Good Natured Medicine Holistic Care, LLC

Patient Information

Last Name: _____First Name: _____Middle Name:_____
Address: _____ City: _____ State: _____ Zip Code: _____
SS#: _____ **Date of Birth:** _____ Sex:____ **Main Ph:**(_____)_____WorkPh:(_____)_____
E-mail:_____ Special Needs:_____
May we leave confidential voice-mail messages for you by phone or e-mail? No Yes (specify): **Home Work Cell**
Previous names that your records have been kept under: _____
Employer/School:_____
Mother's Name (minors only): _____Father's Name (minors only):_____
Insurance Carrier:_____**ID# (alpha prefix +9 digits)**_____**Group#**_____
Primary Subscriber's Name:_____**Primary Subscriber's Date of Birth**_____
Emergency Contact: _____ Relationship to Emergency Contact:_____
Contact's Phone #1: (_____)_____ Contact's Phone #2: (_____)_____
Any racial/ethnicity/creed/gender related information you'd like us to know about?_____
How did you hear about us? _____

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____ First Name: _____ Middle Initial:_____

Address: _____City: _____ State: ____ Zip: _____ Phone: (_____)_____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____
Guarantor's Signature **Date**

Terms of Admission

Privacy Terms: We keep a record of the healthcare services we provide to you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Good Natured Medicine 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 healthcare information at Good Natured Medicine, wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our office at (206) 686-5012.

Financial Terms: I understand that full account payment is due at the time of each visit, and that if in billing insurance, that I am responsible for all charges whether or not they are covered by my insurance. I understand that finance charges will begin accruing on accounts that are 30 days past due for payment at a rate of 1.5% per month. I understand that a cancellation fee of $50 will be charged for all missed appointments and all cancellations within 24 hours of my scheduled appointment. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance, and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if that guarantor is someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

I hereby acknowledge that I have received a copy of Good Natured Medicine's Notice of Privacy Practices and that I agree to the Financial and Privacy terms explained above. Should I refuse or fail to sign this form, I acknowledge that Good Natured Medicine has made a good faith effort to obtain my acknowledgement.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Signature & Relationship to Patient Date

X _____
Guardian/Representative's Printed Name

CONSENT FOR TREATMENT & AGREEMENT TO ARBITRATE:

I hereby voluntarily consent to receive patient care at Good Natured Medicine, including but not limited to routine diagnostic procedures, physical examinations, and naturopathic medical treatment (homeopathy, botanical medicine, nutritional & psychological counseling, hypnotherapy, NAET, and craniosacral). I consent to participate in telemedicine visits, knowing that there are limitations not limited to: technological glitches, and accurate diagnosis is not always possible without a direct clinical exam. Potential Risks include, pain, discomfort, nausea, giddiness, heat; allergic reactions to prescribed herbs or supplements; and aggravation of pre-existing symptoms. Potential Benefits include drugless relief of presenting symptoms and an improved balance of bodily energies, the restoration of 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. I recognize that some treatment modalities may be considered experimental such as NAET and in the event that I choose to undergo such therapies I understand that I have been informed of the benefits and risks of these treatments, and that results are dependent on the unique response of my body and thus cannot be guaranteed. Some treatments (i.e. NAET) are considered experimental by insurance companies and will have to be paid at time of service, or prepaid. I understand that such patient care is provided at my request and will be performed by Dr. Lisa Chavez, her assistant or designee. I further declare that I have been informed of the nature of the aforementioned patient care, and that I have the freedom to refuse any specific treatment or mode of communication such as telemedicine. In office visits may be limited depending on unique needs, presenting symptoms, and governmental or environmental limitations.

Notice to Pregnant Women: All female patients must alert Dr. Chavez or her designee or assistant if they know or suspect that they are pregnant. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from your pregnancy care provider authorizing or recommending such a treatment.

Notice to patients receiving NAET: I recognize that NAET is a method applied for helping me clear my allergies. By no means is the NAET method a guarantee of cure or clearance of said ailments, but the techniques used by Dr. Chavez and the method invented by Dr. Nambudripad are to help me calm my immune system's over-reactivity to stimuli in my food, water and environment. To this end, I attest I have made myself familiar, or will do so before I am treated, with the methods engaged in for NAET sessions, as well as the self-massage of the 8-10 gates at the particular meridian sites on my body to enhance and engage my body's own healing mechanisms for the re-alignment of my immune system. I recognize that if I don't regularly engage and follow up treatments within the guidelines of the treatment plan and techniques set forth that my results may be less than satisfactory I agree to hold Dr. Lisa Chavez, and Good Natured Medicine Holistic Care, LLC harmless and free of blame for any side effects due to my own neglect of adhering to the instructions. _____ ***(initial)***

I understand that I may ask questions regarding my treatment before signing this form and with this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Lisa Chavez regarding cure or improvement of my condition. Additionally, it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, Dr. Lisa Chavez and myself, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Furthermore, 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. I understand that I may look at my medical record by scheduling a time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last treatment.

I hereby acknowledge that I have read and understood Good Natured Medicine's Consent for Treatment and Agreement to Arbitrate form and that I agree to the terms explained above.

_____ _____

Patient's Name (PRINT) Patient/Guardian name (PRINT)

X _____ **X** _____

Patient's Signature Parent or Guardian Signature

_____ _____

Relationship/Representative's Authority Date