INTEGRATIVE WELLNESS SOLUTIONS

Disclosures and Consent Forms – Please read and sign all forms below:

Financial Policies and Disclosures Statement

Please read and sign this form

1. *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* does not bill insurance plans nor engage in insurance disputes under any circumstances.

2. All services are to be paid at the time of service.

3. A credit card is required to book an appointment. Appointments cancelled with less than 24 hours notice will be charged a $50 cancellation fee to the credit card used to book the appointment. Missed appointments will be charged the full price of the appointment to the credit card used to book the appointment.

4. All practitioners hold active license(s) or certifications as required in the State of California.

5. There is no charge for short electronic communications clarifying your current treatment plan; however, electronic communications regarding a subject other than the current treatment plan and/or requiring a lengthy response may be subject to a $25 electronic communication fee.

6. If a collection service becomes necessary for payment of the account, you agree to pay all collection fees in addition to any balances due.

7. A late fee of 1.5% per month may be added to delinquent balances.

8. Medicare does NOT cover services or supplies provided in this office.

9. Release of information: By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This does not give permission for any other release of information by this office, which has not been authorized by me.

I have read, understand, and agree to the above policies:

____ ____________________

Signature (Parent / Guardian, if under 18 years old) Date

____

Printed Name of Patient

Naturopathic Informed Consent to Treat

This document provides important information regarding the services being provided and should be carefully reviewed. Please ask any questions you have regarding services before signing this document.

Consent: I herby request and consent to the performance of naturopathic treatments and/or other naturopathic procedures, including various modes of physical therapy and diagnostic procedures, on me (or on the patient named below, for whom I am legally responsible) by *Dr. Jennifer Greer, ND*, or a licensed Naturopathic Doctor in the state of California, who now or in the future may treat me while employed by, working or associated with or serving as a back-up for the Naturopathic Doctor named above, including those working at the clinic or office listed below or any other office or clinic whether signatores to this form or not.

Type of care: I have had an opportunity to discuss with the Naturopathic Doctor named above and/or with other office or clinic personnel the nature and purpose of naturopathic care and procedures.

I understand that this office utilizes many forms of diagnosis and therapy including but not limited to:
Physical exam: e.g. general, musculoskeletal, cardiovascular, gynecologcial, abdominal, respiratory, neurological, urological.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occuring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygeine: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
Psychological counseling
Hydrotherapies: e.g., hydrocolator, contrast treatments, wet sheet wrap.
Soft tissue manipulation: massage, neuro-muscular technique, muscle energy stretching, visceral manipulation.
Contraception and hormone replacement therapies
Intravenous, Intramuscular and Subcutaneous injections: nutritional supplementation, therapeutic nutrition, pain management, joint care
Oral chelation therapy
No Guarantee: I understand that results are not guaranteed.

Recital of Risks: I understand and am informed that, in the practice of medicine, there is some degree of risk to treatment. Within the general healthcare setting, the possible outcomes of these practices range from minor to fatal.

I understand that some herbs and supplements may be inappropriate during pregnancy, and I will notify the doctor if I am or become pregnant.

I will inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomach ache, vomiting), allergic reactions (hives, rashes, tingling of the tongue, difficulty breathing, headache), or any unanticipated or unpleasant effects associated with the herbs, supplements or other treatment prescribed by the doctor. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Agreement and Continuous Effect: I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

____
Printed Name of Patient

______________________________ __________ ____
Signature of Patient or Patient Representative *Date* *Indicate relationship if signing for patient*

PLEASE INITIAL THE FOLLOWING:

_____ Notice of Privacy Practices: *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* complies with the most recent HIPAA Privacy Practices.
If I am not the above named person, my relationship to the patient is: ____

_____ Acknowledgment of Separate and Distinct Clinic: I acknowledge that the clinic or practice of *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* including its doctor(s) and staff, are distinctly and completely separate from (1) the doctor and or clinic and their staff that referred me, and or (2) the premises of the doctor(s) and or clinic in which care is being rendered.

_____ Consent to Routine Clinical Services: I consent to all services rendered by the doctor, or any other licensed doctor(s) or therapist who are now or will in the future treat me while employed by or associated with *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")*. As in all medical practices I understand that there are risks to manipulation and other routine procedures including but not limited to fracture, injury, stroke, dislocation and sprain. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to any procedure. I understand that no guarantees have been made to me as to the result or cures that may be obtained from examination or treatment. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that I am responsible for knowing where my personal items are at all times while in the office and if I choose to remove or place any of my personal items I am doing it voluntarily and *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* is NOT responsible or liable for any lost, stolen or misplaced items.

_____ Consent to Injections: I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ Notice of and Consent to Electronic Communications: **I understand and agree that electronic communications are not appropriate in the case of a medical emergency, and it is my responsibility to call 911 for any suspected medical emergency.** I understand that electronic communications are not a substitute for seeing a physician. Further, I understand and agree that general Email shall not be used for communication regarding personal health information and social media is not an appropriate arena for receiving medical advice. All electronic communication shall be conducted only through the HIPAA compliant online electronic medical record for the patient. I consent to electronic communication and agree to only use to the electronic medical record patient portal to communicate electronically. I understand that *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* will endeavor to read and respond to my electronic communication within 2 business days but cannot guarantee that any particular message will be read and responded to within any particular period of time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I understand that as part of my healthcare, *Dr. Jennifer Greer, ND, (DBA "Integrative Wellness Solutions")* creates and maintains health records describing my health history, symptoms, examination with test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my case
- A source of information for applying my diagnosis to my bill
- A means in which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations such as assessing quality and reviewing competence of health care professionals

I understand and have been provided a copy of *Dr. Jennifer Greer, ND, (DBA "Integrative Wellness Solutions")* Notice of Health Information Privacy Practices summary to review, which provides a description of information uses and disclosures. I understand I have the right to request a complete copy of the Notice of Health Information Privacy Practices.

I understand that *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* reserves the right to change their notice and practices. Changes will be posted in the reception area.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or normal healthcare operations and that *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* is not required to agree to restrictions I have requested.

By signing below, I agree that I have reviewed the Notice of Health Information Privacy Practices at *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")*.

Signature: ____ Date: ______________

Printed Name of patient: ____

If signature is <u>not by the patient</u>, please indicate Name and Relationship to patient:

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CONSENT FOR LEAVING MESSAGES

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY AND FRIENDS

I understand that my healthcare information at *Dr. Jennifer Greer, ND (DBA "Integrative Wellness Solutions")* is protected and I have received a copy of their Notice of Health Information Privacy Practices.

CONSENT for LEAVING MESSAGES (please check box) ☐ YES ☐ NO

I consent to information regarding myself (or my child's/under the age of 18) test results or detailed appointment reminders/instructions to be left on my voice mail or answering machine.

If yes, allowed phone numbers (circle type): ______________________ cell, home, work, other

________________________cell, home, work, other ______________________cell, home, work, other

CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family or friends to have access to my health care information. The name(s) listed below are family or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem is minimally necessary. I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Protected Health Information Form.

	NAME	RELATIONSHIP
1.	__________________________________	_________________________
2.	__________________________________	_________________________
3.	__________________________________	_________________________
4.	__________________________________	_________________________

____ _________________________

Patient Name Date of Birth

_______________________________________ _________________________

Patient Signature (Parent / Guardian, if under 18 years old) Date

If signature is <u>not by the patient</u>, please indicate Name and Relationship:

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This consent will be considered valid until such time as I cancel it in writing. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only be applied to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.