NEM Natural Elements Medicine

541 791 6537 tel
855-547-6609 fax
nemhealth.com

Patient's Name: _____DOB: _____
First Middle Last

PARENT/GUARDIAN'S NAME (If patient is a minor):_____

Marital status: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone numbers: home _____ work/cell _____ email: _____

Preferred communication for appointment reminders and other messages – no health information will be disclosed (circle) email / work phone / cell phone / home phone / patient portal
Is it ok to receive mail at home from our clinic?
Would you like to receive periodic newsletters via email? Yes / No (circle)

Emergency contact: _____

Relationship: _____ Telephone number: _____

Consent for Treatment

I consent to services rendered and provided to (me/ my child) under the instructions of ***Zia L. Robles Hernandez***, licensed naturopathic physician.
I recognize that there may be potential risks to treatments or procedures and that Dr. Robles Hernandez will educate and alert me to those risks to the best of her knowledge. I do not expect Dr. Robles Hernandez to be able to anticipate and explain all risks and complications.
Potential risks include: allergic reactions, side effects of natural medicines, bruising at injections sites, venipuncture or procedures.
I understand it is my responsibility to let Dr. Zia L. Robles Hernandez know if I have further questions, or concerns regarding treatment or procedures recommended for me/ my child.
I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
Notice to Pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

Signature _____ Date: _____

Email and Text Communication Policy

Email

Using Email for communication has many advantages, and as such many of our patients desire to communicate with us in this way.

Emailing also has some disadvantages including confidentiality risks to your protected health information (PHI). Because of this, HIPAA laws require that we inform you of the risks and your rights and obtain your consent prior to emailing you about your PHI. Natural Elements Medicine has taken several measures to reduce the risk of emailing and maintain HIPAA compliance; however, email is never risk-free.

Natural Elements Medicine provides a patient portal that is HIPAA compliant where you may communicate with Dr. Zia regarding health concerns.

Patient Name: _____ DOB: _____

Risks

There are certain inherent risks to using email. These risks include, but are not limited, to:

- Email may be forwarded, printed, and stored in numerous paper and electronic forms.
- Email may be sent to the wrong address by either party.
- Email may be easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails.
- Email may be intercepted, altered, or used without detection or authorization.
- Email may spread computer viruses.
- Email delivery is not guaranteed.
- Email accounts can be broken into by hackers and viewed by unauthorized parties.

Patient Responsibility

We ask patients who want to use email to communicate with us to agree to:

- Not to use email for medical emergencies. Please call 911.
- Follow up with NEM by phone if you have not received a response to an email within a reasonable time period. Inform NEM of any changes to an email address.
- Inform NEM in writing if you decide to discontinue using email communications.
- Identify yourself clearly in the message body of the email.
- Not disclose medical information in the body of the email.
- USE the NEM Patient Portal for messaging that is HIPAA compliant for messages containing PHI.

Natural Elements Medicine Responsibility

NEM agrees to:

- To take reasonable precautionary measures to protect your PHI sent by email.
- Not sell your email to 3rd parties
- Send you email only for the following reasons: **(except with revoked consent):**
  - ➢ contact you with office updates, including future newsletters
  - ➢ provide appointment reminders
  - ➢ provide invoice/statements**Email Fees**

The cost of messaging (via Patient Portal) is included in your office visit fees and will not incur additional fees if used in a reasonable fashion (follow-up questions related to recent appointment, clarifications of treatment plan etc). NEM reserves the right to charge if emails become excessive. You will be notified ahead of time if we need to do so.

Texting

Natural Elements Medicine uses an automated program to send you text reminders for appointments or when you receive messages to the portal. No PHI is used in these texts. You have the right to revoke permission to use text messaging for these purposes.

By signing below I acknowledge that I have been informed of the inherent risks of the use of e-mail.
I understand that I have the option of not consenting to EMAIL and TEXTS FROM NEM, but if I do consent I may revoke this permission at any time.

____I agree to abide by the patient responsibility requirements in the Email and Cell Phone Text policy.
____I consent to communicate via email with NEM
____I consent to text communications FROM NEM

Signature _____ Date: _____

Patient Name: _____ DOB: _____

Financial Policy

NEM accepts cash, check or credit card (Visa, Mastercard, Discover, AMEX).
Payment in full is due at the end of your visit, unless other arrangements are made.
All lab fees, nutritional supplements and other supplies must be paid in full at time of receipt.

Insurance: *Insurance will only cover the cost of visits and only if your plan includes coverage for office visits with Dr. Zia L. Robles Hernandez.*
LATE PAYMENTS: I 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 below 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 someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.
Appointments may be suspended if payments are not received and will be sent to collections. A $25 charge will be assessed for any checks returned from the bank.
Cancellation policy*: Please give at least 24 hours notice for all cancellations. Cancellations with less than 24 hours of appointments will be subject to a $60 fee.*
Missing an appointment *without notification may incur 100% of the visit cost.*

Financial Policy
I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE COVERAGE (if applicable), I AM RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT FOR ALL CHARGES OF SERVICES, SUPPLEMENTS, MEDICINES, AND LABORATORY WORK I RECEIVE.

Signature _____ Date: _____

GUARANTOR INFORMATION (If different from PATIENT, otherwise leave blank)

Full Name: (print)_____

Address:_____

Phone:_____Today's Date: _____

GUARANTOR SIGNATURE _____

Insurance Information

Insured's Name (if different from patient)_____
Insured's Date of Birth _____/____/_____ Relationship to patient_____
Address_____
Phone: Work _____ Mobile_____ Home _____
Insurance Company _____ Phone _____
Claims Address _____
Insurance ID # _____ Group Number # _____

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Acknowledgement of Receipt of Notice of Privacy

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires providers keep patient information confidential and provides the means for you to understand and control how your health information is used. By law, your medical records information can be used for three purposes, as follows: 1. Treatment: we can use your current record to carry out your medical treatment in-house. Example: discussing your information with a referral physician.

2. Payment-allows the release of information for different financial transactions. Examples: sending office notes to insurance payers so that they will process benefits to you, or other billing activities.

3. Healthcare Operations: Allows us to conduct quality assessments and improve our healthcare activities and customer service. Also allows us to call you by name in the reception room and to disclose your protected health information, as necessary, to contact you for appointment reminders, treatment alternatives or other health-related information that would be of interest to you. Zia L. Robles Hernandez, ND may use or disclose your protected health information as follows without your authorization as required by law: public health issues, communicable diseases, health oversight, abuse or neglect situations; FDA requirements; legal proceedings, law enforcement, coroners, funeral directors and organ donation; research; criminal activity; military activity and national security; worker's compensation and inmates.

All other disclosures will require your written authorization before the information will be released. You may revoke such authorization in writing and no further releases will be made without obtaining new written authorization allowing Zia L. Robles Hernandez, ND to again release your personal health information.

We will not disclose your private health information to family members, other relatives, close personal friends, or any other person unless specifically authorized by you, in writing. You have the right to access, inspect and copy your medical records information.

A written request to see your records must be submitted to Zia L. Robles Hernandez, ND.

You have the right to obtain information of any disclosures of your protected health information. You have the right to request a restriction as to how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice All communications from our office will be confidential and protected from disclosure to the best of our ability.

RECEIPT OF NOTICE OF NOTICE OF PRIVACY

*I acknowledge that I have received and have read a copy of "Notice of Privacy"

* I hereby consent to the use and disclosure of my protected health information ***by Dr. Zia L. Robles Hernandez*** for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

*I have the right to request restrictions to the usage and disclosure of my protected health information.

*I have the right to request an alternative to the standard method of communication of my protected health information.

*I have the right to revoke this consent, in writing, at any time. Revocations will be honored as of the date they are received ***by Dr. Zia L. Robles Hernandez***

Please advise Dr. Zia L. Robles Hernandez if you feel your rights have been violated. There will be no retaliation for registering such a complaint.

Patient Name (print): _____ DOB: _____

Signature _____ Date: _____