All Naturopathic Clinic
9989 SW Nimbus Ave
Beaverton, OR 9700
PH: 503.644.7100
Fax: 503.644.7110

HIPAA Notice of Privacy Practices and Consent / Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic 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 by the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic 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 usage 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 the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic 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 practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic.
- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic by phone at: (503) 644-7100.
- I am aware that the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic reserve 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, the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic will make available a revised Notice of Privacy Practice for my review.

_____ _____
Patient (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

THIS SECTION IS TO BE COMPLETED BY The practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement

[ ] Other (specify):

_____ _____
Name and title of employee Date

The practitioners (Dr. Mai and
Dr. Kacy) at the All
Naturopathic Clinic
971.258.1853
kacyborba@gmail.com

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, UNLESS you are requesting us to bill your medical insurance carrier who requires your social security number for claim billing/reimbursement processes.
In compliance with state and federal guidelines,
The practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic do require a front and back copy of your state drivers' license to be on file for both medical and billing services.

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

_____ _____
Patient (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

The practitioners (Dr. Mai and
Dr. Kacy) at the All
Naturopathic Clinic

NON-COVERED SERVICES WAIVER/ACKNOWLEDGEMENT

MEDICARE / MEDICAID
I understand and agree to the following:

- It is my full responsibility to inform staff and providers of the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic 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.

- Chiropractors on staff ***cannot*** **treat or bill services** for Medicare members, per Medicare regulations, unless otherwise stipulated by Medicare Advantage plans.
- The practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic are not contracted with any Medicaid plans; any services provided to me or charges incurred by me as a Medicaid member are my full financial responsibility.

- If I am a both a Medicare and Medicaid member and choose to receive services at the All Naturopathic Clinic, I am fully aware that payments for any services, supplements, supplies, etc. are my full financial responsibility and **these charges *cannot* be billed** by either me or The practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic to Medicare or Medicaid.

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

- Any and all supplements, supplies, herbs, formulas, etc. prescribed by my provider and/or purchased by me at the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic are my full financial responsibility with payment to be made at the time of service/purchase. No open or unopened products can be returned to the clinic for refund under any circumstances.

- The practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic do 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.
- Treatment/services such as moxa, cupping, hydrotherapy, energy work, injections, IV therapy, etc. are generally not covered by insurance carriers and are my full financial responsibility *(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 practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic 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 the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic.

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

_____ _____
Patient (18 years or older) Date

_____ _____
Parent, Guardian, Responsible Party Date

The practitioners (Dr. Mai and
Dr. Kacy) at the All
Naturopathic Clinic

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, 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 the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic to release information necessary to secure payment.

- I understand that there will be a minimum $20.00 fee for any appointment not cancelled within 24 hours of the scheduled appointment, but that late cancellation/missed appointment fees may vary dependent upon individual providers. Please ask your provider about his/her late cancellation and missed appointment fees or ask the front desk staff for further clarification.

- 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, on occasion such changes may occur without written 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 any coverage 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 the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic can require presentation of proof of insurance at any time, and that my insurance may need to be re-verified for specific coverage details with a minimum frequency of every 6 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 the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic 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 release of information in my medical history to my insurance carrier and assign all benefits for unpaid services to the practitioners (Dr. Mai and Dr. Kacy) at the All Naturopathic Clinic. This release applies to support of the insurance billing processes only. Separate authorization may be required for other entity requests.

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

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date