Lake Meridian Healing Arts, PLLC *Health Care for a Higher Quality of Life*
Alexandria Easter, ND • 15215 SE 272nd ST. Suite 105, Kent WA 98042
P: (425) 395-7542 F: (425) 657-0934

General Office and Financial Policies

Thank you for choosing Issaquah Holistic Health for your health care. As part of providing you with the best care possible, the following is information regarding our office and financial policies. Please read this form carefully and sign at the bottom of the page.

Cancelling/Missed Appointments:
A 24-hour business day notice of cancellation is required (ex. Your appointment is on Monday morning. To avoid a charge the appointment would need to be cancelled by the morning of the Friday prior to the appointment.) For appointments cancelled less than 24 hours there is a $50.00 fee.

Unavoidable emergencies will be considered reasonable exceptions, on a case by case basis.

Appointments:
For new patient visits please arrive 15 minutes prior to your appointment time with forms completed. You must bring insurance card and ID; we are unable to pull insurance from another patients account.
Your office visit is intended for your care only. If a family member needs to seek medical advice, they will need to schedule a separate appointment to address these concerns. Understand that time may not permit for all concerns to be addressed in one visit; in this case, another appointment may be needed.
If you are on a treatment protocol, please schedule your next visit well in advance to secure an appointment, as the doctors' schedules can fill up and not being seen in a timely manner can affect medication refills. Your practitioner will determine the complexity of your condition and determine the appropriate time between visits.
All established patient appointments please arrive 10 minutes prior to your appointment time.

If you are 10 minutes late to your appointment a reschedule will be required and a $50 fee will be charged to your account.

Insurance Billing:
We do not verify benefits in-office; please check with your insurance company prior to your appointment to be sure that you have naturopathic coverage and that the practitioner is an in-network provider. Copays are due at the time of service.
If you are a cash patient, payment is due at the time of service. Please note that patients are responsible for notifying the office staff of any changes to their insurance, address, or other personal information in regards to insurance billing and for the purpose of patient contact. *You are responsible for all fees not covered by your insurance plan.*

Medications:
We require 2-3 business days notice on refills. For refills on prescriptions written by one of our practitioners please ask your pharmacy to fax us a refill authorization. You may be denied refills and required to schedule a follow-up visit prior to receiving a refill depending on your current course of treatment. New prescriptions require an appointment.

I have read and understand the above stated policies.

Signature of Patient or Legal Guardian Date

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Informed Consent for Treatment

I _____, hereby authorize the private practitioners to perform the following specific procedures as necessary to facilitate my diagnosis and treatment.

Common Diagnostic Procedures: e.g. blood draw, pap smears.
Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplements, intramuscular or intravenous vitamins and minerals.
Minor Office Procedures: e.g. dressing a wound, or ear cleaning.
Botanical Medicine: botanical substances may be prescribed as teas, alcoholic tinctures, glycerin tinctures, capsules, tablets, creams/salves, plasters, suppositories or solid extracts.
Lifestyle Counseling and Hygiene: diet therapy, exercise recommendations, sleep hygiene, and stress reduction.
Contraception: e.g. birth control pills, natural family planning.
Pharmaceutical Treatment: prescription of pharmaceuticals, e.g. blood pressure medication, statins, antidepressants, etc. as needed.

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

Potential Risks: allergic reactions to prescribed herbs, supplements, pharmaceuticals. Side effects of supplements and medications prescribed. Inconvenience of lifestyle changes, injury from injections, blood draw, or procedures, and injuries sustained during exercise.
Potential Benefits: restoration of health, relief of pain and symptoms of disease, assistance in injury, and disease recovery, prevention of disease or its progression, less reliance on medication or prescription drugs, increased energy and productivity, increase in mental clarity, emotional balance, increased sense of well-being.
Notice to Pregnant Women: all female patients must alert the doctor if they know or suspect they are pregnant as some therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the physicians, or their staff, 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. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum three, but no more than 10 years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that my practitioner will answer my questions to the best of his/her ability.

_____ _____
Patient Signature Date

_____
Signature of Patient's Representative/Guardian

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Notice of Privacy Practices: Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At this office, we are required by law to maintain your private health information confidential and private. We are also required to give you this notice and to follow the terms of this notice. The HIPAA law permits us to use or disclose your health information to those involved in your treatment. For example, a specialist doctor whom we may involve in your care may conduct a review of your file. We may disclose your health information for payment of your services. For example, we may be required to send a report of your progress to your insurance company. We may use or disclose your health information for normal healthcare operations. For example, one of our staff may enter your information into our computer. We may use your health information to contact you. For example, we may send you information. We may contact you via email. Also, we may call you. If you are not home, we may leave information on your voicemail or with the person who answers the phone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law; including legal proceedings, cases of child or dependent adult abuse or neglect, and cases of imminent danger to self or others.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we may need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you. Please provide a written request regarding the information you want to have sent. If you want a copy of your records, a reasonable fee may be charged for the copies. You have a right to request an amendment or change to your health information. Please provide your request in writing. If you wish to include a statement in your file, please provide it in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents but will add new information. You have the right to receive a copy of this notice. If we change any details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint or for more information or assistance regarding your health information privacy, please contact Issaquah Holistic Health This notice goes into effect May, 2012.

ACKNOWLEDGEMENT: **I have read and received a copy of Issaquah Holistic Health's Notice of Privacy Practices.**

Patient or Legal Guardian Signature: _____ Date: _____

Printed Name: _____