Natural Family Health Clinic

Greetings and thank you for choosing us for your healthcare. It is amazing what we can accomplish together! We ask that you participate with your care through utilization of Patient Fusion, our patient communication application. Please contact our office if you did not receive your invitation through email, or if you would like additional assistance.

Patient Fusion is where our office releases lab results, patient care summaries, and important notices about your treatment plan. Upon scheduling with our office you should have received an email invitation from Patient Fusion. If you did not receive that invitation please contact our front desk to confirm your email address and cell phone number, then ask that the invitation be sent again.

We value your continued communication about the experience you have while at our clinic. As a patient at our clinic you are welcome to send any questions or concerns to our qualified healthcare team and we will work alongside you to reach a resolution. Whether it is discussing your insurance benefits, patient confidentiality, personalized treatment plan, or scheduling needs, we are committed to bringing mindfulness to all of our interactions.

Please complete and return the following paperwork to our clinic on your initial visit. This paperwork is in addition to the complete health history form found through Patient Fusion. Our clinic can be found at the corner of SW Barrows Rd and SW Horizon Blvd in Beaverton. Our address is 14900 SW Barrows Rd, Bldg B Suite 201 in Beaverton, Oregon, 97007. If you require an alternate format of our clinic's health history form, or you have additional questions or concerns, please contact our office at (503) 246-2995.

Our clinic has a 24 hour cancelation policy.
Please observe this policy to prevent additional fees.

Staff Use Only:
I was unable to obtain written acknowledgement from the patient for:
☐ Informed Consent
☐ Medicare Policy
☐ HIPAA/Privacy Policy
☐ Financial Policy
I was unable to obtain written acknowledgement from the patient because:
☐ Patient declined to sign this written acknowledgement
☐ Other: ______________________________

Informed Consent

Welcome to Natural Family Health Clinic! In order to provide the best healthcare experience we encourage your participation in all aspects of your care. Please read the following statements regarding your working relationship with Natural Family Health Clinic (NFHC) and its provider(s)/staff.

1. I understand that many doctors cannot be primary care physicians due to requirements set forth by the insurance industry. While NFHC providers offer many services that are a component of primary care, including but not limited to refilling prescriptions, routine physicals, running routine labs, and making outside referrals, I am responsible for finding and maintaining healthcare elsewhere for any emergency, overnight or weekend needs.
2. I am at liberty to seek or continue medical care from another physician/healthcare provider, and treatment or advice provided to me as a patient of NFHC is not mutually exclusive from any treatment or advice that I may be receiving now or in the future from another physician/healthcare provider. No one at NFHC is recommending that I refrain from seeking or following the advice of another licensed healthcare provider.
3. Naturopathic therapeutic procedures are considered safe and effective methods of care. I understand that, while complications are rare, it is the practice of the NFHC to inform all patients of any complications ahead of the procedure. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury or bruising, dizziness, burns, and temporary worsening of symptoms. More serious complications, however rare, are still possible.
4. It is the policy of NFHC to inform patients of the procedure being performed and the risks and alternative treatments available. I am responsible for requesting additional details if my physician does not explain the procedure and possible complications to my satisfaction.
5. I hold NFHC harmless of any consequences of declining a recommended procedure or treatment.
6. I understand that diagnosis or treatment of me by my providers may be conditioned upon my informed consent as evidenced by my signature.
7. The NFHC has a cancelation/no show fee assessed for any appointments cancelled without 24 hours notice. The late cancelation fee for our office is $50 for the first time, $100 for the second time, and the full cost of your scheduled appointment for the third and beyond. This fee is not billable to insurance.
8. I have the right to revoke this consent at any time, in writing, except to the extent that NFHC has taken action in reliance on this consent.

I have read and understand the Informed Consent of NFHC:

______________________________________ ____________
Signature Date

____
Printed Name

Medicare Policy

Naturopathic services are not covered by the Center for Medicare Services, nor is NFHC participating with Medicare. Our office does not bill Medicare or supplemental plans. Our office can bill secondary insurance plans after receiving a denial from Medicare for services. Please read the following statements regarding our Medicare Policy.

1. It is my responsibility to inform NFHC of my enrollment in Medicare before receiving medical care. I will inform NFHC of any future enrollment with Medicare.
2. It is my responsibility to verify benefits coverage on any secondary insurance plan ahead of receiving service and I understand that I am financially responsible for any non-covered services or additional patient responsibility assessed by my secondary insurance.
3. It is my responsibility to complete and return any necessary paperwork, as provided by the NFHC, to submit to a secondary insurance company for payment.
4. I understand that I must complete the ABN form provided by NFHC before receiving services. If one was not provided with my new patient packet I will ask to complete one before receiving services.
5. If I believe Medicare will cover my laboratory testing I understand that I must have a participating provider order the labs, and pursue care at a participating Medicare facility. I may provide my lab results to NFHC for review.
6. Some third party laboratories do not offer their testing services to Medicare patients.
7. Chiropractors at NFHC are unable to see any Medicare patients.
8. If I am a both a Medicare and Medicaid member and choose to receive services, I am fully aware that payments for any services, supplements, supplies etc. are my full financial responsibility and cannot be billed to Medicare or Medicaid.
9. All applicable fees are due at the time of service.

I have read and understand the Medicare Policy of NFHC:

____ __________

Signature Date

____

Printed Name

HIPAA/Privacy Policy

We understand your right to privacy and believe that it is a collaborative effort to maintain your protected health information in a safe and informed manner. We will never release your protected health information without a legitimate reason to do so. Please read the following statements regarding your right to privacy.

1. I consent to the use or disclosure of my protected health information by the NFHC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the NFHC.
2. My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health, or condition that identifies me or there is reasonable basis to believe the information may identify me.
3. I agree to use Patient Fusion to receive or send electronic communications with the NFHC. If I choose to electronically communicate outside of Patient Fusion I waive my right to the most secure form of communication for email, text and voicemail.
4. I am aware that NFHC reserves the right to change the terms of their HIPAA/Privacy Policy. In the event of amendments, NFHC will notify all patients and make available the revised policy through the patient portal or, on paper by request.

I have read and understand the HIPAA/Privacy Policy of NFHC:

Signature _______________ Date _______

Printed Name _______________

Financial Policy

Some insurance plans do not cover all procedures performed within this office. To ensure that you are able to make informed decisions about your care we want you to have all of the information available to you before our office bills your insurance carrier for services. In order to assist in this process we have created an Insurance Coverage Worksheet for our new patients to use.

Did you know, not all insurance plans cover services performed by a Naturopathic Doctor?

In addition to ensuring that your plan has naturopathic/alternative care benefits, other services that may or may not be covered include but are not limited to; infusion services, injection services, extended office visits, phone appointments, specialty labs, and electromagnetic pulse therapy. If your treatment plan includes any of these services we will provide you with the procedure (CPT) codes that insurance companies use to determine coverage and payment so that you may verify your coverage ahead of time.

All applicable fees for services, copays/coinsurance, and products are due at the time of service. The patient remains responsible for any additional fees assessed by insurance.

We do not bill insurance for any pharmacy or medicinary items, or medical equipment provided as a part of delivered healthcare and any related charges are the responsibility of the patient and/or legal guardian. Our late cancellation/no show fee is not billable to insurance.

We understand if you'd like our office to bill your insurance without verifying your coverage ahead of time. Please know that you will be responsible for any additional costs or denied services as assessed by your insurance plan.

By signing below, I ____ attest that I have
First Name, Last Name (Printed)
read and understand the above statements. I have been given the opportunity to check on my insurance coverage before receiving services. I understand I have this option and want to proceed with treatment. I am responsible for paying any denied charges or additional patient responsibility (copays/coinsurance/deductible).

I agree that lack of awareness about my benefits coverage is not a legitimate reason for contesting any additional patient responsibility.

X____ _____________

Signature Date