



Harmonizing Healthcare

# Consent Form

**PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.**

## Consent To Treatment

Naturopathic therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

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Print Name	Signature of Patient	Date
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## Consent Regarding Use of Information – Please initial if you consent to the statement below, or leave blank if you do not consent.

\_\_\_\_\_ Some physicians at Harmonizing Healthcare use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow Harmonizing Healthcare and its physicians to correspond with you via email in spite of these potential risks.

\_\_\_\_\_ The physicians at Harmonizing Healthcare may write articles in various medical journals and, in some cases, may use real medical cases in the articles. By initialing, you give us permission to use your case in an article, with any identifying information removed.

## HIPAA and “Privacy Rule”

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment and health care operations.

The physicians of Harmonizing Healthcare respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. In some cases, we will be asked to submit sections of your medical chart to your health insurance plan (if applicable) or to another practitioner (with a release of records signed by you.) If at any point you do not want us to share your personal health information, please submit to us a written request. If we need to request your records from another practitioner, we will ask you to sign a “Release of Records” form before doing so.

Please speak with us or with a HIPAA Compliance Officer if you need more information.

I have read and understand the above statement regarding the “privacy rule”.

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Print Name	Signature of Patient	Date
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## Financial Agreement

### **LOW INCOME FEES**

We try to accept all insurance plans that cover our services. If you are uninsured or your insurance does not cover Naturopathic Medicine or Acupuncture, we offer a 40% discount to people who qualify as low income. This includes full-time students. If you are interested in receiving this discount, please discuss your financial situation with Dr. O'Neill or Dr. Haywood. Please note that we are only able to offer the 40% discount **to people who can pay on the day of service.**

### **INSURANCE**

If you are insured, we are happy to work with your plans and even submit claims for you. In some cases, your insurance company may not pay in-full or may not cover our services. **In all cases, you are responsible for paying, in full, for any services received.** Insurance plans can be very confusing and change frequently. **Therefore, we ask our patients to contact their plans directly and follow the steps below.**

**Bring your insurance card and this page to your first appointment.** Please have cash or check ready to cover co-pays and supplements. No insurance plan covers non-prescription medications or supplements. We require payment upfront if we think it is unlikely that your plan will cover

**I have read and understand the above information. I hereby authorize my insurance benefits to be paid directly to the physician, and I understand that I am financially responsible for non-covered services. I also authorize the physician or the insurance company to release any information required to process this claim.**

**Patient or Guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Steps to checking insurance benefits:

- 1) Call the number on your insurance card (customer service, benefits/eligibility).
- 2) When did my coverage begin and when is it valid thru? **Begin Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_
- 3) Does my insurance plan follow a **fiscal** or **calendar** year schedule? \_\_\_\_\_
- 4) Do I need a **referral from my Primary Care Physician** for alternative services? \_\_\_Yes \_\_\_No
- 5) Is Molly O'Neill or Ashley Haywood **In-Network or a Preferred Provider**? \_\_\_Yes \_\_\_No
- 6) **Ask about specific services:**

<b>Naturopathic:</b>	% covered: _____	Co-pay: _____	Yearly Max: _____
<b>Acupuncture:</b>	% covered: _____	Co-pay: _____	Yearly Max: _____
- 7) Is there a co-pay **per visit** or **per specialty**? (circle one)
- 8) What is my **deductible** for the year and has any or all of it been met? \_\_\_\_\_
- 9) Are any of the above **specialties subject to the deductible**? \_\_\_\_\_
- 10) Are **LAB** services covered and which laboratory is preferred (Quest, Lab Corp, etc.)? \_\_\_\_\_
- 11) Are prescription pharmaceuticals covered and which pharmacies are preferred? \_\_\_\_\_
- 10) What is the **name of the representative** that you spoke with? \_\_\_\_\_ Date: \_\_\_\_\_



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**General Patient Information**

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Partner's name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Prefer to receive messages? \_\_\_ Home \_\_\_ Work \_\_\_ E-mail \_\_\_ None Emergency Contact Info: \_\_\_\_\_

Who referred you to us? How did you learn about our clinic? \_\_\_\_\_

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**Private Health Insurance Information**

Name of Insurance Plan: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Co-pay: \_\_\_\_\_

Patient's relationship to subscriber: \_\_\_ self \_\_\_ spouse \_\_\_ child \_\_\_ other

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**Motor Vehicle Accident or Worker's Comp Insurance Information**

\_\_\_ Worker's comp \_\_\_ MVA

Date of Injury: \_\_\_\_\_ Injured Body Part: \_\_\_\_\_ Employer at time of injury: \_\_\_\_\_

Name of Insurance Plan: \_\_\_\_\_ Address: \_\_\_\_\_

Claim representative: \_\_\_\_\_ Phone#: \_\_\_\_\_ Attorney: \_\_\_\_\_ Phone#: \_\_\_\_\_



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**New Patient Information**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Gender: \_\_\_\_\_

What are your top three health concerns?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

List all medications (prescription and over-the-counter) and supplements/herbs that you are taking:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any known allergies to food, drugs or chemicals: \_\_\_\_\_

Are you currently under a physician's care? \_\_\_\_\_ If yes, physician's name \_\_\_\_\_

Last physical exam: \_\_\_\_\_ Last blood work: \_\_\_\_\_ Last dental exam: \_\_\_\_\_

Women: Last Women's Annual Exam: \_\_\_\_\_ Last menstrual period: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Birth Control history: \_\_\_\_\_

Children (names & ages): \_\_\_\_\_

**Health Habits**

Exercise (Type & Frequency): \_\_\_\_\_

Hours of Sleep: \_\_\_\_\_ Quality: \_\_\_\_\_

Tobacco: \_\_\_ Yes \_\_\_ No If yes, how much, how long? \_\_\_\_\_

Caffeine: \_\_\_ Yes \_\_\_ No If yes, how much, how long? \_\_\_\_\_

Alcohol: \_\_\_ Yes \_\_\_ No If yes, how much, how long? \_\_\_\_\_

Your typical diet: Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Drinks: \_\_\_\_\_

## **Medical and Family History**

Please write self or name of family member (siblings, parents, grandparents, children, etc.) next to medical conditions that you or anyone in your family have or have had in the past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abnormal PAP smear    | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Menstrual Disorders     |
| <input type="checkbox"/> Allergies/Hay fever   | <input type="checkbox"/> Glasses/Contacts        | <input type="checkbox"/> Multiple Sclerosis      |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Heartburn/Reflux        | <input type="checkbox"/> Pneumonia               |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Prostate Disease        |
| <input type="checkbox"/> Birth Defects         | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Bleeding Disorders    | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Breast Disorders      | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Frequent colds        | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Infertility             | <input type="checkbox"/> Ulcer                   |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Vaginal Infection       |
| <input type="checkbox"/> Ear infections        | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Varicose Veins          |
| <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Menopause Difficulties  | <input type="checkbox"/> Vertigo/Dizziness       |
| <input type="checkbox"/> Other: _____          |  |  |

Major illnesses/injuries/surgeries/hospitalizations:

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Immunizations received and any adverse reactions:

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Other information you would like us to know:

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**Thank you! We look forward to working with you!**