Informed Consent and Request for Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Darcy A Ries, having had the opportunity to discuss the potential benefits, risks and limitations involved.

I, ________________________, hereby request and consent to examination and treatment with the above mentioned provider.

I understand that I have the right to ask questions and discuss to my satisfaction with the above mentioned provider and/ or with the allied health care provider providing backup:

▪ My suspected diagnosis(es) or condition(s)

▪ The nature, purpose, goals and potential benefits of the proposed care

▪ The inherent risks, complications, potential hazards 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

Naturopathic Evaluation information: I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

▪ Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)

▪ Common diagnostic procedures (including diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)

▪ Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuro-muscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique, maya abdominal therapy, and cranio-sacral therapy)

▪ Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)

▪ Trigger point injection therapy, neural therapy, or neural-prolotherapy (PIT).

▪ Botanical/ herbal medicines, prescription of various therapeutic substances including plant, mineral, and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes or other forms.

▪ Homeopathic remedies (highly diluted quantities of naturally occurring substances)

▪ Hydrotherapy (use of hot/cold water, may include transcutaneous electrode stimulation)

▪ Counseling (including but not limited to nutritional counseling, birth control counseling, lifestyle counseling and behavioral modifications)

▪ Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)

Additional Consent Notices

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. Labor- stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. Any treatment intended to induce labor requires a signed letter from a primary care provider authorizing or recommending such treatment.

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your provider of these conditions.

Please INITIAL the following:

_______ I understand that the above mentioned provider will only prescribe medications if they believe that they are in the best interest of myself, the patient. Appropriate referrals will be provided to manage my prescription medication needs otherwise.

_______ I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however, these have been used widely in Europe, China and the USA for years. The above mentioned provider has extensive training in botanical, nutritional and herbal medicine and will recommend these substances with that knowledge in mind.

_______ I understand that the above mentioned provider is not a psychologist or a psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

I do not expect the above mentioned provider and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the above mentioned provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the results intended from any treatment provided to me. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment

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Printed Name of Patient Signature of Patient Date

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Printed Name of Guardian Signature of Guardian Date

HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by Dr. Darcy A. Ries ND for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

• I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.

• I have the right to request restrictions to the use 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 understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that while the above mentioned medical provider may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by the provider at the following address:

2456 NW Northrup St. Suite 1A
Portland, Oregon 97210

• I understand that if I have any questions or complaints I may submit them in writing to the

address above or contact Dr. Ries by phone at: **503-277-3113**.

• I am aware that Darcy A. Ries ND 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, Dr. Ries will make available a revised Notice of Privacy Practice for my review.

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atient ***print name***

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Patient ***signature*** Date

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Parent (under 18), Guardian, Responsible Party Date

Personal Identification Information Please be aware that you do NOT have to provide your social security number as a form of personal identification to receive health care. However, in compliance with state and federal guidelines, Dr. Ries does require a front and back copy of your state drivers' license. Additionally, Dr. Ries may require your social security number in order to extend certain financial options to you.

Your social security number or parent/guarantor's social security number may be required when:

- Payment for any balance due is being billed to/made by another third party payor, including but not limited to the following: A) Your health, motor vehicle accident, or workers' compensation insurance B) Parent/guarantor, relative, attorney or any other payor agreeing to be financially responsible for charges you incur
- Payment arrangement is requested/made for any balance due not paid at the time of service
- Standard discounts are given for services, supplements, herbs, lab fees, and supplies.

I have fully read and understand the above terms for personal identification information.

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Patient (18 years or older) Date

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Parent, Guardian, Responsible Party Date

Email/Text Consent Form

Texting is not allowed as the clinic has no HIPAA-compliant text messaging established at this time. Please do not text your provider. Phone calls, email, and contact through your patient portal are all acceptable means of communicating with your provider.

Before sending Email to Dr. Ries, please read and agree to the following information regarding the risks and conditions of Email use:

1. Risks Associated with Using Email

Dr. Ries offers patients the opportunity to communicate by Email. However, transmitting patient information by Email/Text has a number of risks that should be considered. These include, and are not limited to, the following risks:

- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email senders can easily misaddress an Email message.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of Email may exist even after sender or recipients have deleted their copy.
- Employers and on-line services have a right to archive and inspect Emails transmitted through their systems.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used as evidence in court.

2. Conditions for the Use of Email Communication

Dr. Darcy A. Ries will use reasonable means to protect the security and confidentiality of Email information sent and received. However, because of the risks outlined above, Dr. Ries cannot guarantee the security and confidentiality of Email communication, and will not be liable for improper disclosure of confidential information that is not caused by Dr. Ries' intentional misconduct. Thus, individuals must consent to the use of Email communication. Consent to the use of Email includes agreement with the following conditions:

- Although Dr. Ries will endeavor to read and respond properly to an Email, it cannot be

guaranteed that any particular Email will be read and responded to within any particular period of time. Thus, *no one shall use Email for medical emergencies or other time-sensitive matters*. Please call 911 for emergencies and go to the nearest urgent care or immediate care center for urgent matters.

• All Emails sent to your provider must be sent to their respective Email address.

• ***Email communication with Dr. Ries is limited to the following***: scheduling, re-scheduling, or cancelling an appointment, questions about an existing treatment plan, inquiries as to possible side effects or reactions to treatment, and clarification regarding lab testing instructions. *Inquiries about medications not part of your current treatment plan or new symptoms or conditions not currently under treatment will be re-routed to an in-office consultation*.

• All Emails to or from Dr. Ries' patients concerning existing diagnosis or treatment will be printed out and, at the Provider's discretion, may be made a part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical records, such as a staff or billing personnel, will have access to those Emails.

• Dr. Ries may forward Emails internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Dr. Ries will not, however, forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

• If the individual's Email required or invites a response from Dr. Ries, and the individual has not received a response in a timely manner or within one business week, it is the individual's responsibility to follow up by telephone to determine whether the intended recipient received the Email and when the recipient will respond.

• *Individuals should not use Email communication regarding sensitive medical information* such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.

• Individuals are responsible for informing Dr. Ries of any types of information that they desire NOT to be sent by Email, in addition to those called out in the above paragraph.

• The individual is responsible for protecting his/her password or other means of access to Email. Dr. Ries is not liable for breaches of confidentiality caused by the individual or any third party.

• Dr. Ries shall not engage in Email communication that is unlawfully practicing medicine across state lines.

• It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

3. Communication by Email

To communicate by Email, patients shall:

• Limit or avoid the use of his/her employer's computer.
• Inform Dr. Ries of changes in his/her Email address.

- • Put the patient's name in the body of the Email.
- • Review the Email to make sure it is clear and that all relevant information is provided before sending to Dr. Ries.
- • Take precautions to preserve the confidentiality of Email, such as using screen savers and safeguarding his/her computer password.
- • Withdraw consent only by Email or written communication to Dr. Darcy A.Ries.

Acknowledgement and Agreement

I acknowledge that I have read and fully understood this consent form. I understand the risks associated with Email communication between Dr. Darcy A. Ries and me, and consent to the conditions outlined above. In addition, I agree to the instructions for communication by Email outlined here, as well as any other instructions that Dr. Ries may impose to Email communications.

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Patient ***print name***

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Patient ***signature*** Date

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Parent (under 18), Guardian, Responsible Party Date

Non-covered Services Waiver/Acknowledgment

MEDICARE I understand and agree to the following:

- • It is my full responsibility to inform staff and Dr. Darcy A. Ries ND that I am a Medicare and/or Medicaid member ***prior to*** scheduling an appointment or receiving services.
- • *Medicare currently does not recognize, contract with, or cover alternative care (CAM) providers*; any services provided to me or charges incurred by me as a Medicare member are my full financial responsibility.

SERVICES/SUPPLEMENTS/SUPPLIES I understand and agree to the following:

- • Any and all supplements, supplies, herbs, formulas, injectables etc. prescribed by my provider and/or purchased by me under the care of Dr. Darcy A. Ries are my full financial responsibility, with payment to be made at the time of service/purchase. No open products can be returned to the clinic for refund under any circumstances.
- • Dr. Ries does not bill insurance carriers, health saving plans or any other like entities for any supplements, herbs, formulas, or supplies. It is my full responsibility to submit the required

information to these entities for reimbursement.

• *Some treatments/services may not be covered by insurance carriers, or coverage may begin only after deductible has been met*. Examples may include: micronutrient injections, cupping, massage or osteopathic manipulation therapies, trigger point injections, neural and neural-prolotherapy, hydrotherapy, kinesiotaping, specialty lab testing, and extended visit time (>30 min.) with Dr. Ries for detailed explanations, education and preventative care. I assume responsibility for knowing my plan's coverage. I assume full financial responsibility for the above services *except where specifically determined by my insurance carrier as included in the primary treatment/service being rendered and clearly stated in the insurance contract with the treating provider.*

• It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to the provider which: **1)** is later deemed by my insurance carrier to not be "medically necessary", and **2)** has resulted in a partial or full refund request by my insurance carrier from Dr. Ries.

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

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Patient (18 years or older) Date

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Parent, Guardian, Responsible Party Date

Statement of Financial Responsibility

I understand and agree to the following general responsibilities:

• Financial options extended to me are based on the personal identification information and documentation I have provided.

• *I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service*, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery of items sent to me, shipping and handling, *and phone calls to the provider or clinic wherein medical advice is provided*.

• I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Dr. Darcy A. Ries to release information necessary to secure payment.

• I understand that there will be a minimum $50 fee for any appointment not cancelled within 24 hours of the scheduled appointment, and for missed appointments. Additionally, if materials

such as injectables have been drawn up in advance of my missed appointment, this may incur an additional fee.

• Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, financial responsibility, particularly that as deemed by an insurance plan, can occur without any notice.

I understand and agree to the following with regards to current and/or future insurance billing:

• The verification of my health, motor vehicle accident, or workers' compensation insurance is used to determine if there is coverage for services through my insurance carrier and is NOT a guarantee of payment by my insurance carrier; *I am fully responsible for being aware of my plan's coverage and any care exclusions.*

• I am responsible for providing in a timely manner all accurate, current and thorough information and documentation required to verify my insurance coverage and/or bill my insurance carrier, including all relevant Coordination of Benefits information such as primary and secondary insurance, Medicare, Medicaid, etc.

• I understand that Dr. Darcy A. Ries can require presentation of proof of insurance at any time, and that my insurance may need to be re-verified for specific coverage details as often as every six months.

• I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified, or not provided in a timely manner and has resulted in Dr. Ries' inability to directly bill for and/or receive reimbursement from my insurance carrier.

• *I am responsible for full and timely payment of all insurance co-pays, deductibles, and co-insurance balances due*, including any and all services not covered or paid by my insurance carrier (subject to individual provider insurance contract provisions).

• I may forfeit the privilege of billing my insurance carrier if I do not comply with any of my financial responsibilities or documentation requirements.

• I authorize the release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to Dr. Darcy A. Ries. This release applies to support of the insurance billing process only.

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

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Patient (18 years or older) Date

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Parent, Guardian, Responsible Party Date