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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

- **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