AIFM Consent to Treatment, Office Policies, and Privacy

Welcome to our All In Family Med, LLC. We look forward to addressing all of your health needs. We encourage your questions and participation in all aspects of your health care. *The 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.* PLEASE NOTE: all forms must be completed 48 hours prior to your visit. Patients may be rescheduled if intake forms are incomplete.

1. OFFICE POLICIES & FINANCIAL AGREEMENT

Office hours & Appointments:

The office is open Monday through Friday 8am to 5pm.
Primary medical care and Naturopathic treatments are individualized, and often require multiple changes in diet and lifestyle. In between your office visits we are happy to answer short questions that clarify treatment plan instructions via email. However, email is not a substitute for an office visit. Your email questions should be no more that 3-5 lines long and pertain to your current treatment plan. If your provider determines that your email is too complex, requires an in-depth explanation or professional advice, or will result in an alteration to your treatment plan, you will be contacted to schedule a 15-30 minute phone or in-office consult with your doctor so your question/s may be adequately and appropriately addressed. Phone calls are billed at the regular office rate and may not be covered on your insurance plan. Payment is due via credit card at the end of each call.
* I have read and agree to the above email policy. ___________________________Initial

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain services, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.
Payment for all services and dispensary items is due at the time of the visit.
* I have read and agree to the above insurance/payment policy. ______________________Initial

The undersigned permits and authorizes All In Family Med, LLC to keep credit card information in a secure processing gateway. I authorize, All In Family Med, LLC to charge my credit/debit card for copays, coinsurance, deductibles, phone consults or visit fees, cancellation fee, and/or other incurred fees related to services provided by Lisa Blackwelder FNP-C. I understand it is my responsibility to keep an updated copy of my credit/debit card information on file. If my credit/debit card is declined for any reason, I am responsible for immediate payment of the full balance by cash or check. I understand that invoices are available for viewing in the patient portal.
* I have read and agree to the Credit Card On File (CCOF) policy. ___________________Initial

* **Missed Appointments** (defined as no cancellation 24-hour hours prior to scheduled visit) incurs a fee of $25.00. This fee is not billable to insurance and must be paid by the client prior to any future appointments. This cancellation must be done over the phone to the receptionist, not as a voice message
* I understand the missed appointment policy. ___________________Initial

NO SHOW (defined as not giving a 24-hour notice and not showing up to your appointment)
After **3** no shows we reserve the right to dismiss you as a patient.
*I understand the No Show policy. __________________________ Initial

The provider or staff may contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available. *I give my permission.
___________________________Initial
Or I do not grant permission ___________________________Initial

ONLINE REVIEWS- If I leave a review online for All in Family Medicine, I give permission for All in Family Medicine to respond to my review.
*I understand the online review policy ______________________________ Initial

2. HIPAA 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. Please check each box appropriately.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information (PHI) 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. *I understand.
___________________________Initial Treatment:
We will use and disclose your PHI 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 PHI, as necessary, to a home health agency that provides care to you. As another example, your PHI 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.
*I understand. ___________________________Initial Payment:
Payment is due at time of service. This may include your copay, co-insurance, or visit fee if noncovered service.
*I understand. ___________________________Initial
Your PHI 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 PHI be disclosed to the health plan to obtain approval for the hospital admission. *I understand.
___________________________Initial Healthcare operations:

We may use or disclose, as needed, your PHI 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 PHI to Medical/Nursing 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 provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI as necessary, to contact you to remind you of your appointment. *I understand. ___________________________Initial

Use required by law:

We may use or disclose your PHI 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. *I understand. ___________________________Initial

YOUR RIGHTS

The following are statements 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 PHI that is subject to law that prohibits access to protected health information.
*I understand. ___________________________Initial

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 PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI 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 provider is not required to agree to a restriction that you may request. If provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.
*I understand. ___________________________Initial

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

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. 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.
*I understand. ___________________________Initial
You may have the right to have your physician amend your PHI: 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.
*I understand. ___________________________Initial
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.
*I understand. ___________________________Initial

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.
*I understand. ___________________________Initial
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 HIPAA Compliance Officer in person or by phone at our main phone number.
*I understand. ___________________________Initial

3. INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved.

I ________________________________ hereby request and consent to examination and treaement with Lisa Blackwelder FNP-C.

I understand that as part of the practice of primary medical care and naturopathic evaluation and treatment may include, but are not limited to:
Physical exams (e.g. general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
Common diagnostic procedures (e.g. venipuncture, pap smears, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
Physiotherapeutic treatments (e.g. trigger point injections, PRP, Hormone Pellets)
Dietary advice/therapeutic nutrition (e.f. use of foods, diet plans, nutritional supplements and intramuscular vitamin injections)
Trigger point injection therapy, PRP, Bioidentical Hormone Therapy
Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, suppositories, tropical creams, pastes, or other forms

Lifestyle Counseling (including but not limited to visualization for improved lifestyle strategies)
Prescription medications, hormone prescription or administration via injection or pellet insertion
Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.
*I understand. ____________________________Initial
Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of preexisting symptoms.
*I understand. ____________________________Initial

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy *I understand. ____________________________Initial

Notice to individuals with bleeding disorders, pace makers, and/or cancer. For your safety it is vital to alert your providers of these conditions. Family Care providers will only prescribe medications(including antibiotics, anti-anxiety and narcotics) if they believe that they are in the best interest of myself, the patient.
*I understand. ____________________________Initial

I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances including compounded medications and dessicated thyroid hormone; however these have been used widely in Europe, China and the USA for years. *I understand. ____________________________Initial

Family Practice providers are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies. I do not expect the naturopathic physicians, and/or any allied healthcare providers to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the doctor explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.
*I understand. ____________________________Initial

Please submit your digital signature below.
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 All In Family Med, LLC, 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.
Name of Patient: ____________________________________ Today's date:________________
Patient's Date of Birth __________________
Name of Guardian (if applicable)____