, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment.

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment.

Financial Terms - Payment is expected following treatment. Treatment fees are as follows unless otherwise arranged: Acupuncture - \$200 for the first visit and then \$100 thereafter, Massage - \$90 for an hour and \$125 for an hour and a half. The treatment fees do not include the cost of herbs or supplements. Please make your payment in full using either check or cash after the treatment. If you are unable to keep an appointment, please notify me at least 24 hours before the scheduled date or it will be necessary to pay the full appointment fee.

With this knowledge, I voluntarily consent to the above procedures and financial terms, realizing that no guarantees have been given to me by David A. Tucker regarding cure or improvement of my condition. I hereby release David A. Tucker from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Signature of patient (or guardian if under 18)

Date

David A. Tucker received his Master's Degree in Acupuncture and Oriental Medicine from Bastyr University in 2005. He has passed the National Board Examination for Oriental Medicine administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and is designated a Diplomate of Oriental Medicine. He is a Licensed Acupuncturist in the State of Washington, holding Acupuncture License number AC2826, active from 2005. David received his massage training from the Brenneke School of Massage and has passed the National Certification Exam through the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB). He is a Licensed Massage Practitioner in the State of Washington, holding Massage License number MA19464, active from 2003.

David A. Tucker, L.Ac., L.M.P. Patient Health History

Name: _____
(first) (middle) (last)

Date: ____/____/____

Date of Birth: ____/____/____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete picture of the patient. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? For what reason?

2. Please identify the health concerns that have brought you here, in order of importance below:

Condition

Past Treatment

a. _____

b. _____

c. _____

d. _____

3. Please list other clinicians or practitioners you are currently under the care of:

Name

Modality (i.e. MD, ND, Chiropractor, Counselor, etc.)

Contact

a. _____

b. _____

c. _____

d. _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

| Name | Dose/Frequency | Reason | Name | Dose/Frequency | Reason |
|------|----------------|--------|------|----------------|--------|
|------|----------------|--------|------|----------------|--------|

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | | |
|--------------------------------|---------------|---------------|-----------------|----------------|---------------|-----------------|
| 6. Family History: | <u>Father</u> | <u>Mother</u> | <u>Brothers</u> | <u>Sisters</u> | <u>Spouse</u> | <u>Children</u> |
| <u>Check those applicable:</u> | | | | | | |
| Age (if living) | _____ | _____ | _____ | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ | _____ | _____ |
| Mental Illness | _____ | _____ | _____ | _____ | _____ | _____ |
| Asthma/Hay fever/Hives | _____ | _____ | _____ | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Age (at death) | _____ | _____ | _____ | _____ | _____ | _____ |
| Cause of Death | _____ | _____ | _____ | _____ | _____ | _____ |

7. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

8. **Blood Pressure:** What is your most recent blood pressure reading? _____ / _____ When was this reading taken? _____

9. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

10. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

11. **History of Traumas:** _____

12. **Hospitalizations and Surgeries:**

| | | | |
|---------------|-------------|---------------|-------------|
| <u>Reason</u> | <u>When</u> | <u>Reason</u> | <u>When</u> |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

| | | | |
|---------------|-------------|---------------|-------------|
| <u>Reason</u> | <u>When</u> | <u>Reason</u> | <u>When</u> |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

14. Do you have any reason to believe that you are pregnant? Y N If so, how far along are you? _____

Review of Body Systems

15. Skin (check all that apply)

| | Current | Past | Notes (office use) |
|--------------------|--------------------------|--------------------------|--------------------|
| Acne | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bruising | <input type="checkbox"/> | <input type="checkbox"/> | |
| Eczema | <input type="checkbox"/> | <input type="checkbox"/> | |
| Itching/Dryness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hives | <input type="checkbox"/> | <input type="checkbox"/> | |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | |
| Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Rashes | <input type="checkbox"/> | <input type="checkbox"/> | |
| Skin Changes | <input type="checkbox"/> | <input type="checkbox"/> | |
| Excessive Sweating | <input type="checkbox"/> | <input type="checkbox"/> | |
| Night Sweating | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hair/Nail Changes | <input type="checkbox"/> | <input type="checkbox"/> | |

16. Head, Eye, Ear, Nose, and Throat (check all that apply)

| | Current | Past | Notes (office use) |
|----------------------------|--------------------------|--------------------------|--------------------|
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | |
| TMJ/Jaw Problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Teeth Grinding | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blurry Vision | <input type="checkbox"/> | <input type="checkbox"/> | |
| Glasses/Contacts | <input type="checkbox"/> | <input type="checkbox"/> | |
| Floater in field of vision | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tearing/Dryness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Eye Pain/Strain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | |
| Earaches | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ear Ringing | <input type="checkbox"/> | <input type="checkbox"/> | |
| Impaired Hearing | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nose Bleeds | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequent sore throats | <input type="checkbox"/> | <input type="checkbox"/> | |

17. Blood, Lymphatic, Cancer, HIV (check all that apply)

| | Current | Past | Notes (office use) |
|----------------------|--------------------------|--------------------------|--------------------|
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | |
| Bleeding Easily | <input type="checkbox"/> | <input type="checkbox"/> | |
| Enlarged lymph nodes | <input type="checkbox"/> | <input type="checkbox"/> | |
| Transfusions | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | |
| HIV or AIDS | <input type="checkbox"/> | <input type="checkbox"/> | |

18. Musculoskeletal (check all that apply)

| | Current | Past | Notes (office use) |
|--------------------------|--------------------------|--------------------------|--------------------|
| Arm or Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthritis - Rheumatoid | <input type="checkbox"/> | <input type="checkbox"/> | |
| Arthritis - Osteo | <input type="checkbox"/> | <input type="checkbox"/> | |
| Back Pain (circle below) | | | |
| Upper | <input type="checkbox"/> | <input type="checkbox"/> | |
| Middle | | | |
| Lower | | | |
| Joint Pain Where? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Leg or Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Muscle Spasm/Cramp | <input type="checkbox"/> | <input type="checkbox"/> | |
| Neck/Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> | |

19. Neurological (check all that apply)

| | Current | Past | Notes (office use) |
|-------------------|--------------------------|--------------------------|--------------------|
| Loss of Balance | <input type="checkbox"/> | <input type="checkbox"/> | |
| Numbness/Tingling | <input type="checkbox"/> | <input type="checkbox"/> | |
| Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seizures/Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | |
| Vertigo/Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | |

20. Cardiovascular (check all that apply)

| | Current | Past | Notes (office use) |
|-------------------------|--------------------------|--------------------------|--------------------|
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heart Murmurs | <input type="checkbox"/> | <input type="checkbox"/> | |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | |
| Palpitations/Fluttering | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | |
| Swelling of Ankles | <input type="checkbox"/> | <input type="checkbox"/> | |
| Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> | |

21. Respiratory (check all that apply)

| | Current | Past | Notes (office use) |
|----------------------|--------------------------|--------------------------|--------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | |
| Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> | |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequent Colds | <input type="checkbox"/> | <input type="checkbox"/> | |
| Persistent Cough | <input type="checkbox"/> | <input type="checkbox"/> | |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | |
| Other: | <input type="checkbox"/> | <input type="checkbox"/> | |

22. Gastrointestinal (check all that apply)

| | Current | Past | Notes (office use) |
|----------------------|--------------------------|--------------------------|--------------------|
| Acid Reflux | <input type="checkbox"/> | <input type="checkbox"/> | |
| Belching | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | |
| Changes in Appetite | <input type="checkbox"/> | <input type="checkbox"/> | |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> | |
| Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | |
| Stomach rumbling | <input type="checkbox"/> | <input type="checkbox"/> | |
| Epigastric Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Flank Pain | <input type="checkbox"/> | <input type="checkbox"/> | |
| Gall Bladder Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hepatitis B or C | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | |
| Passing Gas | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nausea/Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | |

23. Genito-Urinary Tract (check all that apply)

| | Current | Past | Notes (office use) |
|--------------------------|--------------------------|--------------------------|--------------------|
| Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequent Night Urination | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequent UTI | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heavy Flow | <input type="checkbox"/> | <input type="checkbox"/> | |
| Impaired Urination | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | |
| Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | |
| Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> | |

24. Endocrine (check all that apply)

| | Current | Past | Notes (office use) |
|---|--------------------------|--------------------------|--------------------|
| Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hyperthyroid | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | |
| Hypothyroid | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tendency to be more HOT or COLD <i>(please circle)</i> | | | |
| Preference for HOT or COLD <i>(please circle)</i> | | | |
| Aversion to HOT or COLD <i>(please circle)</i> | | | |

25. Female Reproductive/Breasts (check all that apply)

| | Current | Past | Notes (office use) |
|------------------------|--------------------------|--------------------------|--------------------|
| Bleeding btw. Cycles | <input type="checkbox"/> | <input type="checkbox"/> | |
| Clotting | <input type="checkbox"/> | <input type="checkbox"/> | |
| Heavy Flow | <input type="checkbox"/> | <input type="checkbox"/> | |
| Absence of Flow | <input type="checkbox"/> | <input type="checkbox"/> | |
| Spotting | <input type="checkbox"/> | <input type="checkbox"/> | |
| Irregular Cycles | <input type="checkbox"/> | <input type="checkbox"/> | |
| Painful Periods | <input type="checkbox"/> | <input type="checkbox"/> | |
| Premenstrual Problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Vaginal Discharge | <input type="checkbox"/> | <input type="checkbox"/> | |
| Menopausal Syndromes | <input type="checkbox"/> | <input type="checkbox"/> | |
| Difficulty Conceiving | <input type="checkbox"/> | <input type="checkbox"/> | |
| Breast Lump/Tenderness | <input type="checkbox"/> | <input type="checkbox"/> | |
| Nipple Discharge | <input type="checkbox"/> | <input type="checkbox"/> | |

26. Menstrual/Birthing History
(please fill in appropriate boxes)

| | | Notes (office use) |
|---------------------|--|--------------------|
| Age of First Menses | | |
| Length of Cycle | | |
| # of Days of Menses | | |
| # of Pregnancies | | |
| # of Live Births | | |
| # of Miscarriages | | |
| # of Abortions | | |

27. Male Reproductive (check all that apply)

| | Current | Past | Notes (office use) |
|--------------------------|--------------------------|--------------------------|--------------------|
| Penile Discharge | <input type="checkbox"/> | <input type="checkbox"/> | |
| Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> | |
| Erectile Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | |
| Testicular Pain/Swelling | <input type="checkbox"/> | <input type="checkbox"/> | |

28. Sexual History (check all that apply)

| | Current | Past | Notes (office use) |
|----------------------|--------------------------|--------------------------|--------------------|
| Problems with Libido | <input type="checkbox"/> | <input type="checkbox"/> | |
| Contraceptive Use | | | |
| Current: _____ | | | |
| Past: _____ | | | |
| History of STDs | | | |
| Current: _____ | | | |
| Past: _____ | | | |

Is there anything else we should know? _____

29. Lifestyle:

- a. Are you currently in a relationship? Y N
- b. Do you have any restrictions on your diet? Y N If so, please indicate? _____
- c. Do you have cravings for a particular food or flavor (i.e. sweet, salty, etc.)? _____
- d. Exercise routine: _____
- e. Spiritual practice: _____
- f. How many hours per night do you sleep? _____ What time do you go to bed? _____ Do you wake rested? Y N
- g. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
- h. Nicotine/Alcohol/Caffeine Use: _____
- i. Recreational Drug Use:
Current: _____ Past: (include when? for how long?) _____
- j. How many glasses (8oz.) of each do you drink per day? Soda: _____ Juice: _____ Tea: _____ Water: _____
- k. Interests, hobbies: _____

Additional Notes (Office use)

David A. Tucker, MSAOM, L.Ac, LMP

4500 9th Ave NE, Suite 300
Seattle, WA 98105

Notice of Patient Privacy Policy

Dear Valued Patient,

This notice describes this office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from this office, I may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, I gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information that has collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

I value our relationship, and respect your right to privacy. If you have questions about these privacy guidelines, please call during regular business hours at 206-696-1121.

Yours truly,

David A. Tucker, MSAOM, L.Ac, LMP
4500 9th Ave NE, Suite 300
Seattle, WA 98105