HIPPA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

NATUROPATHIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of naturopathic treatments and other procedures within the scope of the practice of naturopathic medicine on my (or on the patient named below, for I am legally responsible) by the naturopathic doctor named below and/or other licensed naturopathic doctors who or in the future treat me while employed by, working or associated with or serving as back-up for the naturopathic doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: homeopathy, botanical medicine, nutritional counseling, flower essences, medical intuitive counseling, hypnotherapy, energy medicine (reiki, polarity, craniosacral), physical manipulation, acupuncture, regenerative injections (Prolotherapy, PRP, Stem Cell Therapy, Trigger Point Injections, etc), intramuscular injections, and massage. I understand that the herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. I will immediately notify the doctor of any unanticipated or unpleasant effects associated with the herbs, remedies, or supplements.

I have been informed that naturopathic medicine is a generally safe method of treatment, but that it may have some side effects, such as a healing crisis which could cause fatigue, nausea, muscle soreness, headache, etc. The herbs, remedies and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding. I will notify the naturopathic doctor who is caring for me if I am or become pregnant or am currently breastfeeding.

I do not expect the naturopathic doctor to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the naturopathic doctor to exercise judgment during the course of treatment which the naturopathic doctor thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that charges are to be paid in full at the time of the visit unless specific arrangements were made prior to my scheduled appointment. Insurance billing may be offered as a courtesy however I understand that I am ultimately responsible for 100% of charges for office visits and other services rendered. I understand that Dr. Kopcio accepts cash, checks, Visa, Mastercard, and HSA (Health Savings Account) cards for payment and I am able to pay him today for my visit with one of these means unless prior arrangements have been made. I understand that supplements, herbs, books and any other medical treatment items must be paid for in full at time of purchase as billing is not available for these items.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of naturopathic medicine and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Patient Signature X_____ Date_____
(Or Patient Representative) (Indicated relationship if signing for patient)

Naturopathic Doctor: Jordan Kopcio, DC NMD