

Walla Walla Naturopathic, PLLC: Consent to Treatment

Methods, Procedures and Therapeutic Approaches: The following may be utilized to assess, determine treatment approaches, treat or otherwise address your health concerns.

- Herbs/ Natural Medicine (prescribing of various therapeutic substances, including plants, minerals, vitamins and animal materials. Be SURE TO INFORM ME IF YOU ARE VEGETARIAN OR VEGAN. Substances may be given in multiple forms including: teas, powders, capsules, tinctures, elixirs, solid extracts, topical creams, pastes, plasters,
- Homeopathic Remedies: highly dilute/no detectable substance present. Remedies based on natural substances.
- Dietary Advice and Therapeutic Nutrition: Addition, subtractions or modification to the diet. Often includes the patient maintaining a diet and symptom diary. Additional supplementation with vitamins and minerals may occur.
- Acupuncture: the use of “healing filaments”, sterile, non-hollow needles on acupuncture points as determined by Traditional Chinese Medicine. This is generally a comfortable and relaxing procedure, well tolerated by most people.
- Cupping or Gua Sha: Cupping utilizes suction to bring blood flow to a specific area, often for muscular pain. Gua Sha applies friction to the area also to promote blood flow. Both techniques may leave temporary bruising, which generally may feel slightly tender for a few days while the tissue heals.
- Lifestyle counseling/Exercise prescriptions

Potential Benefits: Restoration of health and well-being, relief from pain and symptoms of disease, improved energy and mental function.

Potential Risks; Pain, discomfort, blistering, discolorations, infection, tissue injury from needle insertion, allergic reactions to herbs or supplements, aggravation of pre-existing condition (usually related to homeopathic treatment).

Notice to Pregnant Women: All female patients must alert the Doctor if they know or suspect that they are pregnant as some treatments may pose a risk to the pregnancy.

I understand that I may ask questions regarding any of these treatments if I have concerns before signing this form, and that I am free to withdraw my consent and discontinue treatment at any time. With this knowledge, I voluntarily consent to the above treatments/procedures, realizing that no guarantee of cure have been given to me by Walla Walla Naturopathic, PLLC. I understand that a health record will be kept of the health services provided to me and that this record will be kept confidential and will not be released to others unless so directed by myself or my representative or otherwise permitted or required by law.

I attest that I have read the above, and that I may ask questions or express concern regarding any treatment offered to me by Walla Walla Naturopathic.

Patient's Name (Print) _____

Patient's signature _____ Date _____

Guardian/Personal Representative _____ Date _____

Walla Walla Naturopathic, PLLC: Financial and Privacy Terms

FINANCIAL TERMS:

I am in the process of credentialing with the major insurance companies. When I am credentialed I will bill these agencies for you and bill you for any amount not covered including deductibles and percentage payments. If I am not a preferred provider with your insurance company, I will provide you with a super bill that you may submit to your company for reimbursement (generally 50% of the visit fee). If you choose to pay out of pocket at the time of service I will offer a Time of Service discount to you. Co-pay will generally be accepted at time of service. It is strongly encouraged that you check with your insurance provider what your CAM (complementary and alternative medicine) benefits are prior to your visit. Please note that herbs and supplements are not covered by insurance plans at this time.

I (the patient) understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that there is a cancellation policy and that I may be billed for missed appointments or appointments cancelled with less than twenty-four hours notice. I further understand that excessively overdue accounts may be forwarded to an outside agency for collection.

RATES:

Insurance Billing: I am happy to bill your insurance company for you as an In Network Provider or Out of Network Provider. Co-pay is due at time of Service. Please check that your benefits include naturopathic medicine and whether you have a deductible to meet.

After 90 days, unpaid insurance claims will be converted to cash claims.

Patient Statements: Statements are generated the first week of each month and are mailed out within 1-2 days. Balances over 90 days are past due and a 1% monthly interest charge will be assessed.

If required for recovery of past due accounts, you will be charged the collection and/or legal fees. A \$20 fee will be charged for returned checks.

Time of Service Discount: If you choose to pay out of pocket at time of service (i.e. we do not bill insurance) these discounted rates will apply.

First Office Call (One hour and fifteen minutes) \$200.00

Return Office Call (thirty minutes) \$120.00

PRIVACY TERMS:

Walla Walla Naturopathic, PLLC (WWN) keeps a healthcare record of services provided to you. Applicable state and federal laws protect the confidentiality of your record and grant you the right to see or obtain a copy of your record. Moreover, if you believe the information in your record is inaccurate, you may also request that we correct or amend that record. WWN will not disclose your medical record to others unless you direct us in writing to do so or applicable laws authorize or compel us to do so. WWN is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your medical record, wish to inquire about your rights or schedule an appointment to view your record, please contact us with your concerns or questions.

I hereby acknowledge that I have received a copy of Walla Walla Naturopathic's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that WWN has made a good faith effort to obtain my acknowledgement.

Patient's signature _____ Date _____

Guardian/Representative's Signature _____ Date _____