Naturopathic Family Medicine
6501 SE King Road
Milwaukie, OR 97222

CONSENT TO TREATMENT

Patient's name: ____

I. This is to acknowledge that I have been informed and understand that:

i) Any treatment or advice provided to me as a patient of Naturopathic Family Medicine is not mutually exclusive from any treatment or advice that I may be receiving now or in the future, from another health care provider.

ii) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider.

iii) No physician, student, employee nor anyone else under the direction or control of the clinic is recommending that I refrain from seeking or following the advice of another licensed health care provider.

iv) The treatment and therapies provided or recommended by this clinic may be different from those usually offered by another licensed health care provider. I will use the education at my disposal to make an informed decision.

II. I agree to pay any fees for services, intravenous therapies, costs of supplements and remedies, cost of laboratory tests, or other fees that are not covered by my insurance plan. Initial visits are generally $195 and follow-up visits are generally between $65 and $180, depending on the complexity of the case and the time used for the visit. Intravenous therapies are between $85 and $240 depending on the volume and nutrients required.

III. Naturopathic Family Medicine complies with HIPPA (Health Insurance Portability and Accountability Act of 1996) laws and I am guaranteed the utmost privacy of my information, except as excluded by law. The following are considered exclusions: Insurance reimbursement procedures, health plans or other providers involved with my healthcare, phoning in diagnostic or pharmacy orders, and reminder calls for scheduled appointments. I authorize (initial) Naturopathic Family Medicine to communicate with me via telephone messages _____, fax _____, mail _____, email _____.

IV. If I am not able to make a scheduled appointment and do not cancel that appointment with a 24 hour notice, I understand that a fee may be assessed to my account. Fees for not showing up to an appointment will be $50 and if an I.V. was prepared for you, an additional $50 will be assessed. Returned check fees are $25.

V. I hereby authorize and consent to receive treatment at Naturopathic Family Medicine.

VI. I authorize (initial) _____ / I do not authorize _____ the release of any medical or other information necessary to process insurance claims. I also request payment of benefits to the party who accepts assignment.

______________________________	____________________	___________
(Patient name)	(Signature)	(Date)

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Patient's Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPPA). HIPPA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right of privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPPA the charge will be .10 per page.
4. You are entitled to make an amendment to your patient health information within those records.
5. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. You have the right to specify how access to your health information is restricted and from whom.
7. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
8. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
9. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
10. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPPA in establishing that standard.

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipts of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

______________________________	____________________	___________
(Patient name)	(Signature)	(Date)

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FINANCIAL POLICY

Naturopathic Family Medicine (NFM) operates under a cash policy which is: All payments are due in full at the time of service.

Our office accepts Visa and MasterCard as well as checks and cash. It is the patient's responsibility to pay the balance due and notify Dr. McClanen in case of financial difficulties in advance to avoid expensive collection procedures. Otherwise, payment is due in full at the time of service.

Patients who have group health insurance that covers naturopathy, also fall under our cash policy in that payment is due at the time of service. NFM is continually searching for beneficial insurance companies to contract with, and will post an updated status of all currently contracted insurance companies. If you utilize an insurance company which contracts with NFM, we will bill your insurance claims for you. However, co-pays and co-insurance will be due at the time of service.

Additionally, NFM will bill car insurance companies and worker's compensation carriers for personal injury cases. However, the total bill for services and products rendered are ultimately the responsibility of the patient, and failure of the insurance carrier to pay in full for a personal injury case will result in a bill being sent directly to the patient for immediate payment.

Please let the front desk know of your insurance status so that a fee slip can be copied if needed to submit to your insurance company.

I HAVE READ THE ABOVE CASH POLICY AND AGREE TO ITS REQUESTS.

____________________________________ ____________________
Patient (Responsible party) Date

______________________________ ____________________ ___________
(Patient name) (Signature) (Date)