Integrative Medicine of Pueblo
200 W B St Ste 110
Pueblo, CO - 81003

Consent to Treat

Welcome to Integrative Medicine of Pueblo. We are committed to your treatment being successful and strive to help you achieve optimal health. The following information makes it possible to offer you the highest quality of care. This document is comprised of three sections:

1. Office policies and financial agreement
2. HIPAA privacy policy
3. Consent to treatment

Please make sure to read through this document in its entirety, mark each box appropriately, and sign your signature at the bottom.

OFFICE POLICIES & FINANCIAL AGREEMENT

Responsibility for Payment: Dr. Patrick is not contracted with any insurance providers but will provide a superbill (medical receipt) upon request so I may seek reimbursement from my insurance provider. I understand that my insurance provider may or may not reimburse me for the medical care I receive at Integrative Medicine of Pueblo and that payment for my care at Integrative Medicine of Pueblo is my sole responsibility. *

☐ I agree

If I have Medicaid or Medicare: - I agree to not submit a claim (for such items or services, even if such items or services are otherwise covered) - I agree to be responsible whether through insurance or otherwise, for payment of such items or services, and understand that NO reimbursement will be provided for such items or services by Medicaid or Medicare - I acknowledge that no limits apply to amounts that may be charged for such items or services - I acknowledge that Medigap plans do not, and other supplemental plans may elect not to, make payments for such items and services because payment is not made with Medicare - I acknowledge that, as a Medicare or medicaid beneficiary, I have the right to such items or services provided by other physicians or practitioners, from whom payment would be made under Medicare or Medicaid *

☐ I understand

The policy of Integrative Medicine of Pueblo is to collect payment at the time of services are rendered. Debit, check, credit cards and cash are accepted as forms of payment. *

☐ I understand

It is my responsibility to verify coverage and benefits with my insurance company prior to the first office visit and to know the limits and exclusions of insurance coverage. All charges and outstanding balances are ultimately my responsibility. *

☐ I understand

Payment is due at the time of service unless other arrangements have been made ahead of time. A $5.00 re-billing fee will be charged monthly on outstanding balances. If payment is not received after 60 days, the account will be charged an interest rate of 12%. If there is still no payment after another 30 days, the account will be sent to collections. We will work with you on a payment plan, if needed. Please contact us at contact@integrativemedicinepueblo.com to set up a payment plan. *

☐ I understand

It is my responsibility to keep track of my appointment dates and times. As a courtesy, I will receive a reminder email three days in advance of my appointment. In order to keep the schedule running smoothly, I will aim to arrive for my appointment on time. If I arrive more than 15 minutes late to an appointment, I will be rescheduled. *

☐ I understand

Cancellation requests must be made at least 24 hours in advance. There will be a fee of $50.00 for the first missed appointment. If there is a second missed appointment, you will be charged the entire cost of the visit. Three late reschedules, no-shows, late cancellations or combination thereof may result in a discharge of care. *

☐ I understand

I understand that prescription refills, referrals and/or special doctor requests require a minimum of 72 business hours to process. I will give the office enough notice to process requests in a timely manner. *

☐ I understand

I would like to receive email communication, such as newsletters, promotions, and office updates/closures. I understand I can opt-out at any time. *

☐ Yes ☐ No

HIPAA NOTICE OF PRIVACY PRACTICES, USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Integrative Medicine of Pueblo follows HIPAA guidelines for my protection and I have the right to my medical information. If I am interested in learning more, I may read more about it here: http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/consumers/consumer_rights.pdf *

☐ I understand

I have read and understood the HIPAA Notification of Privacy Practices Document also included in my email. *

☐ I agree

INFORMED CONSENT AND REQUEST FOR INTEGRATIVE MEDICINE CONSULT AND OSTEOPATHIC MEDICAL CARE

The intention of this consent form is to help patients and authorized representatives become better informed so that they may give or withhold consent to undergo diagnosis and treatment after having an opportunity to discuss health concerns - including potential benefits and risks, and treatment alternatives. Informed Consent I hereby authorize my physician to advise use of the following therapies: - Osteopathic Manipulative Treatment: a wide variety of gentle techniques applied to the musculoskeletal system; - Nutritional Supplementation: concentrated dosages of vitamins, minerals, and other substances naturally occurring in food; - Lifestyle counseling and hygiene: changes in diet, exercise, sleep, and balancing of work and social activities; - Injection Therapy: trigger point injection, IV therapies (Myers cocktail, Immune Booster), vitamin B12 injections, joint corticosteroid injections Acupuncture, Dry Needling: inserting needles into specific points of the body to elicit specific physiologic or energetic responses - Mindfulness techniques: variety of practices utilized with the goal bringing awareness to the present moment - Life and health coaching: analysis of thoughts and emotions and how these drive our actions and ultimately our results I recognize the potential risks and benefits of these therapies as described above. *

☐ I understand

I acknowledge and accept that there are risks to the diagnosis and treatment measures that fall within and outside the conventional standard of care and that these risks may include: unintended exacerbation of symptoms, new symptoms, allergic and other unintended injury and side effects from exercise, lifestyle modifications, dietary modifications, herbal and nutritional supplements, injected or intravenous therapies, adverse interactions with drugs, herbs and/or nutrients. The specific risks associated with the proposed procedures have been explained to me and/or the patient's representative. *

☐ I understand

I understand the U.S. Food and Drug Administration has not evaluated or approved some of the above treatments, nutritional/herbal supplements or homeopathic remedies. I understand that, as with drugs, nutritional/herbal supplements and homeopathic remedies may cause some side effects in certain sensitive individuals, may interact with certain prescription medications or lab tests, or cause symptoms due to certain pre-existing disease conditions. These will be discussed with me by my practitioner. *

☐ I understand

I do not expect my physician to be able to anticipate and explain all the risks and potential complications. I wish to rely on her to exercise judgment in recommending therapies she feels are in my best interest, based on available knowledge. I have the opportunity to ask questions and discuss with my physician; 1) my condition, 2) the nature, purpose, and potential benefit of the proposed therapies, 3) the material risks inherent in therapies, 4) the probability of those risks occurring, 5) the likelihood of success, 6) reasonable, available alternatives to the proposed therapies, 7) the material risks inherent in such alternatives and the probability of such risks occurring, 8) the possible consequences if advice is not followed and/or no therapies are undertaken. *

☐ I understand

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 myself or my representative or unless it is required by law. Exceptions to confidentiality are: danger to myself, danger to another, or child abuse. The privileged nature of communication with my physician ceases under these circumstances. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. *

☐ I understand

I understand my physician does not function as a primary care physician, and that she offes her services in addition to other services I receive. I understand services do not replace the services of my primary care physician or specialist(s) (e.g. oncologist, cardiologist, rheumatologist, OB-Gyn, etc.) I will discuss all my prescription medication questions and changes with my primary care doctor and/or specialist. I understand that osteopathic treatments do not replace conventional medical advice/care. *

☐ I understand

I acknowledge and agree that this consent form will cover the entire course of treatment for the present condition and for any future condition(s) for which treatment is sought. *

☐ I understand

With this knowledge, I voluntarily consent to the above therapies, realizing that no guarantees have been given to me by the physician or any of her personnel, regarding prevention, treatment, or cure of my condition or any condition. I understand that I am free to withdraw my consent and to discontinue participation in these therapies at any time. *

☐ I understand

I acknowledge the right, opportunity and responsibility to ask questions and to become informed regarding the patient's diagnostic and treatment recommendations to his or her satisfaction. I acknowledge that all questions asked have been fully answered by the physician. *

☐ I accept

I acknowledge that the clinician cannot know or anticipate and explain every possible risk or complication, and that the client or representative willingly chooses to rely on the clinician to exercise their best judgment within the bounds of their licensure for any of the above. *

☐ I understand

Responsibility to report possible pregnancy, notice to pregnant patients: All patients must alert the physician if they know or suspect that they are pregnant, as some of the supplements used could present a risk to the pregnancy. *

☐ I understand ☐ Not applicable

Willing participation: I understand that the clinician may consult with preceptors, clinical medical students, residents, and colleagues related to the care provided and that I or my authorized representative have the right to decline their presence or involvement during any aspect of my care. *

☐ I understand

Please sign below.

By signing and submitting this form, I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Integrative Medicine of Pueblo, and will comply with them in all respects. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Full Name * _____

Today's Date * _____

PATIENT SIGNATURE * _____