



INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I acknowledge that I am accepting treatment from a licensed Naturopathic Doctor (N.D) at the Tahoe Center of Natural Medicine. I understand that there are intrinsic differences between the care of Naturopathic Doctors (N.D.'s) and Medical Doctors (M.D.'s).

Stephenie Riley is licensed by both the States of Washington and California as a Naturopathic Doctor. In the State of California, Naturopathic Doctors are licensed to diagnose and treat disease and have limited prescriptive rights.

I hereby authorize the Naturopathic Doctors of Tahoe Center of Natural Medicine to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g. venipuncture, Pap smears, urine analysis.

Minor office procedures: e.g. ear lavage, skin scraping, skin cryotherapy.

Medicinal use of nutrition: e.g. therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: e.g. botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

Physical medicine: e.g. massage, hot and cold therapy, stretching, manipulation, electrical muscle stimulation, and therapeutic ultrasound.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks include but are not limited to: allergic reactions and other side effects to prescribed herbs and supplements; aggravation of pre-existing symptoms; discomfort, pain, infection, burns, nausea, light headedness; inconvenience of lifestyle changes, injury from injections, venipuncture, or other procedures. Please notify Tahoe Center of Natural Medicine if you experience any symptoms which may be secondary to the above procedures.

Potential benefits include but are not limited to: restoration of health and the body's maximal functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.

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.

At this time, it is my decision to pursue Naturopathic treatment. I do understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all of the conditions I may have. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the Tahoe Center of Natural Medicine, or any of its personnel, regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

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 myself, or my representative, or unless it is required by law.

Patient/Guardian Signature

Date

Physician/Witness

Date



**Tahoe Center
Of Natural Medicine**

PO Box 6869 • 600 North Lake Blvd • Tahoe City, CA 96145 • Phone 530-583-0002 • Fax 530-583-0044

FINANCIAL POLICY

We are a cash-based practice. At this time we are unable to accept, nor do we bill, insurance for any of our in-house services. Full payment of all charges is required at time of service. We accept payment by cash, check, and credit card. Checks denied for insufficient funds will incur a fee of \$35.00.

At this time we are not contracted with any insurance providers, and our services are not covered by insurance in California. As a courtesy, we will provide you with a Super Bill for services rendered. This can be submitted to your insurance company for review of possible benefits. The provided Super Bill, and any insurance submission for possible reimbursement, are the sole responsibility of the patient. ***Copies of Super Bills can not be reproduced if lost, please maintain copies for your own files.***

In the cases of financial hardship, special circumstances for payment may be considered. Such arrangements must be made in advance with the front office.

First Office Call: \$225 - 250 (This does not include required tests or supplements.)
Chiropractic Only Visit: \$90

Return Office Call: 15-minute: \$60 *Chiropractic Follow-up Only:* \$50
30-minute: \$85
45-minute: \$115
60-minute: \$155

Re-establishing Care: \$175 - 225
Patients not receiving care for a period greater than 2 years will require an extended return office call to re-establish healthcare baselines.

Phone Consultations: Charged accordingly with in-office visits.
The phone consultation fee is not charged if you are calling for clarification of an on-going medical therapy, or when the doctor has specifically requested you call with a treatment status. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call. Insurance does not reimburse for phone appointments.

Emails: At this time we do not conduct patient communication via email.

Cancellations: We require a minimum of 24 hours for any changes to your scheduled appointment.
We reserve the right to charge for missed appointments, or appointments cancelled with less than 24 hours notice.

Supplements: Nutritional supplements, herbs, homeopathics and other products are often recommended as a part of your treatment plan. We do carry most of the products we recommend at competitive prices, although you are free to purchase from any source you choose. However, products available to health care providers are often of a higher quality not found in many of over-the-counter brands.

Other Tests: We do not mark-up any outsourced testing services offered through our offices. For all out-of-office tests you will pay the lab directly, providing you with the lowest cost possible.

Patient/Guardian Signature

Date



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FINANCIAL DISCLAIMER

I claim full responsibility for services rendered at the Tahoe Center of Natural Medicine (TCNM). I understand that payment is required within full at the time of service, unless other arrangements have been made.

If other arrangements have been made, I am held responsible for making monthly payments until my bill is paid in full.

A Super Bill with diagnostic and procedural information is provided for you to submit to your insurance company for possible reimbursement. At this time I understand there is no official insurance reimbursement for naturopathic care. TCNM does not submit to insurance on the behalf of the patient, it is the sole responsibility of the patient. The Super Bill is provided at the time of service, they can not be reproduced later and should be maintained for your own records.

It is our policy we receive 24-hour cancellation notice. If we do not, we reserve the right to charge the full fee for a missed appointment.

Patient Signature

Date

PRIVACY RULE CONSENT

By signing this form, you are giving Tahoe Center of Natural Medicine permission to use and disclose your protected health information for the purposes of treatment and payment associated with your care.

We have a "Notice of Privacy Practices" that provides more detailed information regarding how we may use and disclose your health information. You have the right to review this document I detail at any time. You have the right to request restrictions on how we may use and disclose your health information. We are not required by law to agree with your request, but we will do whatever we can to accommodate requests that are reasonable. You also have the right to revoke this consent in writing at any time, unless your health information has already been used or disclosed in reliance on this consent for the diagnosis, treatment or payment for the medical services for which you sought treatment.

A copy of our "Notice of Privacy Practices" may be obtained by contacting our offices at 530-583-0002, or in writing at POB 6869, Tahoe City, CA 96145. Please note that our "Notice of Privacy Practices" may be changed as needed to comply with Federal Law.

Printed Name

Patient Signature

Date

Chiropractic Registration and History

Patient Information

Date _____

SSN/HC/Patient ID # _____

Patient Name _____

Last Name

First Name

Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SSN _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home Phone (_____) _____ Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SSN _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to

Dr. _____ all insurance benefits, if

any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____



Health History

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toninitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____

Drinks/Week _____

Cups/Day _____

Reason _____

Are you pregnant? Yes No

Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name _____

Pharmacy Phone (_____) _____