A WellSpring of Natural Health, PC

Person-Centered Health Care ◦ Natural Medicine for the Whole Family

Adult Returning Patient - Administrative Forms

☐ Mitchell Bebel Stargrove, ND, LAc ☐ Lori Beth Stargrove, ND

Patient Name _____ Date of Birth _____

Patient-Clinician Relationship Acknowledgement

The undersigned patient ("Patient") understands and agrees that Patient is retaining the services of a **clinician** ("Clinician") at A WellSpring of Natural Health, P.C. ("WellSpring") **as an independent health care and medical practitioner**.

Patient recognizes, understands and agrees that the **Clinician they are working with is a sole practitioner** and is not a partner or otherwise affiliated with any other Clinician who may be providing similar services at WellSpring.

Patient recognizes, understands and agrees that their **Clinician at WellSpring is not their Primary Care Physician** within their insurance coverage system.

Patient further recognizes, understands and agrees that the clinician they are seeing is solely responsible for and shall provide all professional services to Patient and that Patient is relying solely on the skill of the Clinician they have engaged for the professional services rendered at WellSpring. The Patient is free to receive medical treatment and health care services from any other clinicians(s) of their choice. This agreement is not intended to restrict the Patient from receiving medical treatment or healthcare services from other clinicians at this clinic or anywhere else.

Patient further recognizes that their Clinician may prescribe medication(s), which may be purchased from a seller of the patient's choice.

☑ _____

READ, UNDERSTOOD AND AGREED

PATIENT

_____ _____

Printed Name Date

_____

Signature (or Signature of Parent/Legal Guardian)

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Informed Consent for Treatment

I, _____, hereby request and consent to receive naturopathic, acupuncture and/or Chinese medical treatment and health care by the licensed acupuncturist and/or licensed naturopathic physician ("Clinician") at A WellSpring of Natural Health, P.C. ("WellSpring") who now or in the future may treat me while working at or associated with WellSpring. Further, such consent and request applies equally to any other licensed acupuncturist and/or licensed naturopathic physician serving as for medical care back-up or in *locum tenens* for my Clinician at WellSpring, whether signatories to this form or not. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have also read and understand the attached "Notice of Patient Privacy", which discusses my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Examples of Diagnostic Procedures, Health Care and Medical Treatment:

- Customary diagnostic procedures: including but not limited to general physical exams, venipuncture, PAP smears, blood and urine lab work.
- Traditional naturopathic, Chinese and other natural medicine systems of diagnosis and pattern evaluation, such as pulse and abdominal palpation, tongue and facial appearance, muscular armoring and tension dynamics, gait and postural observation.
- Lab tests and procedures: including referral for x-ray, MRI, or other diagnostic imaging.
- Minor office procedures: e.g., dressing a wound, ear cleaning, incision repair, laceration repair, wart removal, skin biopsy, etc.
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, injections of nutrients.
- Botanical therapies: substances may be prescribed as teas, infusions, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- Homeopathic medicine: the use of diluted quantities of naturally-occurring substances to gently stimulate the body's self-healing responses, given orally, topically, or by injection.
- Prescription of pharmaceuticals or bio-identical hormones.
- Counseling: life choices, psychological processes, self-actualization, creative expression, health promotion including recommendations for exercise, sleep, contraception, and stress reduction.
- Naturopathic manipulative therapies: specific manipulation of muscles, joints (including cranial bones), or soft tissue.;
- Tui na massage, cupping, moxibustion, heating or bleeding of acupuncture points.
- Acupuncture and trigger point needling, including injections such as bee venom therapy, prolotherapy, homeopathic injections.

I have had the opportunity to discuss with my Clinician at WellSpring the nature and purpose of health practices, acupuncture, naturopathic therapies and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic medicine and acupuncture and other practices of Chinese medicine, pose some level of risk. Within the general clinical setting, the possible adverse outcomes of these practices by a naturopathic physician and/or acupuncturist range from minor to potentially fatal.

The health care and medical treatment we provide may or may not be directed at a specific disease or disorder. It may be preventive in nature, designed to improve overall health and well-being, restore your body's innate self-healing processes, and support you in living consciously and creatively. We will always strive to provide full disclosure of all information relevant to your clinical care. I understand that in providing treatment my Clinician is relying on the information that I am providing to them about the

Patient, the Patient's health, and the Patient's response to therapies and my own behavior. I agree that the information I provide will be true and accurate and that I will disclose to the physician everything needed for treatment.

The herbs, homeopathic medicines and nutrients (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic and/or Chinese medicines. It is extremely important that the prescribed recommendations be followed when taking herbs, homeopathic medicines and nutritional agents because they may induce adverse effects when taken in excessive amounts or inappropriate situations. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs and nutrients may be inappropriate during pregnancy, and I will immediately notify those providing my clinical care at WellSpring if I become aware that I may be or am pregnant.

I will immediately inform the Clinician at WellSpring if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), bruising or burns (associated with acupuncture, injections, cupping or moxibustion), or any unanticipated or unpleasant effects associated with treatment or the herbs or other therapies prescribed by the Clinician at WellSpring. I understand that while this document describes the most common risks of treatment, other adverse effects and risks may occur. In order to properly treat my medical condition and support my health and medical progress, the Clinician at WellSpring must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, it is important to seek treatment immediately from an emergency care facility or call 911.

With this knowledge, I voluntarily consent to the above procedures and that I acknowledge that no guarantees have been given to me by my Clinician or the staff of A WellSpring of Natural Health, P.C. regarding cure or improvement of my health and medical condition(s).

I have read, or have had read to me, and understand the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name _____ Date _____

Signature (or Signature of Legal Guardian) _____

Print Your WellSpring Clinician's Name _____

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Economics and Billing

Dear Returning Patient:

Welcome back to WellSpring. We, the clinicians and staff at A WellSpring of Natural Health, P.C. ("WellSpring"), look forward to providing for your medical needs and health goals. We encourage your questions and participation in all aspects of your medical treatment and health care.

You understand that you are retaining the services of only the clinician named below. You recognize, understand and agree that your clinician is a sole practitioner and is not a partner or otherwise affiliated with any other healthcare practitioner who may be providing similar services at WellSpring or elsewhere. You further recognize, understand and agree that your clinician is solely responsible for and shall provide all professional services to you and that you are relying solely on your clinician's skill for the professional services rendered at WellSpring.

You are important to us. We wish to keep you informed of our policies regarding your payment responsibilities. We feel that it is essential that we share a clear understanding of our economic relationship so as to enhance and not interfere with our therapeutic relationship. We recognize and appreciate that health care can involve a significant financial commitment. That is exactly why we want you to know that our primary goal of the healthcare providers at WellSpring is to provide you with safe, effective and affordable healthcare.

As the patient of your healthcare provider, you are responsible for the total charges incurred from each clinic visit. **Charges are to be paid at the time of the visit unless specific arrangements have been made prior to the office visit**. We accept VISA, MasterCard, checks and cash. There will be a charge of $30.00 each for any returned check(s). **If we are billing your insurance, we require that your deductible has been met and that payment of your co-portion of each bill is paid at the time of each visit**. If your insurance company does not pay the outstanding balance within 60 days of the treatment date, you will be required to pay the full amount along with any new charges incurred. If immediate full payment will present major difficulties for you, please ask about our procedures to assess your financial abilities and formulate a payment plan with you.

You are encouraged to bill your insurance company directly for services we provide. **The terms of your insurance policy and its riders may or may not cover the care you receive at WellSpring.** We are willing to assist you in billing your insurance company when naturopathic and/or acupuncture care is covered. We provide initial billing to your insurance company, for each visit as a courtesy at no additional charge. If it becomes necessary to re-bill your insurance company for any outstanding balance, a $10.00 per re-billing fee may be charged. We will only bill your insurance twice. Be aware that any account over 60 days past due will accrue interest at 1.5% monthly (18% per annum). Please remember, that **you have the primary relationship with your insurance company and are responsible for the total amount owing if your insurance carrier determines that it will not pay for services that have been provided.**

The terms of the Affordable Care Act require that acupuncture and naturopathic medical services be covered in accordance with licensing of providers and their respective scope of practice as defined by the State of Oregon. Specifically, Section 2706 – the provider non-discrimination provision of the Public Health Service Act as amended by the Affordable Care Act mandates that insurance coverage prohibits insurance companies from discriminating against naturopathic physicians or licensed

acupuncturists (or any other provider for that matter) when the clinician is treating the same conditions or performing the same services that the insurer would otherwise cover.

Your clinician may prescribe nutrients, herbal preparations and/or other medications, which may be purchased either at this location or elsewhere. Such products are available at this site from a separate business; payment for all medicinary items is not related to your clinical or economic relationship with WellSpring. Most insurance policies do not cover or reimburse for the nutrient and herbal products that your Clinician prescribes, but certain medical savings accounts or employee benefit plans may reimburse for prescribed medicines. In such cases, WellSpring will provide you with an appropriate Letter of Medical Necessity for submission.

If you have any questions concerning any of these policies, or need to formulate a payment plan, please feel free to contact our staff *before* your office visit. If you accept these terms of relationship, please sign the bottom of this form and hand it in at the front desk.

I have read and understand the above-stated policies of A WellSpring of Natural Health, P.C. and will comply with them in all respects. If my insurance company requires a release of my medical records, I hereby give my permission by signing this form.

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name

Date

Signature (or Signature of Legal Guardian)

Print Your WellSpring Clinician's Name

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Missed Appointment and Late Cancellation Policy

Scheduling an appointment with a clinician at WellSpring represents a bond of trust and good faith between you as a parent or legal guardian, the patient, your clinician and the clinic as a whole. It implies that we will be here to serve you and that you will be present and on time for your appointment. We schedule appointments in increments of time that balance your individual needs and the typical time requirements for effective health care and medical treatment. We do our best to stay on schedule in a comfortable and caring environment. While always respectful of your time, we do encounter situations where patients require more than the scheduled time. We ask for your understanding and patience on these occasions. You will appreciate our efforts at balancing timeliness and attentiveness some day when you need extra time and attention.

Contact the clinic as soon as possible to reschedule if you will be unable to be at your appointment in a timely manner. For rescheduling or canceling appointments, we require a 24-hour notice, or one full business day in the case of weekends and holidays. If you are not able to reach us during clinic hours you may leave a message in the front desk mailbox of our voicemail system; a message left outside of normal business hours will be considered as received at the opening time of the next business day. A cancellation without adequate notice will be considered a missed appointment. Likewise, if you are more than 15 minutes late for your scheduled time, the appointment will be considered as "missed" and will have to be rescheduled.

Established patients will be billed a $100 fee for a missed appointment or late cancellation of an appointment with less than one full business day (i.e., 24 business hours) advance notice. This charge will not be submitted to your insurance company. Any emergencies warranting special consideration will be respected as a reasonable exception. **Furthermore, arriving for an appointment 15 minutes late or more qualifies as a missed appointment and a $100 fee may apply; you may not be able to receive care during that scheduled appointment.**

Patients will be billed a $150 fee for a second missed appointment or late cancellation of an appointment with less than one full business day (i.e., 24 hours) advance notice (within a one year period). In the event of more than two or more missed appointments and/or late cancellations within a one year period, scheduling of further appointments will require that a plan of consistent care can be agreed upon.

We appreciate your understanding of this policy. Our goal is to nourish a professional relationship based upon trust, confidence and mutual respect, which will enhance the quality of your health care and medical treatment. Please talk to the office staff if you need clarification of this policy. This policy may be revised with thirty days notice at WellSpring.

☑ **READ, UNDERSTOOD AND AGREED**

Printed Name

Date

Signature (or Signature of Legal Guardian)

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Notice of Patient Privacy (Short Form)

Health Insurance Portability and Accountability Act (HIPPA)
Effective Date: April 14, 2003 Updated: June 21, 2015

A WellSpring of Natural Health, P.C. ("WellSpring") is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and WellSpring's responsibilities with respect to your Protected Health Information.

WellSpring may use or disclose your PHI for the purpose of diagnosing or providing medical treatment, obtaining payment for health care bills or to conduct health care operations. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected medical and health care information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing.

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of our most current NOTICE in effect, please ask at the front desk and we will provide you with a copy. This document is also available in the Forms section of the wellspringofhealth.com website.

We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

You may contact our Privacy Officer, Clinic Director Dr. Lori Stargrove at 503.526.0397 if you have any questions, concerns or complaints or seek further information about the complaint process.

By signing this form you are acknowledging that you have been provided information regarding our privacy practices pertaining to your "Protected Health Information."

☑ **READ, UNDERSTOOD AND AGREED**

PATIENT

Printed Name _____ Date _____

Signature (or Signature of Legal Guardian) _____

Print Your WellSpring Clinician's Name _____

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Appointment Courtesy Reminder Preference

Printed Name _____ Date _____

Please mark your preference: ☐ Text message ☐ Phone call

Designate Your Preferred Phone Number for Reminder:

Mobile Phone _____

Home Phone _____

VitalGoods Information Transfer Permission

Please sign below to grant permission to A WellSpring of Natural Health, PC, to share your phone number and email address with Health Resources Unlimited, Inc. in relation to its VitalGoods.com website and/or medicinary sales.

We promise that your personal information will not be shared without your permission.

By signing below I grant such permission:

Printed Name _____ Date _____

Signature _____