Dear New Patient,

Welcome to our clinic. We, the healthcare providers at Whole Family Wellness Center, look forward to addressing all of your health needs. We encourage your questions and participation in all aspects of your health care.

This following document is comprised of three sections: 1) office policies and financial agreement, 2) HIPPA privacy policy, and 3) consent to treatment. Please make sure to read through this document in its entirety, mark each box appropriately, and insert your signature at the bottom.

1. OFFICE POLICIES & FINANCIAL AGREEMENT

Office hours & Appointments:

☐ The office is open Monday through Friday, by appointment only.

☐ Payment for all services and dispensary items is due at the time of the visit.

☐ You will be charged a Missed Appointment fee of $50.00 for any missed appointments or late cancellations (less then 24 hours notice).

☐ I give permission for the staff at WFWC to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.

☐ Unless a specific payment plan has been agreed upon and put into writing, we reserve the right to charge interest on any outstanding balance on the account. After 2 months, a 5% compounded interest will accrue, after 6 months, 8% compounded interest will accrue.

Health Insurance for Naturopathic Medicine and Acupuncture Services (*please read carefully*):

☐ For naturopathic medicine services we will directly bill your insurance company for payment only after your insurance coverage has been verified. If your insurance benefits have not been verified at the time of your first visit, you are required to pay for your office visit in full at the time services are rendered. The healthcare providers at WFWC are in-network providers on *some* insurance plans, and out-of-network with other plans, which means that you remain responsible for full payment of all fees, should your insurance company deny part of or all of your claims. You will be billed and are expected to pay any outstanding balance. Your insurance policy is a contract between you and your insurance company and we cannot guarantee payment of your claims.

☐ **Please note:** All patients with health insurance coverage of both naturopathic medicine and acupuncture services, should note that the following items are not covered by most health insurance plans and you will be directly responsible for payment of these services or products:

- ***Late cancellation fees***
- ***Telephone consultations***
- ***Medicinary items***

2. *HIPPA* NOTICE OF PRIVACY PRACTICES

Please review this notice carefully. It describes how medical information about you may be used *and disclosed and how you can get access to this information.*

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to

☐ **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Use required by law: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure

HIPPA NOTICE OF PRIVACY PRACTICES (CONTINUED)

☐ **YOUR RIGHTS**

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAACompliance Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on January 2, 2008.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAACompliance Officer in person or by phone at our main phone number.

3. INFORMED CONSENT AND REQUEST FOR ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE

I, _____, hereby acknowledge that being treated with tradi- tional Chinese Medicine can include any of the following techniques:

☐ Insertion of various styles and sizes of acupuncture needles into my body at various depths and loca- tions.

☐ Heat treatments using Artemesia vulgaris (moxibustion) or a conventional heat lamp may be placed on or near any part of my body. For indirect moxabustion treatments, the moxa is placed on the head of the needle or on top of a barrier (such as a slice of ginger or salt) which rests on the skin. When direct moxa is used, a very tiny amount of moxa is placed on a protective cream on the skin. The heat generated from the moxa treatments may involve slight discomfort of leave a small blister or scar on the skin. With any type of heat, there is always a risk of a burn.

☐ A massage technique called "gua sha" may produce red or purple discoloration of the skin (similar to a bruise) which may remain for 1 to 7 days. There may also be a slight tenderness in the area treated.

☐ A method called "cupping" involves placing glass cups over the skin to produce a vacuum and promote the circulation of "qi," or energy, through the meridians. Cupping may also produce skin discoloration and tenderness 1 to 7 days after the treatment.

☐ Electro-acupuncture may be performed in cases of pain or stagnation in order to facilitate the movement of qi and blood. This technique involves clipping a wire to the body of the needle in order to deliver a mild electrical current. I acknowledge that that I may experience a slight buzzing or tingling sensation around the needle.

☐ The practitioner may leave press-balls, press-tacks, press-seeds, interdermals, or magnets on my body. I will receive directions on how to care for, how to and when to dispose of these healing adjuncts.

☐ I may also receive herbal prescriptions or recommendations pertaining to nutrition, diet, exercise, or other life-style habits. I understand that I am not required to take these herbal substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain ad- verse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these sub- stances, I should suspend taking them and call the clinic as soon as possible.

☐ The acupuncture practitioner must be advised if the patient has a pacemaker or a bleeding disorder, might be pregnant or has a contagious disease. If the patient has a potentially serious condition that is out of the practitioner's scope of practice, the patient will be referred to the emergency room or to a licensed physician with regard but not limited to: cardiac conditions including uncontrolled hypertension; acute, severe abdominal pain; acute undiagnosed neurological changes; unexplained weight loss or gain in a three month period; suspected fracture or dislocation; suspected systemic infections; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history.

☐ I have been informed that I have the right to refuse any form of treatment and that I have the right to terminate our treatments at any time. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and was given the opportunity to ask questions pertaining to my treatment. I also understand that there is always the possibility of unexpected complication and I understand that no guarantee can be made concerning the results of the treatment. I am aware that acupuncture or traditional Chinese medicine does not substitute for appropriate advice and care from a li- censed medical doctor.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Whole Family Wellness Center, and will comply with them in all respects. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date
_____	_____	
Printed Name of Guardian	Signature of Guardian	