Inspire Your Health | 6464 SW. Borland Rd. Suite C-1, Tualatin, OR. 97062 | 503-406-8748

CONSENT FOR TREATMENT

I am requesting and hereby authorize services offered to me by Inspire Your Health including physical examination, specialized tests, and treatment deemed appropriate by my provider. As a patient, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment.

I understand that I am responsible for all fees at the time of service, regardless of insurance coverage or treatment outcome.

I recognize that the doctor is a licensed naturopathic doctor in the state of Oregon, and that she has been trained to act on my behalf as a primary care general practice physician, this includes training in diagnosis and treatment modalities including but not limited to nutritional counseling, homeopathy, botanical medicine, physical medicine and lifestyle counseling.

Inspire Your Health requires a 48 hour cancellation notice for all appointments. Missed appointments will be charged a $50.00 cancellation fee.

I confirm that I have read and fully understand the above prior to my signing.

Signed by: ______________________ ______________________ ______________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

______________________ ______________________

Print Patient's Name | Print Name of Legal Guardian, if applicable

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Inspire Your Health to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Inspire Your Health describes such uses and disclosures more completely.)

I have received Inspire Your Health's Notice of Privacy Practices prior to signing this consent. Inspire Your Health reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Practice Manager, Inspire Your Health, 6464 SW. Borland Rd. Suite C-1, Tualatin, OR. 97062.

With this consent, Inspire Your Health may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Inspire Your Health may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Inspire Your Health may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Inspire Your Health restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Inspire Your Health to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Inspire Your Health may decline to provide treatment to me.

Signed by: ______________________ ______________________ ______________________

Signature of Patient or Legal Guardian | Date | Relationship to Patient

______________________ ______________________

Print Patient's Name | Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form