

# **Informed Patient Consent For Diagnosis and Treatment**

## **Andrea Minesaki, NMD - Licensed Naturopathic Medical Doctor**

I understand that Dr. Andrea Minesaki, N.M.D./Wellspring Clinic is a Naturopathic Medical Doctor. She is licensed through the Arizona Naturopathic Board of Medical Examiners. Dr. Minesaki/Wellspring Clinic practices natural and traditional medicine. I am relying upon Dr. Minesaki/Wellspring Clinic's skills and treatment as N.M.D.s and understand that she and Clinic doctors will treat me according to the generally accepted standard of care for physicians.

I have been told that Naturopathic remedies are natural substances which do not contain drugs of any kind (other than procaine, which is based on a B-vitamin formula). Naturopathic remedies may also include vitamin and mineral therapies. As licensed Naturopathic Medical Doctors, Dr. Minesaki/Wellspring Clinic is qualified to treat me by use of these remedies.

I understand that as a N.M.D., Dr. Minesaki/Wellspring Clinic may elect to utilize chelation therapy, acupuncture, vitamin and mineral therapies, peroxide therapies, manipulative therapies, herbal therapies, dietary and natural therapies, biological therapies, light therapies, magnetic and electromagnetic therapies, and minor surgery. When these therapies are rendered by Dr. Minesaki/Wellspring Clinic they are provided specifically under naturopathic licensure.

I understand that Dr. Minesaki/Wellspring Clinic may elect to use standard naturopathic procedures (such as electrocardio-grams and blood tests) these procedures are being performed under Dr. Minesaki/Wellspring Clinic's naturopathic licensure.

I understand that naturopathic physicians are not included in the Medicare Program. I understand that Medicare does not pay for services provided by naturopathic physicians. I understand that currently the majority of insurance companies do not pay for services provided by a licensed naturopathic physician. As a method of keeping our costs reasonable, our office does not bill insurance companies. Reimbursement for services is the patient's responsibility; most insurance companies do not cover alternative medical procedures. This includes but is not limited to: acupuncture, vitamin injections & intravenous nutrition and metabolic therapy. The natural medicines or other medications that are prescribed may be purchased at a pharmacy of your choice. Because Medicare and most insurance companies do not pay for services provided by Dr. Minesaki/Wellspring Clinic, I agree to pay her for services directly.

I understand that I may be asked to sign specific consents for an individual therapy (such as chelation or peroxide therapy). Such additional consents will describe in detail the nature, risks, alternatives, possible benefits, and possible complications of the treatment being offered. Such additional consents notwithstanding, I also give my general consent for Dr. Minesaki/Wellspring Clinic and her staff to administer to my needs according to the best standards of naturopathic practice.

I understand that no patient will be involved in any research or experimental procedure without his/her full knowledge and consent. I understand that each patient has the right to consent, or not to consent, to any proposed procedure or therapeutic course. Your signature below fully authorizes our staff and doctors to perform any examinations, diagnostic tests & or treatment as we may consider necessary & to release all information pertinent to your health. In addition, you give your full consent & agreement to all terms & conditions regarding payment of accounts explained here.

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Who Referred You To The Clinic? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature or Authorized \_\_\_\_\_ Date: \_\_\_\_\_

Representative: \_\_\_\_\_



## NEW PATIENT INFORMATION

Patient's Name: (print) EMAIL: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Fax: \_\_\_\_\_ Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male  Female      Occupation \_\_\_\_\_ Hours work per week \_\_\_\_\_

**If visiting from another state or city please list local address and phone #'s:**

Local Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Other Number: \_\_\_\_\_

Marital Status:  Single     Married     Widowed     Divorced     Separated

Name of Spouse: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Name of nearest relative not living with you: \_\_\_\_\_ Phone #: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Financially responsible party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Please list any drug allergies:**  Not Allergic to Any Medications

Medication	Type of Reaction

**Please mark the MAIN and secondary reason(s) for your visit:**

New Patient Visit	Primary Reason for Visit	Secondary (would like to discuss)
Weight Loss/Management		
Natural Hormone Replacement		
Cardiovascular: Plaque Removal Treatment		
Nutritional IV Therapies		
Fibromyalgia/Chronic Fatigue		
Wellness Programs: Immune System Builders		
<b>Other:</b> Please list and explain below:		



Patient:

D.O.B.:

## Personal Medical History

PLEASE CHECK ANY CURRENT or PAST CONDITIONS

Diagnosis: Please check all that apply and List Your Condition	Yourself	Year	Mother	Father	(Wellspring Clinic Use Only)
Neuro: Head/Brain conditions					
ENT: Ear/Nose/Throat - Eye conditions					
Cardiac: Heart conditions					
Pulmonary: Lung conditions					
Musco/Skeletal: Joint/Bone conditions					
Gastro. I.: Stomach conditions					
Endocrine: conditions					
Diabetes					
Liver Disease					
Kidney Disease					
Other					
Genital/Urinary: conditions					
Blood Disorders: conditions					
Cancer: List Type & Stage					
TYPE                                      STAGE					
Emotional: Depression					
Other Conditions: Please List					



Patient: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

## Personal Medical History

Please list any medications you are taking at this time

Medications	Dosage	Time(s) of Day	Medication	Dosage	Time(s) of Day

### HABITS

Do You?	Yes	No	Qty per day	Do You?	Yes	No	Qty per day
Drink Coffee				Have stairs to climb			
Smoke Cigarettes				Take care of others			
Use Recreational Drugs				Have trouble sleeping			
List Type(s):							

### OPERATIONS – FRACTURES – OR SERIOUS INJURIES

TYPE	Year	Description/Outcome/Relative Information



## Medical Appointment Cancellation Policy

Dear Valued Patient:

Wellspring Clinic strives to render excellent medical care to you, your family, and all our patients. In order to be consistent with this philosophy, Wellspring Clinic uses an appointment system that sets aside time for a patient dependent on that patient's current need. When you do not show for your appointment or notify us of your inability to keep that appointment by phone at least **48 hours in advance**, the time that has been allotted for your visit cannot be used to treat another patient and is time lost in our office. With that in mind, and in order to keep our costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

### Policy

We request that you please give our office a minimum of **48 hours' notice** in the event that you need to reschedule your appointment. This will also make it possible to reschedule your appointment more efficiently. Unfortunately, when a patient doesn't show for a scheduled appointment, another patient loses the opportunity to be seen. If a patient missed an appointment and does not contact our office with at least 48 hours' notice, we consider this to be a missed appointment. If you call our office after hours, please leave a message to cancel or reschedule, and we will confirm with you by phone on the next business day. Without this notification, you will be responsible for a non-cancellation fee in accordance with the schedule outlined below.

**A \$75.00 fee will be assessed for all appointments cancelled (including no show) with less than 48 hours' notice.**

If you have any questions or concerns, please notify our staff and we will be happy to assist you.

**I have read and understand the Medical Appointment Cancellation Policy of the practice and agree to be bound by these terms. I also understand that this notice may be changed at any time by the practice.**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_



# Financial Policy

Dear Patient:

Thank you for choosing Wellspring Clinic. We realize that questions may arise about our Payment and Collection Policies and this notice is designed to provide an overview of these policies. Our goal is to provide quality medical care for our patients and it is important that we work together. Our Office Manager will be happy to discuss these policies with you.

## Insurance:

1. You are directly responsible for payment of your medical care and you are expected to pay for any services, supplements, and lab fees at the time of service.
2. Wellspring Clinic **accepts no insurance!** You will be provided with an itemized statement with all of your charges and your diagnosis. It is then your responsibility to submit this to your insurance for reimbursement. Your insurance company may or may not pay for all or any of your health care costs. Please keep in mind that your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover.
3. Please expect to **pay in full** at the time of the office visit for services rendered.

## Billing:

1. Delinquent accounts will be transferred to a collection agency or our attorney when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years.

Please understand that maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

**I understand and acknowledge this financial policy.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name Printed: \_\_\_\_\_



## **We Accept the Following Credit Cards: Visa, MasterCard, American Express, Discover and Care Credit**

We would like to welcome you to our clinic! As a convenience to you, in order to **extend you credit**, we would be happy to keep a credit card on file. Please provide us with your account information. We would also like to notify you that lab work may take several weeks to be billed. When and if this happens we will need to collect for all lab charges at the time we receive the bill, this may be **several months after the date of service. We will keep your credit card on file for these purposes.**

Method of payment:

Visa     Master Card     Discover     American Express     Care Credit

Name as it appears on Credit Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code 3 or 4 digit: \_\_\_\_\_

Name of Patient that is authorized to use this credit card: \_\_\_\_\_

**I Authorize the Wellspring Clinic to charge my credit card for my treatment program.**

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Arbitration Agreement

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration, It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future threat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here \_\_\_\_\_. Effective as of the date of first professional services rendered.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

X \_\_\_\_\_  
PATIENT SIGNATURE (or patient representative) (indicate relationship if signing for patient)

X \_\_\_\_\_  
OFFICE SIGNATURE



# Notice of Privacy Practices

## Protecting Your Confidential Health Information is Important to Us Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### Our Promise!

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPPA – Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

### So what has changed? Why a privacy policy now? Very good questions!

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

## How your HEALTH INFORMATION may be used

### To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

### To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government-appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

### In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

### Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgement, when we believe we are specifically required or authorized by law or with the patient's agreement.

### Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.



# Protecting Your Confidential Health Information Is Important to Us

## For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances. If you are a victim of a crime or in order to report a crime.

## Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgement when sharing your health information only when it will be important to those participating in providing your care.

## To Coroners, Funeral Directors and Medical Examiners:

We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral.

## Medical Research

Advancing medical knowledge often involves learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

## Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State, or Local law requires us, we will not discuss your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment:

Patient Name(s): \_\_\_\_\_

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you soon!

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

### Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

### Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

### Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

### Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

### Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

### Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our Privacy Practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

# Protecting Your Confidential Health Information Is Important to Us

**Fill This Form Out If You Wish to Allow Us to Release Your Medical Information Upon Request  
Who Can Receive Your Medical Information?**

Date: \_\_\_\_\_

Check this box if you DO NOT authorize the release of medical information to anyone

I \_\_\_\_\_ authorize in-office or telephone disclosure of my medical information regarding condition, billing, treatment and prognosis to the following individuals.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

In the event we cannot reach you I give permission to leave messages regarding my medical information, condition, billing, treatment and prognosis at the following phone numbers:

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Patient Name(s): \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

