Winter Wellness

INFORMED CONSENT FOR HEALTH CONSULTATION

Consent to Treat
I consent to services rendered and provided to me by the attending physician and licensed professionals at Winter Wellness, participating in or consulting about my care. I hereby authorize my Practitioner to advise use of the following therapies: nutritional supplementation, botanical medicine including medical marijuana, homeopathic remedies, lifestyle counseling, psychological aid, acupuncture, cupping, IM injections, trigger point therapy, regenerative injection therapies, aesthetic procedures, and hormone replacement therapy. I recognize the potential risks and benefits of these therapies, such as allergic reactions and side effects to prescribed herbs, medications and supplements, and inconvenience of lifestyle changes.

I may be given additional consent forms for specific therapies that contain more information. My practitioner will additionally discuss all treatments with me, and answer questions as needed

I understand the U.S. Food and Drug Administration has not evaluated or approved nutritional/herbal supplements or homeopathic remedies. I understand that, as with drugs, nutritional/herbal supplements and homeopathic remedies may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain pre- existing disease conditions.

I do not expect my Practitioner to be able to anticipate and explain all risks and potential complications. I wish to rely on her to exercise judgment in recommending therapies she feels are in my best interest, based on the available knowledge. I have the opportunity to ask questions and discuss with my Practitioner: 1) my condition, 2) the nature, purpose, and potential benefit of the proposed therapies, 3) the material risks inherent in the therapies, 4) the probability of those risks occurring, 5) the likelihood of success, 6) reasonable available alternatives to the proposed therapies, 7) the material risks inherent in such alternatives and the probability of such risks occurring, and 8) the possible consequences if advice is not followed and/or no therapies are undertaken.

Notice to Pregnant Women: All female patients must alert Practitioner if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy. This is especially true for medical marijuana: there are dangers to the fetus using medical marijuana while pregnant, and also dangers to a baby that is breastfeeding from a mother who uses medical marijuana. It is not recommended to use marijuana while pregnant or breastfeeding, and I understand that certain professionals may have a duty to report such use to the Department of Child Safety.

I understand that there are alternatives to all treatments (medical marijuana included). Alternative treatments may include herbal therapies, acupuncture, hydrotherapy, chiropractic therapies, massage therapy and supplements. With this knowledge, I voluntarily consent to the above therapies, realizing that no guarantees have been given to me by Dr. Erin Winter, ND or any of her personnel, regarding prevention, treatment, or cure of my condition or any condition. I understand that I am free to withdraw my consent and to discontinue participation in these therapies at any time. **I understand that it is not being recommended for me to discontinue any other treatment or care being provided by any other health care professional.**

I understand Dr. Erin Winter, ND does not function as a primary care physician (unless specifically requested), and that she offers her services in addition to other services I receive. I understand she does not replace the services of my primary care physician or specialist (e.g. Oncologist, Cardiologist, Rheumatologist, OB-Gyn, etc.) unless specifically discussed in office. I will discuss all my prescription medication questions and changes with my primary care doctor and/or specialist. I understand that naturopathic therapies do not replace conventional medical advice/care.
I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or my representative or unless it is required by law. Exceptions to confidentiality are: danger to yourself, danger to another, or child abuse. The privileged nature of communication with Dr. Erin Winter, ND ceases under these circumstances. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that full disclosure of information has been made to me and all my questions have been answered to my full satisfaction.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content. By signing this agreement, I consent to be legally bound by the terms and conditions of this agreement. I can revoke consent at any time in writing.

Patient Name, Print: _____ Date of birth:_____

Patient Signature: _____ Today's Date:_____

If signed by Authorized Representative, please state legal
authority to act on behalf of patient, e.g. healthcare power of
attorney, healthcare surrogate, guardian, parent of minor, etc.: _____

Winter Wellness

OFFICE POLICY CONSENT FORM

Office Policies
Terms & Conditions We aim to provide the highest quality of care and service. Our policies support you in the best way possible and keep our clinic running smoothly for the benefit of every patient.

1. Appointment Information Because we treat the whole person, Dr. Winter takes time to get to know you. To get the most out of our services, a new patient will begin with a first office visit and follow up with a return office visit 2-6 weeks later. Additional appointments vary depending on your treatment plan.
Cancellation Charge We respect your time and trust that you respect ours. We require a minimum of 24 hours' notice of cancellation. If we do not receive a minimum of 24 hours' notice, you will be billed for 50% of the scheduled office visit cost.
Please understand that this policy is in place as a means of respecting the time and efforts of your doctor and her office staff, as well as other patients who would have benefited from a medical visit during this time. Should we have to change appointments, we will do our best to give you 2 business days' notice and will be sure to accommodate your needs and reschedule your appointment in a timely fashion.
Phone Consultations If you are unable to come to our office, follow-up visits via telephone are available after an initial in-person visit. These are billed at the regular in-office rate and payment is due via credit card at the end of each call. We are legally bound to perform all medical marijuana certifications and re-certifications as in-person appointments.
Email Consultations Naturopathic treatments are individualized and often require multiple changes in diet and lifestyle. As such, we do not offer consultations via email. Because the changes can be complex, you may need to clarify a matter regarding your current treatment plan before your follow-up appointment. You may email the office with short, concise questions that should be no more than 3-5 lines long and pertain to your current treatment plan. Please note that email is not considered to be a secure form of communication. By emailing your doctor, you are accepting the risk that your message may be intercepted or otherwise seen by an unauthorized third party. Email is not a substitute for an office visit. If your doctor determines that your email is too complex, requires an in-depth explanation or professional advice, or will result in an alteration to your treatment plan, please know that your email will be forwarded to our staff. They will contact you to schedule a 15-30 minute phone consult with your doctor so that your question may be adequately and appropriately addressed. These calls are billed at the regular in-office rate with payment due via credit card at the end of each call. If you email your doctor directly, you may receive an automated response that will direct you to call our office. For supplement refills or to report acute symptoms not requiring emergency care, please call our office at 928-277-7414. In an emergency, do not email or call us. Call 911 or proceed to the ER.

2. **Supplements** We sell supplements as a convenience to our patients and to make available the most effective and highest quality products. These products are often only available for sale through licensed professionals, and by selling them we guarantee their authenticity. You are not required to purchase your supplements at our clinic. All refills must be paid for at the time they are dispensed and can be picked up at the office or mailed to your home. If you need to pick up supplements after hours, supplements are left out at your own risk. All sales of supplements and botanicals are final.
3. Scent-Free Policy In order to support the health of our chemically sensitive clients, our office is a fragrance-free zone. Please refrain from wearing perfume, cologne and other scented products when visiting us.
4. Insurance & Payment Because your health insurance policy is a contract between you and your insurance company, you are responsible for understanding your coverage. Some private insurance companies have policies that do cover some or part of the care you receive from a Naturopathic Doctor. However, Dr. Winter does not contract with any insurance companies at this time.
Whether your particular policy is one that has such coverage is a detail verify with your insurance agent; our office does not have access to this information. All charges incurred at our office are your responsibility regardless of insurance coverage. Payment in full is due at the time of service. This includes fees for medical office visits, labs and any herbal/nutritional supplements prescribed for you. For your convenience we accept cash, check, Visa and MasterCard. At the end of each visit, you can be provided with a superbill that you can submit to your insurance company for possible reimbursement. Dr. Winter does not bill insurance and federal programs such as Medicare and Medicaid do not currently reimburse for naturopathic medical services.

Bounced checks incur a $25 processing fee. Refunds on labs are available with a $25 processing fee, provided labs were not performed, kits were not tampered with and are returned in a reusable state no later than 10 months after their issue. There are no refunds on services and/or supplement purchases. Any outstanding bills will be sent to a collections agency if not paid in full within three months of their due date.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content. By signing this agreement, I consent to be legally bound by the terms and conditions of this agreement. I can revoke consent at any time in writing.

Patient Name, Print: _____ Date of birth:_____

Patient Signature: _____ Today's Date:_____

If signed by Authorized Representative, please state legal authority to act on behalf of patient, e.g. healthcare power of attorney, healthcare surrogate, guardian, parent of minor, etc.: _____

Winter Wellness

HIPAA ACKNOWLEDGEMENT AND APPOINTMENT REMINDERS CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my Protected Health Information (PHI) to:

- Plan and provide for my care and treatment;
- Communicate to other healthcare professionals who may either directly or indirectly contribute or participate in my care or treatment;
- Obtain authorization, confirm service provided and collect payment from third party payers (e.g. my insurance company);
- Perform the routine healthcare operations of your practice;
- Participate in educational and/or research purposes, in which case all information that can identify me personally will be removed.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I authorize Winter Wellness to contact me via mail, email, text message or voice call regarding routine healthcare operations such as appointment reminders. If I am unable to answer the telephone, I give Winter Wellness permission to leave a message on my answering service or with the person answering the telephone. I understand that it is my responsibility to keep my contact information updated.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I would like to authorize Winter Wellness to receive and provide Protected Health Information (PHI) to the following individuals:

1. Name: _____ Contact Phone: _____
2. Name: _____ Contact Phone: _____
3. Name: _____ Contact Phone: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content. By signing this agreement, I consent to be legally bound by the terms and conditions of this agreement.

Patient Name, Print: _____ Date of birth:_____

Patient Signature: _____ Date:_____

If signed by Authorized Representative, please state legal authority to act on behalf of patient, e.g. healthcare power of attorney, healthcare surrogate, guardian, parent of minor, etc.: _____