Seven Circles Natural Medicine

Patient Responsibility and Policy Agreement

We ask that every patient read and sign their agreement to the following. You will receive a copy for your records.

- Please be prepared to provide insurance card (if applicable) at the time of each visit.
- A **minimum of 24 hours notice of appointment cancellations is required** except in legitimate emergencies. Cancellations made less than 24 hours from the appointment **may be charged a $50 fee** for the first absence and the full amount of the visit for all missed appointments thereafter.
- Each patient is **responsible for knowing the terms and coverage of your insurance plan**. If you have insurance that the practitioner "accepts," it does not guarantee payment will be made from your insurance company. You will then be personally responsible for the bill. Please note; Medicare and any supplemental plans will not cover any acupuncture or naturopathic care unless you also have a secondary plan.
- Patients are seen **by appointment only**. In the case of an urgent medical need patients can call the office to be scheduled an emergency visit. In the case of an after-hours, urgent medical need, established patients can call (503) 349-5038.
- Dispensary items must be acquired by the physician or with written prescription from another doctor. If a refill is needed, please allow 48 hours for adequate processing.
- Payments for dispensary items and/or copays are due at the time of service; cash, check, credit or debit cards are accepted.
- Though advice or recommendations may be declined, neither Dr. Marleen Haverty nor Seven Circles Natural Medicine will be held accountable for anything that may happen as a result of your refusal.
- You may authorize that medical information including, but not limited to, lab results, be communicated via voicemail or email by indicating and intialing here:

Phone for voicemail:_____ Initials:_____

Email: _____ Initials:_____

By signing below you acknowledge your understanding of the terms and conditions listed above and agree to adhere to the policies of the clinic and physician.

_____

Patient Signature or Signature of Legal Guardian

_____

Printed Name Date

New Patient Registration

Full Legal Name: _____

Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Email: _____ Gender: M F

Date of Birth: _____ SSN: _____

Responsible Party/Emergency Contact: _____

Emergency Contact Phone (if different than above): (____) _____

Address (if different than above): _____

Primary Insurance

Insurance Carrier: _____ Insurance Phone: (____) _____

ID Number: _____ Group Number: _____

Co-Pay: _____ Relationship to Patient: _____

If you wrote "Self" in Relationship to Patient you may leave the following blank.

Subscriber Name (if not patient): _____

Date of Birth: _____ SSN: _____

Phone: (____) _____ Address: _____

Secondary Insurance

Insurance Carrier: _____ Insurance Phone: (____) _____

ID Number: _____ Group Number: _____

Co-Pay: _____ Relationship to Patient: _____

Subscriber Name (if not patient): _____

Date of Birth: _____ SSN: _____

Phone: (____) _____ Address: _____

Is this visit injury related? Yes No If yes, is the injury work related? Yes No If yes, is the injury from a motor vehicle accident? Yes No State: _____

Employer: _____ Injury Date: _____

By signing I agree that all the information provided above is complete and correct.

_____

Signature Date

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your health information is important to us and we are committed to protecting it. Federal law requires that we provide each of our patients with an official notice of our privacy practices. This notice is to inform you of ways we use and share your information and it will describe your rights and duties regarding the use and disclosure of health information.

Laws require us to:

- Keep your health information private.
- Give you this Notice of Privacy Practices
- Abide by the terms of the Notice of Privacy Practices currently in effect.

We have the right to change our privacy policies and the terms of this notice at any time, provided that law permits the changes. If any changes are made we will update this notice and provide it for immediate review and acknowledgment.

Listed here are some of the ways we may use or disclose your information without your specific consent or authorization. Not all possible uses or disclosures are listed:

- For Treatment: We may use your health information to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, and/or any others who are providing care to you. We may also share health information with your health care providers to assist in your treatment.
- For Payment: We may use and disclose your health information for payment purposes.
- For Health Care Operations: We may use and disclose your health information for our health care operations. For example: We may use health information about you to review our treatment and services and evaluate the performance of our staff in caring for you.

Other Possible Uses and Disclosures:

- In response to a legal proceeding
- For other healthcare provider's treatment activities
- For other covered entities and provider's payment activities
- In case of threat to public health or safety
- To notify a family member in certain emergency situations
- To workers' compensation or similar programs for processing of claims
- In domestic violence or neglect situations
- Other used and disclosures not in this notice will be made only as allowed by law or with your written authorization.

The health and billing records we create are the property of this health care facility. The heath information in it, however, belongs to you. You have a right to:

- Request and receive, from us, a copy of the most current Notice of Privacy Practices.

- Look at or receive copies of your health information. You may make this request in writing and we have a form available for that purpose. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request.
- Ask us to restrict certain uses and disclosures. You must submit this request in writing. We are not required to grant the request, but will comply with any request granted.
- Have us review a denial of access to your health information-except in certain circumstances.
- Ask us to change your health care information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- Request a list of disclosures of your health information. The list will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by other means or at another location. Please sign, date and give us your request in writing. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.
- Cancel a prior authorization to use or disclose health information by giving us a written revocation. Your revocation does not affect any information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

If you have any Questions or wish to report a problem you may contact the Privacy Officer at (360) 297-2975. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a complaint with the Privacy Officer at our practice or with the U.S. Secretary of Health and Human Services. All complaints must be made in writing. You will not be penalized or discriminated against for filing a complaint.

By my signature below I acknowledge receipt of this Notice of Privacy Practices and the information held within.

_____

Signature Date

Informed Consent for Treatment

I, the undersigned, hereby authorize Seven Circles Natural Medicine to perform the following specific procedures necessary to facilitate my diagnosis and treatment. Medical treatments and procedures not within the scope of our licensed practice will be referred to an appropriate provider.

Diagnosis and Treatment

- Common Diagnostic Procedures: venipuncture, pap smears, laboratory, and physical exam, etc.
- Minor Office Procedure: dressing a wound, ear lavage, etc.
- Botanical Medicine: granulation teas, alcohol-based tinctures, capsules, tablets, creams, poultices, compresses, suppositories, etc.
- Homeopathic Medicine: the use of high quality dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- Lifestyle Counseling and Hygiene: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- Psychological Counseling
- Contraception: oral birth control pill, diaphragm.
- Acupuncture: insertion of specialized sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
- Cupping: a technique to relieve symptoms with cups made of glass, bamboo, or other materials, which are placed on the skin to create a vacuum with heat or other device.
- Gua Sha: a rubbing technique on areas of the body with a round instrument.
- Moxa: an indirect warming technique on an acupuncture point using an herbal stick, string, or ball moxa.
- Tuina: an ancient massage used to treat a wide variety of common disharmonies.
- Legend substances: pharmaceutical agents approved for prescription by naturopathic physicians.

Potential Risks: discomfort, pain, infection, blistering, and temporary discoloration of the skin at the site of procedure, an aggravation of symptoms existing prior to treatment, allergic reactions to prescribed herbs and supplements, side efffects of natural medications, inconvenience of lifestyle changes, injury from needle insertion, injections, venipuncture, or other procedures.

Notice to Pregnant Women: All female patients must alert the doctor immediately if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that Seven Circles Natural Medicine has given me no guarantees regarding cure or improvement of my condition. I hereby release Seven Circles Natural Medicine from any and all liability which may occur in

connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I acknowledge that Seven Circles Natural Medicine is not responsible for patient compliance and will not be held responsible for outcomes due to patient non-compliance. I understand that I am free to withdraw my consent and to discontinue participation in the above procedures at any time.

I understand that a record will be kept of all health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that I may look at my medical record and request a copy of it. I understand that my medical record will be kept no longer than ten years after the date of my last treatment. I understand that my practitioner will answer any questions I have.

By signing I agree that I have read and understand the above and consent to treatment.

_____

Signature Date