CAPE CORAL ACUPUNCTURE

This clinic specializes in acupuncture and herbal care. We ask you to fill out this form for either consultation or examination purposes. Examinations are done routinely to determine the nature and extent of the problem. The acupuncturist will explain the level of examination

NAME____

ADDRESS____________________CITY______________________STATE_________________ZIPCODE________

PHONE_____________________________EMAIL____

BIRTHDATE______________________________MARITAL STATUS__________________________________

NO. OF CHILDREN___________________OCCUPATION____

EMPLOYER_____________________________________ REFERRED BY_____________________________

What is your primary concern_______________________________ Any other concerns?__________________

When was the first time you were aware of this condition?____________________________________

What type of service do you desire?
_____1) Temporary relief of symptoms/pain control
_____2) Eradication of tendencies causing condition
_____3) Balanced optimum health—elimination of root cause of problem, if possible
_____4) Maintenance care—regular balancing to keep in good health

Have you ever received treatment for this condition? ____Yes ____No
If so, where ____
By Whom: ____
What were the results of treatment?
Has the condition been getting___ better, ___ worse, or ___ staying the same?
Has this condition affected your___ home life, ___ work, ___ social life,___ ability to exercise, ___ rest, or ___ sleep?

How did this condition develop?_

Tendency to faint, tendency to bruise or discolor easily, tendency to bleed for a long time, hepatitis, AIDS, high blood pressure, heart problems, respiratory problems, treated by acupuncture before, presently using other therapies, past surgeries, taking medications, hungry at present time, exhausted at present time, nervous at present time.

Please note that occasionally some people experience minor bleeding or a tiny bruising from gently piercing the skin. This does not adversely affect your health; on the contrary, it can promote healing.

QUIET, PEACEFUL, HEALING

RANDEL B. WING AP, DOM, NMD

822 DEL PRADO BLVD. S., CAPE CORAL FLORIDA 33990 239-989-9892

PATIENT PROFILE

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms. Thus, it is essential to indicate time on the symptoms.
Indicate with one (x) check any condition that you sometimes experience; use two (xx) checks for those conditions that often occur; and three (xxx) checks for symptoms that are a major concern

WATER ELEMENT

Hearing Loss
Dizziness
Lower backache with
Neck pain
Sinus congestion
Edema
Under eye darkness
Emotional instability
Aversion to cold
Hair thinning or loss
Premature aging
Frequent urination
Kidney stones
Perspire very easily
Weakness of legs/knees
Asthmatic cough
Rapid weight change
Loose teeth
Reduced sexual energy
Thyroid problems
Diabetes

WOOD ELEMENT

Headaches
Migraines
Ringing in the ears
Poor eyesight
Dry eyes
Eczema
Shingles
Herpes simplex
Warts
Nervousness
Convulsions, spasms
Hemorrhoids
Hepatitis
Ulcer
Vomiting
Gallstones
Indecisive
Fullness below ribs
Shoulder/neck tension
Insomnia

FIRE ELEMENT

Dry scalp
Skin eruptions, rashes
Cysts, tumors
Ear infections
Sore throat, tonsillitis
Lymphatic swelling
Hot palms & soles
Heart palpitations
Aversion to heat
Bitter taste
Gum problems
Nose bleed
Facial redness
Itching/burning skin
Hot hands/feet
Thirst
Vivid dreaming
Dark urine
Night sweats

EARTH ELEMENT

Indigestion
Flatulence
Food Allergies
Diarrhea
Anemia
Halitosis
Mouth sores
Heartburn
Strong appetite
Weak appetite
Nausea
Abdominal bleeding
Low body weight

METAL ELEMENT

Bronchitis
Asthma
Shallow breathing
Cough
Sinus congestion
Nasal infections

OTHER

Fatigue
Arthralgia
Sciatica/nerve pain
Cold hands/feet
Tendonitis
Bursitis

PAIN & COMMENTS

____
____
____
____
____

Metabolic Assessment Form™

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ______________________

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

How many times do you eat raw nuts or seeds per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

List the three worst foods you eat during the average week: ____________ ____________ ____________

List the three healthiest foods you eat during the average week: ____________ ____________ ____________

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

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CAPE CORAL ACUPUNCTURE

MEDICAL HISTORY
Please list any significant illnesses, surgeries, or accidents.

Age 0-6:

Age 7 – 12:

Age 13 – 20
:
Age 21 – 30
:
Age 31 – 40
:
Age 41 to present

FOR MALE PATIENTS ONLY

Sexual Drive

Increased_____ Decreased_____ Impotent_____ Seminal Emission_____ Premature Ejaculation

Hernia_____ Prostate Problems_____ Infertility_____ Sterility

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CAPE CORAL ACUPUNCTURE CLINIC

WAIVER and ASSUMPTION of RISK--INFORMED CLIENT CONSENT

Randel B. Wing, AP, DOM, NMD is a Licensed Acupuncturists in the state of Colorado and Florida.
As such, he does not diagnose. Rather, Randel B. Wing supports lifestyle balance and health through Traditional Chinese Medicine and nutrition, which includes acupuncture, nutritional blood analysis and nutritional counseling.
It is important to note that the basic goal of dietary recommendations, supplementation and lifestyle change is to support nutritional balance and should not replace or interfere with your medical treatment prescribed by your physician. Nutritional strategies and Traditional Chinese Medicine are only one component of your overall healthcare plan. Blood analysis is recommended purely to make recommendations of herbs and dietary guidelines as allowed by the state of Florida.

I, ____ as the undersigned patient, understand that acupuncture treatment along with information provided on the relationship between nutrition, lifestyle factors and health is not meant to replace competent medical treatment for any health problem or condition. Health education and medical care are complementary and integrative when properly delivered. **I, therefore, voluntarily make and grant this Waiver and Assumption of Risk in favor of Randel B. Wing, DOM, PC of The Cape Coral Acupuncture Clinic (as Provider) in consideration for monies paid to the provider.** I am fully aware that any services offered with regards to acupuncture and nutritional counseling are considered holistic and alternative in nature and are not a medical practice. I have chosen to exercise my right, under the law to seek alternative and holistic advice. I choose to improve my health by assuming greater self-responsibility by reducing or eliminating unhealthy behaviors that are contrary to my well-being. Furthermore, I understand the advice and/or supplements have not been evaluated by the FDA and are not intended to diagnose, prevent, treat, cure or mitigate any disease or medical condition. I waive and release any and all claims whether in contract or in person from bodily injury, property damage, losses and/or death that may arise from aforementioned use of or receipt of acupuncture treatment or nutritional consultation. I understand and recognize there are certain risks, dangers and perils connected with such use of and/or receipt of. I acknowledge such dangers and perils have been fully explained to me and I fully understand, accept, assume and acknowledge after inquiry and investigation of extent, duration, and completeness which is wholly satisfactory and acceptable to me. I further agree to use my best judgment in undertaking these activities, use of and/or receipt of and to faithfully adhere to all safety instructions and recommendations, whether oral or written. I hereby certify that I am a competent adult assuming these risks of my own free will, being under no compulsion or duress.

This Waiver and Assumption of Risk is effective on the date signed below and may not be revoked, altered, amended, rescinded or voided without the express prior written consent of Provider. I understand that no services will be provided to me without my signature on this Waiver.

Patient Signature ____Date______________________

CAPE CORAL ACUPUNCTURE CLINIC

Financial POLICY / DISCLOSURE

Thank you for choosing us as a health care provider. We are committed to your treatment being successful. An understanding of our financial policy is a very important part of your care.

I understand that as a patient of this clinic I am ultimately responsible for any and all fees incurred as a result of treatment and services service.

For your convenience we accept cash, checks, Visa, MasterCard, American Express and Discover Card.

FEE SCHEDULE (Effective Jan. 2014)

Initial Consultation with Treatment....................... $125.00

Acupuncture Treatment (individual)..................... $ 75.00

Eight Treatments (pre-pay)………………………..… $500.00

Home Visit..$125.00

Eight Home Treatments (pre-pay)....................... $800.00

I have read and understand the **DISCLOSURE / FINANCIAL POLICY:**

Signature____Date___________________________

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CAPE CORAL ACUPUNCTURE CLINIC

DISCLOSURE

EDUCATION:
Randel B. Wing is a graduate of the UNIVERSITY OF WYOMING, holding a Bachelor of Science Degree in Chemistry and a graduate of the COLORADO SCHOOL OF TRADITIONAL CHINESE MEDICINE; a 2300 hour course in ACUPUNCTURE and CHINESE HERBOLOGY. He is National Board Certified in Acupuncture (NCCAOM). Additional training includes 720 hours at HEILONGJIANG UNIVERSITY OF TRADIONAL CHINESE MEDICINE in Harbin, China, where he received his DOM. Dr. Wing received his Naturopathic Medical Doctor Degree in 2006 from the American Naturopathic Medical Institute. Dr. Wing is a member of the American Manual Medicine Association (AMMA) and the American Institute of Naturopathic Medicine (AINM).

HEALTH COMPLIANCE:
Randel B. Wing complies with the rules and regulations promulgated by the Department of Health with respect to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of his acupuncture office. Randel B. Wing uses only one-time single use needles in his practice.

REGULATION:
The practice of acupuncture is regulated and licensed by the Department of Health of the state of Florida
You, as a patient, are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. You, as a patient, may seek a second opinion from another health care professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department Of Regulatory Agencies for the State of Florida.

ADJUNCTIVE THERAPIES:

Randel B. Wing, as a graduate of the COLORADO SCHOOL OF TRADITIONAL CHINESE MEDICINE, has had training in the application and recommendation of adjunctive therapies and Chinese Herbology as defined by traditional oriental medical concepts. He has also received extensive training in functional blood chemistry and Acupoint Injection Therapy. Randel B. Wing is licensed by the State of Colorado and the State of Florida.

Randel B. Wing, AP., DOM, NMD,
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DO'S AND DON'TS BEFORE AND AFTER AN ACUPUNCTURE TREATMENT

1. Do not come for treatment on an empty stomach. Have something light to eat a few hours before the treatment.

2. Do not eat a large meal within one hour after a treatment. Do have something light to eat if you are very hungry after the treatment.

3. Do not have coffee, alcohol, or caffeine on the day of treatment.
4. Do not eat ice-cold foods or have iced drinks especially on the day of treatment and preferably not during the course of your treatments.

5. Do not brush your tongue or suck on colored candies, etc., on treatments days as we have to see your tongue in its natural state. This is an important part of our diagnostic procedure.

6. Do not take a bath or shower for several hours after a treatment. If possible do this on the following morning.

7. It is better not to have a massage or chiropractic treatment for the rest of the day following an acupuncture treatment. However, the day before or earlier in the day prior to your acupuncture treatment is fine.

8. Do not perform any strenuous exercise the rest of the day following a treatment.

9. Do rest if you feel a little tired following a treatment. This is a common initial reaction to the treatment as the body begins the healing process. If you feel very energetic following the treatment, it is still better not to over-exert yourself that day.

10. Please call us if you ever have any questions or concerns following your treatment.

The reasons for these guidelines may seem a bit confusing at first but there is a simple explanation. With acupuncture treatment we are stimulating the body to regulate itself better and thereby to function more efficiently. This is accomplished by influencing the brain and central nervous system with the subtle stimulation of acupuncture. Therefore, we want you to avoid anything that strongly stimulates your nervous system for a while before and after your treatment so that your body will pay attention to the message we are sending it and not be distracted before the proper response is achieved. These few "do's and don'ts" may be a minor inconvenience but we want you to get the best possible results from your treatment and you will soon find it is worth the effort.

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CONDITIONS RESPONDING TO ACUPUNCTURE TREATMENTS

This is only a partial list of conditions treatable with acupuncture. If you have a problem not listed, please feel free to ask whether acupuncture may help.

Acne
Allergies
Angina Pectoris
Anxiety
Appendicitis (chronic)
Arthritis
Asthma
Atrophic Rhinitis

Backache
Bedwetting
Bell's Palsy
Bronchitis
Buergers Disease
Bursitis

Carpel Tunnel Syndrome
Colitis (all types)
Common Cold Flu
Conjunctivitis
Constipation

Cramps
Crohns Disease
Cystitis

Deafness (nerve)
Dermatitis
Diabetic Neuropathies
Diarrhea
Disc Pathology
Dry Eye Syndrome
Dyspepsia

Eczema
Edema
Enteritis
Esophagitis

Facial Pain/Spasms
Facial Paralysis
Fainting
Fatigue (chronic)
Fibrocystic Breast Disease
Frequent Urination
Frozen Shoulder

Gall Bladder Problems
Gastritis
General Weakness
Goiter
Gynecological Disorders

Hay fever
Headaches
Heartburn
Hemiplegia
Hiccups
Hives
Hot Flashes
Hyper/Hypo Acidity
Hypertension

Impotence
Indigestion
Infertility
Insomnia
Insufficient Lactation
Irritable Bowel Syndrome

Kidney Disorders
Knee Problems

Laryngitis
Liver Problems
Low Back Pain
Low Blood Pressure

Mastitis
Meniere's Disease
Menopausal Problems
Menstrual Disorders
Migraines
Morning Sickness
Multiple Sclerosis
Muscle Spasms/Strains

Myalgia

Nasal Congestion
Nausea
Nephritis
Neuralgia
Neuritis
Night Sweats

Numbness/Tingling

Ocular Nerve Degeneration

Painful Scars
Pancreatitis
Paralysis
Paraplegia
Parkinson's Disease (early cases)
Pleurisy
PMS
Poliomyelitis
Poor Appetite
Poor Circulation
Post-Operative Pain
Postpartum Problems
Prostate Trouble
Psoriasis

Quadriplegia

Raynaud's Disease
Recurrent Colds
Renal Colic
Renal Insufficiency
Rheumatism

Sciatic Pain
Shin Splints
Sinus Problems
Stiff Neck/Shoulders
Stop Smoking
Smoke Residuals

Tendonitis
Tennis Elbow
Tics
Tonsillitis (chronic)
Tremors
Trigeminal Neuralgia

Ulcer

Vertigo
Visual Problems

Weak Bladder
Whiplash

239-989-9892

CAPE CORAL ACUPUNCTURE CLINIC

HIPAA PRIVACY FORM 1

This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.
We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003.

NOTICE OF PRIVACY PRACTICES

Randel B. Wing, AP DOM, NMD,

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you make to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a
complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Randel B. Wing
Telephone: 239-989-9892
E-Mail: RWINGTCMDOC@earthlink.net
Address: 822 Del Prado Blvd. Cape Coral Florida 33990

I hereby acknowledge having read the above Notice and that I have received a copy of said Notice for my personal information.

Signed Dated____

This Form is educational only, does not constitute legal advice, and covers only federal, not state law (Aug. 14, 2002).
Randel B. Wing,
AP,DOM, NMD,