Advanced Medical Therapies (AMT)

Disclosures and Consent Forms – Please read and sign all forms below:

Financial Policies and Disclosures Statement

Please read and sign this form

1. AMT does not bill insurance plans nor engage in insurance disputes under any circumstances.

2. All services are to be paid at the time of service.

3. All practitioners hold active license(s) or certifications as required in the State of Washington.

4. If a collection service becomes necessary for payment of the account, you agree to pay all collection fees in addition to any balances due.

5. A late fee of 1.5% per month may be added to delinquent balances.

6. Medicare does NOT cover services or supplies provided in this office.

7. Release of information: By signing this, I give this office permission to release information required by law or insurance regulation to insurance agencies involved in my case. This does not give permission for any other release of information by this office, which has not been authorized by me.

I have read, understand, and agree to the above policies:

_____ _____

Signature (Parent / Guardian, if under 18 years old) Date

PLEASE INITIAL THE FOLLOWING:

_____ Notice of Privacy Practices:

Advanced Medical Therapies complies with the most recent HIPAA Privacy Practices. If I am not the above named person, my relationship to the patient is: _____

_____ Acknowledgment of Separate and Distinct Clinic: I acknowledge that the clinic or practice of Advanced Medical Therapies including its doctor(s) and staff, are distinctly and completely separate from (1) the doctor and or clinic and their staff that referred me, and or (2) the premises of the doctor(s) and or clinic in which care is being rendered.

_____ Consent to Routine Clinical Services: I consent to all services rendered by the doctor, or any other licensed doctor(s) or therapist who are now or will in the future treat me while employed by or associated with Advanced Medical Therapies. As in all medical practices I understand that there are

risks to manipulation and other routine procedures including but not limited to fracture, injury, stroke, dislocation and sprain. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to any procedure. I understand that no guarantees have been made to me as to the result or cures that may be obtained from examination or treatment. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I understand that I am responsible for knowing where my personal items are at all times while in the office and if I choose to remove or place any of my personal items I am doing it voluntarily and Advanced Medical Therapies is NOT responsible or liable for any lost, stolen or misplaced items.

_____ Consent to Injections; Ligament and Trigger Point: I consent to all injection procedures rendered by the doctor who are now or will in the future treat me while employed by or associated with this practice. I understand there are risks to injections including but not limited to severe pain, bruising, inflammation, injury, numbness, allergic reaction and infection. I do not expect the doctor to anticipate and or explain all risk and possible complications. I rely on the doctor to exercise judgment during the course of treatment with regards to any procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ Consent to Intravenous Therapy: I consent to all intravenous therapy procedures rendered by the doctor(s) who are now or will in the future treat me while employed by or associated with this practice. I understand that there are risks to intravenous therapy including but not limited to pain, bruising, inflammation, injury, infection, allergic reaction and metabolic disturbances. I do not expect the doctor(s) to anticipate and or explain all risk and possible complications. I rely on the doctor(s) to exercise judgment during the course of treatment with regards to my procedure. I intend this consent to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

_____ For ANY patient who may be consulting in this office with regard to cancer / integrative oncology care. They should be aware that the laws of the State of Washington restrict the primary treatment of cancer for patients with cancer diagnoses to physicians who are MD or DO licensed. The Physicians at Advanced Medical Therapies are licensed naturopathic physicians (ND or NMD).

Any involvement in diagnosis, treatment or other means by healthcare providers who do not have MD or DO qualifications should be considered adjunctive or ancillary care. It is always advisable for patients with cancer to seek the advice and care of a qualified Oncologist, but to fulfill the requirements for Washington must at least have a health care relationship with an MD or DO physician.

BY INITIALING ABOVE I acknowledge that I have been informed of the law in the State of Washington regarding primary cancer treatment, and as a patient will direct my healthcare in whatever way best suits my own personal needs and desires.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

I understand that as part of my healthcare, Advanced Medical Therapies creates and maintains health records describing my health history, symptoms, examination with test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information serves as:

I understand and have been provided a copy of Advanced Medical Therapies Notice of Health Information Privacy Practices summary to review, which provides a description of information uses and disclosures. I understand I have the right to request a complete copy of the Notice of Health Information Privacy Practices.

I understand that Advanced Medical Therapies reserves the right to change their notice and practices. Changes will be posted in the reception area.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or normal healthcare operations and that Advanced Medical Therapies is not required to agree to restrictions I have requested.

By signing below, I agree that I have reviewed the Notice of Health Information Privacy Practices at Advanced Medical Therapies.

A basis for planning my care and treatment •

A means of communication among the many health professionals who contribute to my case •

A source of information for applying my diagnosis to my bill •

A means in which a third-party payer can verify that services billed were actually rendered •

A tool for routine healthcare operations such as assessing quality and reviewing competence of health¬• care professionals

Signature: Date: _____

Printed Name: _____

If signed by person other than patient, check relationship to patient:

Guardian Durable Power of Attorney Parent: _____

Adult Child Spouse/Domestic Partner Adult Sibling: _____

ADVANCED MEDICAL THERAPIES

CONSENT FOR LEAVING MESSAGES

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY AND FRIENDS

I understand that my healthcare information at Advanced Medical Therapies is protected and I have received a copy of their Notice of Health Information Privacy Practices.

CONSENT for LEAVING MESSAGES (please check box) □ YES □ NO

I consent to information regarding myself (or my child's/under the age of 18) test results or detailed appointment reminders/instructions to be left on my voice mail or answering machine.

If yes, allowed phone numbers (circle type): _____ cell, home, work, other

_____cell, home, work, other _____cell, home, work, other

CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family or friends to have access to my health care information. The name(s) listed below are family or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem is minimally necessary. I understand that information is limited to verbal discussions and that no paper copies of my protected health information will be provided without my signature on a Release of Protected Health Information Form.

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

_____ _____

Patient Name Date of Birth

_____ _____

Patient/Parent Signature Date

If signature is <u>not by the patient</u>, please indicate Name and Relationship:

_____

This consent will be considered valid until such time as I cancel it in writing. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only be applied to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.