

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

4425 Fremont Avenue North  
Seattle, WA 98103

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## -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. Social Security No \_\_\_\_\_ 12. Driver's License No \_\_\_\_\_

13. Occupation \_\_\_\_\_ 14. Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

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## BRIEF CASE HISTORY

16. Chief Complaint \_\_\_\_\_

17. Complaint result of:  Auto Accident  Injury  Job Related  Other

18. Date of accident/Injury/Other \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

19. Have you seen any other doctor about this condition? \_\_\_\_\_ If yes, when? \_\_\_\_\_

21. Spouse's name \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

22. Nearest relative not living with you \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Phone \_\_\_\_\_

23. In case of emergency, call \_\_\_\_\_  
Name Street City Phone

FOR FEMALES: Are you pregnant? \_\_\_\_\_ IF YES, HOW LONG? \_\_\_\_\_

FOR MINORS: List both parents' names and addresses  
\_\_\_\_\_  
\_\_\_\_\_

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## FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one)  Cash  Check

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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.

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

Referred by \_\_\_\_\_

**David A. Tucker, L.Ac., L.M.P. - Informed Consent**

4425 Fremont Avenue North

Seattle, WA 98103

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.
- **Use of an Audio Recording Device:** In aiding a proper diagnosis, it can be helpful to have an audio recording of the intake process. This will not take place without first informing the patient prior to the intake.

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 - \$160 for the first visit and then \$85 thereafter, Massage - \$85 for an hour and \$120 for an hour and a half, Extended Appointment - acupuncture followed by 20-25 minutes of massage/acutonics/qi gong/meditation - \$120. 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
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<b>6. Family History:</b>	<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)	<input type="checkbox"/>	<input type="checkbox"/>	
Upper			
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 (please circle)			
Preference for HOT or COLD (please circle)			
Aversion to HOT or COLD (please circle)			

**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)

	Current	Past	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, L.Ac, LMP

4425 Fremont Avenue North  
Seattle, WA 98103

## 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 425-466-3037.

Yours truly,

David A. Tucker, L.Ac., L.M.P.  
4425 Fremont Avenue North  
Seattle, WA 98103

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

4425 Fremont Avenue North  
Seattle, WA 98103

## 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

