A Renaissance Health Center for Natural Medicine
130 NW Miller Ave., Gresham, OR 97030 PH: 503.665.2344

Consent Form

PLEASE READ CAREFULLY BEFORE INITIALING OR SIGNING.

Consent To Treatment

Naturopathic, Chiropractic, Massage Therapy, Acupuncture & Chinese Medicine therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury or bruising, dizziness, burns, temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result.

_____

Print Name Signature of Patient Date

Consent Regarding Physicians, Practitioners and Staff Leaving Messages on Phone

_____ Our Physicians and Practitioners at A Renaissance Health Center may need to follow up with patients regarding blood lab testing, pap smear results, diagnostic imaging results or other topics pertaining to personal health status. By signing below, you are consenting to allow A Renaissance health and it's practitioners to leave private information on the phone number listed below.

I agree to allow my practitioner to leave messages concerning results or information about my health at the phone number below:

Phone number to call with personal info:_____ home cell work

_____ Signature of Patient

Consent Regarding Use of Information

_____ Our Physicians and Practitioners at A Renaissance Health Center may use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be read by a malicious outside party with the technical skills to intercept such correspondences. By initialing this line, you are consenting to allow A Renaissance Health and its practitioners to correspond with you via email in spite of these potential risks.

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Financial Agreement for A Renaissance Health Center

1. Payment is due at the time of service. I understand that I am financially responsible for all services I receive at A Renaissance Health Center.

2. We bill your insurance for you as a courtesy. It is your responsibility to pay your deductible and the portion your insurance does not pay. After 60 days if your insurance has not paid, we will expect full payment from you for the balance due. We do not accept payment plans. However, we accept VISA, MC, American Express and money orders.

3. Our office cannot guarantee that your Insurance will pay for services you have received here. All amounts are an estimate of cost, or an estimate of what insurance may pay. If only partial payment is received or your insurance claim is denied, you are responsible for the full amount due on your account immediately. Our office will not enter into a dispute with your insurance company over your claim.

4. Your account is current if it is less than 60 days old. After 60 days, interest will be charged on all overdue accounts at a rate of 15% per month.

   There is a **$50.00** fee for all appointments without a 24 hour notice of cancellation or a "No Show."

   There will be a **$35.00** fee for any returned check.

5. Office hours are Tuesday through Friday from 9 – 6 pm, and Saturdays from 9-5 pm. Last appointments are one hour before closing. If you choose to be seen other than our regular scheduled hours, there will be an additional "After Hours Office Call" fee of $75.00.

6. If you discontinue care without the Physician's recommendation, the balance of your account is due in full immediately, even if your insurance is billed.

7. I understand that I am responsible for all collection costs regarding my account. If necessary, accounts are turned over for collection to Quick Collect, Inc.

8. I have read and understand this financial agreement and agree to the terms as listed above.

_____

Patient or Guardian Signature Date

_____

A Renaissance Staff Signature Date

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Consent for Use and Disclosure of Health Information

This notice describes how medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:

For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.

For billing and collection purposes, we may release records of your health care and information that you have provided to your insurance carrier or other financially responsible parties.

For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other then your home or if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Medical Director.

Name (print)	Signature	Date

If you are a minor, or if you are being represented by another party:

Personal Representative Name (Print)	Personal Representative Signature	Date