3025 S Corbett Ave. Portland, OR 97201
Scheduling: 503-552-1551

NATUROPATHIC MEDICINE, CLASSICAL CHINESE MEDICINE, AND NUTRITION CONSENT TO ESTABLISH CARE

Informed consent is a process, not a form, and involves an ongoing, interactive dialog between you and your provider. The process of informed consent occurs when communication between you and your provider results in your authorization or agreement to undergo a specific medical intervention.

I do hereby give my consent to services rendered and provided to me (or the patient named below, for whom I am legally responsible) as a patient of the National University of Natural Medicine (NUNM) Health Centers. I understand that patient care is directed by licensed health care providers who are employees of NUNM. I consent to services rendered to me under the instructions of these professionals, as well as volunteer staff physicians who may be associated for the purpose of consulting.

I recognize that NUNM is a teaching institution. I agree that persons who are students and resident physicians will participate in my care as part of the educational programs of the institution. I hereby request and consent to examination and treatment with the providers, students, and affiliated providers at NUNM Health Centers.

I understand I have the right to ask questions and discuss to my satisfaction with the above-mentioned providers and/or students:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals, and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, and/or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that evaluation and treatment may include, but is not limited to:

- **Common diagnostic procedures** (including but not limited to physical examination, laboratory testing of blood and other bodily fluids, electrocardiogram, lung function testing, ultrasound, and referrals for external diagnostic procedures).
- **Natural substance prescriptions** (including but not limited to plant/herbal, mineral or animal-based substances in full strength or highly diluted/homeopathic). Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain alcohol), suppositories, topical creams, pastes, plasters, washes, or other forms.
- **Over-the-counter and prescription medications** (including only those medications listed on the Oregon Board of Naturopathic Medicine formulary).
- **Dietary and therapeutic nutrition recommendations and counseling** (including but not limited to the use of foods, individualized diet plans, nutritional supplements, and parenteral (intravenous or intramuscular) vitamin injections (see separate Parental Injection consent below).
- **Counseling** (including but not limited to mindfulness techniques, behavioral change, stress management techniques, and tobacco/substance use cessation).

- **Hydrotherapy** procedures (including but not limited to alternating hot and cold applications, baths, sauna, ice, towels and/or sheets, electrical stimulation, ultrasound and diathermy) and other therapies. Possible risks and complications associated with these procedures may include:
  - Mild skin burns or irritation
  - Skin rash
  - Overheating
  - Dizziness
  - Temporary decrease in blood pressure

- **Classical Chinese medicine** procedures including, but not limited to acupuncture, moxibustion, cupping, electro- acupuncture, herbology, and massage. Possible risks and complications associated with these procedures may include:
  - Slight burns
  - Fainting
  - Bleeding
  - Nausea
  - Scarring
  - Infections and blisters
  - Bruising
  - Tingling/soreness near needling sites that may last a few days

- **Soft tissue treatment** (including but not limited to massage, neuro-muscular technique, and muscle energy technique) and naturopathic osseous manipulation of the spine and extremities. (See below)

- **Physical medicine treatments** including examination, diagnostic procedures, manipulation and/or mobilization of the neck, spine, and extremities involving movement of the joints and soft tissues, and soft tissue therapies (specifically: manual soft tissue therapies, instrument-assisted soft tissue mobilization (IASTM), percussion/vibration therapy and therapeutic tape procedure). Physical therapy, including exercise, electrical stimulation, hot/cold therapies, ultrasound, diathermy, TENS units, microcurrent, low-level laser therapy, traction, and other therapeutic modalities recommended for my condition may also be used. Possible risks and complications associated with these procedures may include:
  - Soreness
  - Sprains and strains
  - Mild to moderate bruising
  - Muscle spasms
  - Dizziness
  - Physical Therapy burns (rare)
  - Temporary increase in symptoms
  - Fractures/joint injury
  - Stroke (rare, neck manipulation)

- **Trigger point injection/Prolotherapy** with or without vitamin substances. (See below)

- **Parenteral Injection** (Intravenous [IV] and Intramuscular) Therapy treatments including drips, pushes, and IV chelation (heavy metal detoxification). This treatment involves inserting a needle or catheter and injecting a standardized formula into veins or muscles. Possible risks and complications associated with these procedures may include:
  - Pain, bruising, or infection at injection site
  - Inflammation of vein used for infusion (phlebitis)
  - Blood pressure changes, low blood sugar, headache/dizziness, electrolyte changes
  - Severe allergic reaction or anaphylaxis, resulting in cardiac arrest, possibly death

- **Alternatives to IV Therapy include**:
  - Oral supplementation
  - Lifestyle and dietary change

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INFORMED CONSENT AND REQUEST FOR CARE (CONTINUED)

I understand that some medicines, supplements and procedures may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform my provider or student so that my treatment plan may be re- evaluated.
*Please note: There are additional consent forms for parenteral injections or chelation therapy (IV Therapy), minor surgery, hormone treatments and other special procedures or services.

I have fully read and understand the above and hereby consent to services.

Signature of Patient Date

Signature of Parent/Guardian (if Patient is under 15) Date

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HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT

I hereby consent to the use and disclosure of my Protected Health Information by National University of Natural Medicine (NUNM) Health Centers for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- NUNM has posted their Notice of Privacy Practices on the NUNM Health Centers website, www.nunmhealthcenters.com, which provides more detailed information about the usage and disclosure of my Protected Health Information. I have a right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.
- 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 the NUNM Health Centers at the following address: 3025 SW Corbett Avenue, Portland, Oregon 97201.
- I understand that while NUNM may honor these requests, they are not required by law to do so.
- NUNM is part of an organized health care arrangement including participants in OCHIN and Care Everywhere. A current list of Care Everywhere participants is available at www.ochin.org. As a business associate of NUNM, Care Everywhere supplies information technology and related services to NUNM and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. Care Everywhere helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by NUNM with other Care Everywhere participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. **The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw the consent for Care Everywhere, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.**
- I am aware that NUNM reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all Protected Health Information that they maintain. In the event of amendments, NUNM will make available a revised Notice of Privacy Practice for my review.

AUTHORIZATION: *(Please sign and date below)*

I have fully read and understand the above agreements and authorizations.

_____ _____

Signature of Patient OR **Parent / Legal Guardian Signature** (*if patient is under 15)* **Date**

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STATEMENT OF FINANCIAL RESPONSIBILITY

At NUNM (National University of Natural Medicine) our policy is to collect payment for all services rendered at the time of service. Patients who are not able to pay or who have not made arrangements with our billing office may be required to reschedule their appointment. Patients may also receive a bill for additional services rendered, such as in-house labs and procedures ordered during an office visit, if the insurance company adjusts the bill, or if new information is acquired bringing about new charges. These bills are non-negotiable.

FOR ALL PATIENTS:

- There will be a flat fee of $20 for any appointment that is either missed or not canceled within 24 hours of the appointment time.
- You acknowledge that you are financially responsible for all charges. Any account over 120 days (about 4 months) old will be sent to collections. If it becomes necessary to affect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. You hereby authorize the NUNM Health Centers to release information necessary to secure payment.
- You are responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including Medicinary, lab work, and tests, as well as any physician ordered add-on lab work and tests.
- Refund Policy: We will issue a refund of any credit on an account 30 days from the issue of the credit to the account. Refunds are issued by check and mailed to the address on the guarantor account.

TIME OF SERVICE AND OTHER DISCOUNTS:

- If you apply and qualify for any discounts, you are responsible for providing accurate information for all required documentation within 30 days.
- As a courtesy of paying in full at the time of service, you will receive medical services at a discounted rate. If you do not pay at the time of service your account will not reflect a time-of-service discount.
- Discounts through our Compassionate Care program may be extended to you based upon the gross annual income information you provide.

IF YOU ARE INSURED:

- You authorize release of information in your medical history to your insurance carrier and assign all benefits for unpaid services to the NUNM Health Centers. This release applies to support of the insurance billing process only.
- The pre-verification by NUNM of your health insurance is used to determine if there is coverage for services through your insurance and is NOT a guarantee of payment by your insurance.
- You are responsible for providing all accurate and thorough documentation required to verify your insurance coverage and / or bill your insurance carrier.
- You understand that the NUNM Health Centers can require proof of insurance at any time and that your insurance may need to be re-verified for specific coverage details as often as every 6 months, if there is a denial of a claim, or if you have a change in coverage.
- You are responsible for full payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid for by your insurance carrier at the time of service.
- You are responsible for payment even if your insurance company determines that the care received was not medically necessary.

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STATEMENT OF FINANCIAL RESPONSIBILITY (CONTINUED)

- You may forfeit the privilege of billing your insurance carrier if you do not comply with any of your financial responsibilities or documentation requirements.
- You understand that NUNM Health Centers will not bill motor vehicle insurance.

AUTHORIZATION: *(Please sign and date below)*

I have fully read, understand, and agree to these financial policies.

_____ _____

Signature of Patient OR Parent / Legal Guardian Signature (*if patient is under 15)* Date

MINORS SEEKING TREATMENT WITHOUT A PARENT/GUARDIAN (AGES 15-17):

I, _____, certify that I am _____ years old. I am seeking outpatient health services from the National University of Natural Medicine (NUNM). I have been fully informed of the services to be rendered and consent to those services.

Payment Method (*choose one and initial)*

1. _____ I agree to allow NUNM to notify my parent(s)' to the extent necessary to obtain insurance coverage for the services provided.

2. _____ I do NOT want NUNM to notify my parent(s)' regarding any of these services unless required by (initial if yes) law to do so. I do not wish that NUNM obtain my parent(s)' consent to bill insurance. I fully understand that NUNM requires me to pay for all services in advance and that my failure to do so may result in termination of services. In the event that I am unable to pay for these services, NUNM may, at its sole discretion, terminate this relationship and refer me to appropriate health providers.