Whole Body Wellness
AN INTEGRATIVE MEDICAL CENTER

647 N Main St, Fort Bragg, CA 95437
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OFFICE ONLY: Date Rec'd: _____
Date Sent: _____
Doctor: Lisa Edens-Tan, ND

The term 'health care provider(s)' in this form means Whole Body Wellness, their doctors, employees and members of the medical staff who provide care to patients.

CONSENT TO TREAT

I _____, hereby authorize the health care providers of **Whole Body Wellness ~ An Integrative Medical Center** to perform with my approval and consent, as they deem necessary in the course of my care, the following procedures for my diagnosis and treatment:

Physical Exam: general, cardiac, lung, EENT, neurological, musculoskeletal, etc.

Common Diagnostic Procedures: including but not limited to venipuncture, diagnostic imaging, laboratory evaluation of blood, urine, stool, saliva, and hair, pap smears, neurological and musculoskeletal assessment.

Physical Medicine: muscle release techniques, naturopathic osseous manipulation of the spine and extremities using manual or device-assisted manipulation including traction, craniosacral therapy, trigger point therapy, muscle energy stretching, visceral manipulation, photobiomodulation (LLLT) and Dural Attachment Therapy.

Hydrotherapy: including but not limited to the therapeutic use of varied temperature water-based topical applications, e-stim machine, Peat

Topical Treatments: including but not limited to topical application of natural or synthetic substances.

Dietary Advice and Therapeutic Nutrition: which may include lifestyle and nutritional counseling, diet plans, oral nutritional supplements (with vitamins, minerals, and amino acids), intra-muscular and intravenous vitamin or supplemental injections.

Botanical Medicine: with teas, tinctures, capsules, tablets, and creams.

Homeopathic Medicine: using highly dilute quantities of naturally occurring plant, animal, or other substances for healing.

Chelation: heavy metal detoxification, oral and intravenous therapy.

Infrared sauna: Heating of the body to raise core temperature. Benefit is to detoxify, raise Heat Shock Proteins (HSP) and indirectly bring about weight loss.

Electromagnetic and Thermal Therapies includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, and microcurrent stimulation.

I understand that referral for specialty conventional medical care may at times be necessary for my safety.

Potential risks: pain, discomfort, discoloration from topical applications; allergic reactions to prescribed herbs or supplements, soft tissue or bone injury from physical manipulations, and aggravation of preexisting symptoms.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Whole Body Wellness ~ An Integrative Medical Center or any of its personnel regarding cure or improvement of my condition. I understand that I am at liberty to seek alternate opinions or care and may discontinue treatment at any time. I will not hold Whole Body Wellness ~ An Integrative Medical Center responsible for treatment outcomes should I choose to disregard the medical advice given to me. 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 so directed by my representative or me or otherwise permitted or required by law.

RELEASE OF INFORMATION

I understand that as part of my health care, health care providers create and maintain health records that may include my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as a basis for planning my treatment and care and is a tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

FINANCIAL RESPONSIBILITY

I agree to pay all charges for my health care treatment. If charges to my account are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information

(PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient's Representative(s): (the following must be filled out, even if the answer is none)
This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

*** I hereby authorize the following individuals to have access to my healthcare information:**

_____, Relationship to Patient _____
_____, Relationship to Patient _____
_____, Relationship to Patient _____

With this knowledge I voluntarily consent to the above procedures realizing that no guarantees have been given to me by **Whole Body Wellness ~ An Integrative Medical Center** or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation at any time.

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ **Date** _____

Patient or Responsible Party Signature _____

Responsible Party's Relationship to Patient _____

Witness _____ **Date** _____

** *If you would like a copy of this form, once signed, please ask the receptionist* **

Patient Compliance Assurance Notification

To our valued families and patients:
The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!