Everhope Clinic PLLC
Naturopathic Medicine

CONSENT FOR TREATMENT

I hereby authorize the healthcare providers (physicians, employees, and members of the medical staff) at Everhope Clinic PLLC (Everhope Clinic), in accordance with the scope of their practice, to perform such examination, testing, procedures, and treatment as they deem necessary in the course of my care.

I have a right to be informed about my condition and recommended care. I may give, or withhold, my consent after having an opportunity to discuss my condition, treatment options including potential benefits, risks, and side effects, the likelihood of success, alternative treatment options, and potential consequences if treatment or advice is not followed and/or nothing is done. I acknowledge that no expressed or implied guarantees have been made to me by any physician or staff regarding cure or improvement of my condition. I understand physicians cannot anticipate and explain every possible risk or complication, and I wish to rely on the physicians' judgment with respect to treatment.

NOTICE TO PREGNANT WOMEN

All female patients must alert the physician if they know or suspect that they are pregnant as some of the therapies used could pose a risk to the pregnancy.

FINANCIAL RESPONSIBILITY

I understand a credit card payment may be required to book an appointment. This payment will be applied to the total charges incurred on the date of service. This payment is fully refundable if I cancel my appointment by giving at least 48 hours' notice and half will be refunded with less than 48 hours' notice.

Payment for service is due at the time of checkout. We accept cash, checks, VISA, MasterCard, American Express, and Discover cards.

_____ (initial) I understand that if my insurance, including Medicare or Medicaid, does not cover the cost of labs ordered, I am financially responsible for the unpaid portion.

PATIENT REPRESENTATIVE

If you would like to allow a family member or friend to discuss your healthcare with us on your behalf, their name(s) **must** be listed below. If their name is not listed, we will not be able to speak to them about your health concerns.

_____, Relationship to Patient: _____

_____, Relationship to Patient: _____

_____, Relationship to Patient: _____

___ I do not wish for Everhope Clinic to discuss my medical concerns with anyone.

EMERGENCIES

Who should we contact in the event of an emergency?

Name: _____

Relationship to Patient: _____

Telephone: _____

OBSERVERS

I understand that practitioners at Everhope Clinic from time to time may offer preceptorships to medical students (Observers) who may observe or participate in the care provided and I have the right to decline their presence during my visit, procedure or treatment at any time. I understand that medical students and office staff are subject to, and will abide by, the Notice of Privacy Practices.

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

We are required by federal law to provide you with a Notice of Privacy Practices (Notice) that describes how the medical information we maintain about you, which includes health history, symptoms, results of any physical exams and lab work, diagnoses, treatment, and plans for future treatment, may be used or disclosed and provides a description of your rights and our obligations under federal and state privacy laws. A summary of our Notice is as follows:

Uses and Disclosures
Your medical record will be kept confidential and will not be released to others unless directed by you or your representative, as may be required by law, or as necessary for insurance claim processing reasons. Some of the reasons we may use or disclose your information include:

- To provide information about your health condition to other health care providers who may treat you;
- To report a communicable disease, or other legal reporting requirements; or
- To comply with a court order requiring the disclosure of your medical record.

These examples are merely illustrative. For a full description of the uses and disclosures that we are permitted to make, please consult the Notice on our website.

Your Rights
While the records we maintain about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a written or electronic copy of the medical information we maintain about you and to request we amend information you believe is incomplete or incorrect. Also, you may request a list of certain instances in which we have disclosed medical information about you. You also have the right to be notified following a breach of your unsecured Personal Health Information (PHI). All of these rights are subject to some exceptions that are described in full in the Notice of Privacy Practices.

Our Obligations
We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may change the Notice from time to time. All amendments apply to prior information we may have about you. Our full Notice of Privacy Practices is available upon request and on our website at www.everhopeclinic.com. Please read it carefully. If you have any questions or require additional information, please contact our office.

ACKNOWLEDGMENT

By signing below, I acknowledge I have been provided ample opportunity to read, or have been read, this form, have received or declined a copy of our Notice of Privacy Practices, and have had any questions satisfactorily answered. I agree to use this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment. I also understand I am free to withdraw my consent and to discontinue participation in any treatment or procedures at any time.

_____ _____
Patient Name - Printed Date

_____ _____
Patient or Responsible Party Signature Relationship to Patient

If you would like a copy of this signed form, please ask.