SUNSHINE FAMILY HEALTHCARE

REGINA FLANAGAN, NATUROPATHIC DOCTOR

643 N. GRANT ST., CANBY, OR 97013 – P. (503)451-1024 – F. (888)972-5611

SUNSHINEFAMILYHEALTHCARE.COM – INFO@SUNSHINEFAMILYHEALTHCARE.COM

Informed Consent for Treatment by a Naturopathic Doctor

PATIENT NAME:_______________________________________

To the Patient: Please read this entire document and ask any necessary questions prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of Naturopathic Medicine

The primary treatments used by doctors of naturopathy are natural, non-invasive techniques which stimulate the body's natural healing capacity. Naturopathic medicine is considered a complement to traditional allopathic medicine. We will use clinical nutrition, botanical medicine, homeopathic medicine, lifestyle counseling and physical medicine to treat you.

Analysis / Examination / Treatment

As a part of your case history you are consenting to the analysis, examination, and treatment recommended by our clinic. This may include a basic/complaint oriented physical examination including specific urine and/or blood laboratory tests.

The material risks inherent in Naturopathic medicine

As with any healthcare procedure, there are certain complications which may arise during even the most basic of Naturopathic treatments. These complications may include, but are not limited to, aggravation of pre-existing conditions, allergic reactions to supplements or herbs, complications in certain physiological conditions such as pregnancy and lactation, complications for patients on multiple medications, young children, elderly patients, or patients with specific diseases such as heart, liver, kidney, cancer, or diabetes. Complications from any manipulative therapy provided include, but are not limited to, fractures, disc injuries, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention, it is your responsibility to inform the doctor of such conditions. Please advise the doctor if you are pregnant, suspect you are pregnant, are trying to become pregnant, or if you are breastfeeding. I understand that my doctor will answer any questions that I have to the best of their ability. I understand that, as with any type of treatment, results cannot be guaranteed. I do not expect my Naturopathic doctor to be able to anticipate and explain all risks and complications. With this knowledge, I

voluntarily consent to the assessment and therapeutic procedures/treatments recommended by the doctor.

Notice: All female patients must alert the doctor if they know or suspect they are pregnant as some of the therapies used could present a risk to pregnancy. All individuals with bleeding disorders, pace makers, and/or cancer must also alert the doctor.
________(Initials)

The relationship with other healthcare providers.

Naturopathic Medicine may be a complement to traditional allopathic medicine. I acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive, from any other licensed health care provider.
- I am at liberty to seek or continue medical care from a physician or surgeon or other qualified health care provider.
- No employee or other practitioner under our clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider.
- The treatment and therapies rendered or recommended by our clinic may differ from those typically offered by a traditional allopathic doctor or other licensed health care provider.

_______ (Initials)

The availability and nature of other treatment options.

Other treatment options for many conditions may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs
- Hospitalization
- Surgery

If you chose to use one of the above noted other treatment options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may worsen your condition. Over time this may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Regina Flanagan, ND to perform diagnostic tests and render naturopathic therapies and other treatment to my minor son/daughter/legal dependent: ______________________________. This authorization also extends to all other doctors and office staff members and is intended to include laboratory and radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the naturopathic medicine and related treatment. I have discussed it with Regina Flanagan, ND and have had my questions answered to my satisfaction. I understand that it is my responsibility to request the Doctor to explain therapies and procedures to my satisfaction. By signing below, I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

____
Patient’s Printed Name

____
Patient’s Signature Date

____
Signature of Parent or Guardian (if a minor) Date

SUNSHINE FAMILY HEALTHCARE

REGINA FLANAGAN, NATUROPATHIC DOCTOR

643 N. GRANT ST, CANBY, OR 97013 – P.(503) 451-1024 – F.(888)972-5611

SUNSHINEFAMILYHEALTHCARE.COM – INFO@SUNSHINEFAMILYHEALTHCARE.COM

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information.

Release my protected health information to the following physician/entity and/or those directly associated in my medical care:

Sunshine Family Healthcare, LLC.
Regina Flanagan, ND
643 NW 4th Ave
Canby, OR 97013
Phone: 503-451-1024   Fax: 888-972-5611

Patient Name:____Date of Birth:____________

Prior Provider Name and Contact information:

____

The information you may release subject to this signed release form is as follows:

Please **initial** the relevant spaces.

__Complete Records
__Lab Reports
__Treatment Record
__Progress Notes
__Other (please specify) ____

__Medication Record
__Mental Health info
__HIV Status

The purpose for this release of information is as follows: ________________________________
____

Patient name:____DOB_________________

Printed name of representative:____

Signature of patient or representative:____Date_______

SUNSHINE FAMILY HEALTHCARE

REGINA FLANAGAN, NATUROPATHIC DOCTOR

643 N. GRANT ST, CANBY, OR 97013 – P.(503) 451-1024 – F.(888)972-5611

SUNSHINEFAMILYHEALTHCARE.COM – INFO@SUNSHINEFAMILYHEALTHCARE.COM

Informed Consent for Telemedicine Naturopathic Treatment

I,___________________________________, hereby authorize Dr. Flanagan to perform diagnosis,
Patient/Parent/Guardian

consultation, treatment, education, care management, self-management via information and communication technologies otherwise known as **Telemedicine** for ___________________________________.
Myself/Dependent.

I understand that I must be present in the state of Oregon when communicating with the doctor.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: allergic reactions to prescribed supplements, medications, and herbs, which may be severe such as anaphylaxis, cardiac arrest and death. Side effects between natural medications and pharmaceuticals, inconvenience of lifestyle changes and aggravation of present conditions.

Notice: patients must inform the doctor if they know, suspect, or may be pregnant as some of the therapies used could present risk to the pregnancy and fetus.

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 in recommending the treatments that the doctor feels at the time, based on the facts then known, are in my best interest. I have had the opportunity to ask questions and discuss with Dr. Flanagan:

1) my suspected diagnosis or condition
2) the nature, purpose and potential benefit of the proposed care
3) the inherent risks, complications, potential hazards, or side effects of the treatment or procedure
4) the probability or likelihood of success
5) reasonable available alternatives to the proposed treatment/procedure
6) the possible consequences if treatment or advice is not followed and/or nothing done.

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by **Dr. Flanagan** regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

Signature of Patient/Parent or Guardian: _________________________________ Date: ____/____/________

SUNSHINE FAMILY HEALTHCARE

REGINA FLANAGAN, NATUROPATHIC DOCTOR

643 N. GRANT ST, CANBY, OR 97013 – P.(503) 451-1024 – F.(888)972-5611

SUNSHINEFAMILYHEALTHCARE.COM – INFO@SUNSHINEFAMILYHEALTHCARE.COM

Notice of Privacy Practices Regarding Protected Health Information. Your Privacy is our Priority.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Sunshine Family Healthcare we are committed to treating you and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective December 1, 2015, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Sunshine Family Healthcare, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses and a plan for care of treatment. This information, often referred to as your health or medical record, serves as a:

• Basis for planning your care and treatment

• Means of communication among the health professionals who contribute to your care

• Legal document describing the care you received

• Means by which you or a third-party payer can verify that services billed were actually provided

• A source of data for our planning and marketing

• A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where and why others may access

your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Sunshine Family Healthcare, the information belongs to you. You have the right to:

• Obtain a paper copy of this notice of information practices upon request

• Inspect and copy your health record as provided for in 45 CFR 164.524

• Amend your health record as provided in 45 CFR 164.528

• Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528

• Request communications of your health information by alternative means or at alternative locations

• Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522

• Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Sunshine Family Healthcare is required to:

• Maintain the privacy of your health information

• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

• Abide by the terms of this notice

• Notify you if we are unable to agree to a requested restriction

• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we may mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you, or give the revised notice to you at your next visit.

We will not use or disclose your health information without your authorization, except as

described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in this authorization, except as required by law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our office at 503-234-4270. If you believe your privacy rights have been violated, you can file a complaint with our office. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and health Operations

We will use your health information for treatment.

For example: Information obtained by a member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your care provider will document in your record the actions they took and their observations. In that way, the care provider will know how you are responding to treatment. We will also provide any subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: if appropriate, a bill may be sent to you or a third-party payer. The information on or accompanying your bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For example: Members of the healthcare staff, the risk and quality assurance manager, or members of the quality assurance team may use information in your health records to assess the care and outcomes in your case and others listed. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology and laboratory services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fundraising: We may contact you as a part of a fund-raising effort.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you acknowledge that Sunshine Family Healthcare has provided you with a copy of its Notice of Privacy Practices. You consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name Printed____________________________________Date of Birth____________________

Signature____Date__________________________

For Personal Representative of Client (i.e. – parent for a child, if applicable):

Print Name of Personal Representative Relationship to Patient

____ ____________________________________

Signature of Personal Representative______________________________Date______________

For Practice Use Only:

Does patient have access to a copy of the Privacy Notice? [ ] Yes [ ] No

Please explain why the client was unable to sign an acknowledgement form and Sunshine Family Healthcare's efforts in trying to obtain the patient's signature:

____

Signature of Employee____Date__________________________

Sunshine Family Healthcare, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you acknowledge that Sunshine Family Healthcare has provided you with a copy of its Notice of Privacy Practices. You consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name Printed_____________________________________Date of Birth____________________

Signature____Date___________________________

For Personal Representative of Client (i.e. – parent for a child, if applicable):

Print Name of Personal Representative Relationship to Patient

____ _____________________________________

Signature of Personal Representative_______________________________Date______________

For Practice Use Only:

Does patient have access to a copy of the Privacy Notice? [ ] Yes [ ] No

Please explain why the client was unable to sign an acknowledgement form and Sunshine Family Healthcare's efforts in trying to obtain the patient's signature:

____

Signature of
Employee____Date___________________________

SUNSHINE FAMILY HEALTHCARE

REGINA FLANAGAN, NATUROPATHIC DOCTOR

643 N. GRANT ST, CANBY, OR 97013 – P.(503) 451-1024 – F.(888)972-5611

SUNSHINEFAMILYHEALTHCARE.COM – INFO@SUNSHINEFAMILYHEALTHCARE.COM

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

This document is meant to establish and communicate office and financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our policies.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or prefer to not use insurance, we offer a discounted price, payable at the time of your visit.
2. **INSURANCE:** In order to bill your insurance and to meet filing guidelines, we ask for a copy of your policy card, name & birthdate of policy holder.
    - **"IN-NETWORK"** We are a participating provider ("in-network") with many insurance plans. We file insurance claims for patient visits. Please be sure to check with your insurance carrier to verify coverage.
    - **"OUT-OF-NETWORK"** If we are not listed in your plan's network we would be considered "out-of-network" and you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you, however, **you will be required to pay a minimum charge of $85.00 due at the time of service** until insurance coverage with your plan is established.
    - Benefits quoted by any insurance carrier are not a guarantee of payment and all plans will require you to be eligible at time of service and meet all terms and conditions of your plan. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.**
    - If your insurance company does not pay the claim for your visit within a reasonable period of time, you will be billed for any balances due. If we later receive payment from your insurer, we will refund any overpayment to you.
    - Due to the many different insurance products now available, and our inability to access your plan information, we cannot guarantee your eligibility and coverage. Any benefits quoted by your insurance company are not a guarantee of payment and therefore, it is your responsibility to check with your insurer's member services department about benefits prior to your appointment.

3. **ACCOUNTING PRINCIPLES:** Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service.
4. **CANCELLATIONS OR MISSED APPOINTMENTS:** In consideration of the provider, office, and other patient time that is disrupted by absent visits, if you do not cancel your appointment at least 3 business days in advance, or if you are absent at the scheduled time of your appointment, we will assess a $35.00 missed appointment fee.
5. **RESPONSIBILITY FOR PAYMENT:** I understand that I am personally financially responsible to **Sunshine Family Healthcare** for charges billed and not covered by the assignment of insurance benefits. **Phone consultations and telemedicine** may not be covered by insurance and we require payment at time of service. You may pay over the phone or send a check.
6. **CONSENT TO TREAT:** I voluntarily consent to medical treatment for myself and/or my dependents.
7. **NOTICE OF PRIVACY AND RELEASE OF INFORMATION:** **Sunshine Family Healthcare** will maintain the privacy of your health information. Under certain conditions, information that identifies you as well as your diagnosis and/or procedures provided, will be disclosed, such as in the process of filing medical claims, injury and compensation claims, legal request for information, or referral to other practicing providers. In the case of a minor, we require the signature of the parent of guardian.

- I hereby acknowledge that I am financially responsible for all charges incurred under treatment as outlined above. I assign any insurance payments to be paid directly to **Sunshine Family Healthcare** or to **Dr. Regina Flanagan ND**

- I hereby authorize and direct **Sunshine Family Healthcare** to release (verbally or in writing) confidential information including medically identifiable information to any person, entity, governmental agencies, insurance carriers or others who are financially liable to Sunshine Family Healthcare or provider for charges for medical treatment and for quality management, utilization review, transfer of medical care, collection of accounts and follow-up purposes. I understand that a copy of this document may be used with the same effectiveness as the original.
- I have read and understand the Office and Financial Policies of **Sunshine Family Healthcare** and I agree to be bound by its terms. I understand that such terms may be amended from time to time by **Sunshine Family Healthcare.**

____

Printed Name

____

Signature   Date

SUNSHINE FAMILY HEALTHCARE

REGINA FLANAGAN, NATUROPATHIC DOCTOR

643 N. GRANT ST, CANBY, OR 97013 – P.(503) 451-1024 – F.(888)972-5611

SUNSHINEFAMILYHEALTHCARE.COM – INFO@SUNSHINEFAMILYHEALTHCARE.COM

Patient Information Form

Name_________________________________Date of Birth___________Gender____

Address____

City, State ______________________________________ Zip ___________________

Is it okay to leave detailed messages on your voice mail? Please mark one. Yes No

Preferred contact phone____

Email____

Would you like us to have authorization to discuss your health information with a family member or friend? Please mark one. Yes No

If yes:Name:____

Phone:____

Relationship:____

Phone number if yes.____

Name of Parent/Guardian or Emergency Contact with phone number:

____

Do you consider Dr. Flanagan your primary care provider? Yes/No

Insurance Company____

Name of Policy Holder ____________________________Date of Birth______________

Insurance Address____

Insurance Phone number (for provider's use)__________________________________

Group number ______________________ID number_____________________________

Patient Information Form Page 2

Name: _____________________________________ Date: ____________________

Are you allergic to any medications, supplements, or foods? If so, please list them along with your typical **reaction**.

What medications are you currently taking or do you take occasionally?

What supplements are you currently taking?

List any other health care providers you see and why you see them.

Thank you!