Clinic Policies

Patient Name: ____

FINANCIAL POLICY: If you are covered by a health insurance plan we are contracted with and provide us the necessary information we will bill your insurance carrier for you. All co-payments, deductibles and payment for known non-covered services and natural pharmacy items are due at the time of service. While Naturopathic Physicians are covered by many insurance carriers, each company and each plan within that company may differ. Please take the time to learn your benefits, caps, deductibles and exclusions. If you are unsure of your coverage, you may opt to pay for your visit in full, at the time of service, for a discounted rate (20% discount) via cash, check or credit card. We will bill your insurance that amount and if paid, will reimburse you. If you currently do not have insurance coverage, you must pay at the time of service in order to receive a 20% discounted rate.

CANCELLATION POLICY: When you schedule an appointment, we reserve that time for you. If you do not provide 24-hour notice of cancellation or do not show up for a scheduled appointment you may be charged a fee of up to 50% of the expected visit charge.

PHONE CALLS: If you are calling about a new health concern you may be asked to schedule an appointment or you may be charged for a phone consult. Consult fees are $40 per 15 minute increments.

INFORMED CONSENT TO TREAT: I hereby authorize Dr. Flanagan to perform the following procedures as necessary to facilitate diagnosis and treatment: common diagnostic and minor office procedures, use of botanical medicine, nutrition, homeopathy, counseling, physical medicine and bodywork. Dr. Flanagan will explain the risks and benefits involved with these procedures and treatments and I may voluntarily choose to withdraw my consent and discontinue participation in these procedures at any time.

NOTICE TO ALL PREGNANT WOMEN: All female patients should 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.

INITIAL THAT YOU HAVE READ AND CONSENT TO THE ABOVE: ______________

CONFIDENTIALITY:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): 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 my lawful representative, or me, or unless law permits or requires it. I understand that Spokane Naturopathic Healthcare (SNH) will use and disclose health information about the patient in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Policy as outlined by Federal Regulations. I have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. I also understand SNH is not required by law to agree to such requests. My signature below acknowledges I am aware of my rights in accordance to HIPAA.

INITIAL THAT YOU WERE OFFERED A NOTICE OF PRIVACY PRACTICES:________

RELEASE OF HEALTH INFORMATION: SNH keeps a record of the health care services we provide me or my child. I may ask to see and copy that record (copy charges may apply). I may ask us to correct that record. If I would like that record sent to another provider, my request to Spokane Naturopathic Healthcare must be made in writing.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE. I UNDERSTAND I WILL BE FINANCIALLY RESPONSIBLE OR SERVICES THAT MY INSURANCE COMPANY INDICATES ARE "PATIENT RESPONSIBILITY."

Patient/Parent/Guardian Signature____

Date____________________