Bridges Family Wellness PC
7831 SE Lake Rd, Suite 102
Milwaukie, OR 97267

Consent forms

Dear New Patient, Welcome to our clinic. We, the healthcare providers at Bridges Family Wellness, 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 ☐ I understand

Office hours & Appointments:
The office is open Monday through Saturday, by appointment only.* *

We offer urgent on call service for established patients 24 hours per day. You may page the doctor directly for a response within 1 hour. You will be charged a minimum of a $50 fee for any use of this service. * ☐ I understand

Unless prior arrangement is made, full payment is due at the time of service. Payment may be made by cash, personal check, Visa, or MasterCard. For patients paying in full at the time of services, there is a 35% discount on all services. This does not apply to supplements, products, labs, insurance co-pays or deductibles.* * ☐ I understand

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

Unless a specific payment plan has been agreed upon and put into writing, we reserve the right to charge a late payment fee. Any account left unpaid after 30 days will be charged a $10 late fee each month it remains outstanding.* * ☐ I understand

I give my permission for the staff at Bridges Family Wellness to contact me via telephone or patient portal and leave a message that may contain appointment or medical information if I am not available. * ☐ I understand

I have read the policies above and understand them. I understand that I will be provided a copy of this policy at my request. I agree to promptly pay all fees and charges for treatment provided to me and/or my family. I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance. I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date. Should legal action be taken by this office to collect an unpaid balance for services provided, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.* *

☐ I understand

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

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 Bridges Family Wellness 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. *

☐ I understand

Please note:
All patients with health insurance coverage of 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, specialty testing, *

☐ I understand

I understand that It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to Bridges Family Wellness which 1. is later deemed by my insurance carrier to not be"medically necessary", and 2. has resulted in a partial or full refund request by my insurance carrier from Bridges Family Wellness. *

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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. Please check each box appropriately.

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. *

☐ I understand

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. *

☐ I understand

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. *

☐ I understand

Healthcare operations:

☐ I understand

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:

☐ I understand

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. *

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. *

☐ I understand

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. *

☐ I understand

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

☐ I understand

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. *

☐ I understand

You may have the right to have your physician amend your protected health information: 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
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
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
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

3. INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE AND ACUPUNCTURE SERVICES

I have the right to be informed about my health	☐ I understand

☐ Others _____

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, allergic reaction to prescribed herbs, supplements; aggravation of pre-existing symptoms. *	☐ I understand
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
Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your providers of these conditions. *	☐ I understand
Naturopathic doctors will only prescribe medications if they believe that they are in the best interest of myself, the patient. *	☐ I understand
I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years. *	☐ I understand
Naturopathic physicians and Acupuncturists 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 physicians 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

I do not expect the providers of Bridges Family Wellness, and/or any allied health care provider to be able to anticipate and explain all of the risks and complications and I wish to rely on the provider to exercise all judgement during the course of the procedure based on the known facts. I also understand that it is my responsibility to request my providers to 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. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment. *

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Please submit your 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 Bridges Family Wellness, 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 * _____

Name of Guardian (if applicable): _____

Today's date: * _____