819 SE Morrison St. #115 Portland, OR 97214 | p. 503-956-9396 | f. 503.206.4791| www.HeartSpringHealth.com

HIPAA Notice of Privacy Practices and Consent/Written Acknowledgement

I hereby consent to the use and disclosure of my protected health information by Heart Spring Health Center (HSH) for the purposes of **treatment**, **payment and healthcare operations**, or as otherwise required by law.

- I acknowledge that HSH has provided me with a copy of its Notice of Privacy Practices which describes how medical information about be may be used and disclosed, and how I can access this information. I have a right to review the Notice of Privacy Practices prior to signing this consent and to receive a printed copy of the Notice of Privacy Practices.
- 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 while HSH 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 HSH at the following address: **819 SE Morrison St. #115**, **Portland, OR 97214**
- I understand that if I have any questions or complaints I may submit them in writing to the address above or contact HSH by phone at: **503-956-9396**
- I am aware that HSH 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, HSH will make available a revised Notice of Privacy Practice for my review.

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, HSH does require a front and back copy of your state drivers' license. Additionally, HSH 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.

Research Consent

Heart Spring Health may contact me for voluntary participation in clinical research projects. I do, however, have the right to refuse these programs without jeopardizing my future care at Heart Spring Health in any way.

Medicare/Medicaid

I understand and agree to the following:

- It is my full responsibility to inform staff and providers of HSH 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.
- HSH is 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 HSH, 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 HSH to Medicare or Medicaid.

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 HSH are my full financial responsibility with payment to be made at the time of service/purchase.
- HSH 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.
- Treatment/services such as moxa, cupping, hydrotherapy, energy work, injections, 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 provider and/or HSH 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 provider or HSH.
- Please note that opened supplements purchased through HSH cannot be refunded.

Statement of Informed Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended allopathic as well as integrative and complementary procedures that are used to treat this condition and your general health. While the risk of complications or side effects from any treatments is rare, it is our policy to inform our patients about them. These complications may include, but are not limited to, soreness, bruising, itching, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications of specific treatments is available upon request.

Natural medicine addresses health conditions by treating the patient holistically to improve their health rather than solely treating the actual disease, condition, or diagnosis. Therefore, the way in which we choose to treat people will often be different than the conventional care of your MD. It is our policy to always inform you of the procedure being performed and any risks and alternative treatments available to you.

Naturopathic, Classical Chinese Medicine, Chiropractic, Acupuncture and Massage Therapy evaluations and treatments may include, but are not limited to:

- Relevant and indicated physical exams
- Common diagnostic procedures (including venipuncture, pap smears, 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 and cranio-sacral therapy)
- Manipulations involving movement of joints and soft tissues, along with physical therapy modalities and rehabilitative exercises
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical medicines, nutraceuticals, prescribing 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, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)

- Hydrotherapy (use of hot and cold water, may include transcutaneous electrode stimulation)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications (including only those medications on the Formulary of Oregon Naturopathic Physicians)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Use of electrical, mechanical and magnetic devices
- Moxa (indirect burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Tuina (ancient Chinese massage)
- Dietary advice (based on traditional Chinese medicine theory)
- Chinese herbal formulas in the form of teas, powders, tinctures, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials
- Guasha (used to relieve symptoms of pain with a tool that brushes along skin surfaces)

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; stroke; dizziness, soreness; joint injuries; physical therapy burns.

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 and 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.

- I understand that Heart Spring Health Physicians will only prescribe medications that are in the best interest of the patient. Appropriate referrals may be provided to manage my prescriptive medication needs.
- 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 more years than pharmaceuticals.

The treatment you receive in this clinic is voluntary and you are voluntarily consenting and authorizing these treatments and procedures. Please understand that you can refuse treatment and or procedures at any time and such requests will be respected.

No warranty or guarantee has been made as to result of care. It is important that you provide all pertinent information in order to facilitate proper treatment and the best medical care possible. Reactions to treatment can be minimized when the doctor is carefully told about all medications you are on including prescription, herbal, and over-the counter medications. There is some risk of reaction to treatment that cannot be predetermined, and that it is important for you to contact the doctor immediately if a reaction occurs in order to properly manage the situation as soon as possible.
By signing this, you agree that you will not discontinue any medications or treatment without the approval of the prescribing or qualified doctor.

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 HSH to release information necessary to secure payment.
- I understand that **if an appointment is If an appointment is missed, canceled OR rescheduled within 36 hours of the scheduled appointment date, I will be billed a minimum of 50% of the out of pocket rate of the visit** and 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 and thorough 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 coverage.
- I understand that HSH 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 HSH's 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).
- For patients paying toward a deductible, a time of service charge will be required. We will make every attempt to submit visit charges and have the full payment apply toward your deductible. In the event that insurance does not cover or partially covers your visit, your full payment will be retained for your provider's services.
- 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 HSH. This release applies to support of the insurance billing process only.

Health Insurance Disclaimer & Responsibility

I understand and agree to the following:
As a courtesy, Heart Spring Health will bill your insurance on your behalf. Therefore, it is essential we have complete and accurate information about your insurance carrier. Heart Spring Health will be following protocols for verifying your insurance coverage. Insurance information given to Heart Spring Health by your insurance company is **not** a guarantee of payment. This includes information provided about covered treatments, copays, coinsurance, deductibles, and pre-authorizations. For patients paying toward a deductible, a time of service charge will be required. We will make every attempt to submit visit charges and have the full payment apply toward your deductible. In the event that insurance does not cover or partially covers your visit, your full payment will be retained for your provider's services.

It is your responsibility to read your own policy, know your coverage, and review explanation of benefits statements regarding payments.

Please remember your insurance policy is an agreement between you and the insurance company and it is ultimately your reasonability to pay for any balance not paid or covered by insurance.

Any charges that are not covered by the given insurance company will be billed to you.

Non-Covered Services/Waiver Agreement

Below is a list of some procedure codes that may not be covered by your insurance, but may be necessary during the normal course of an examination to diagnose, evaluate and give you the care you need. These services and/or supplies are not insurance reimbursable; therefore if your provider incorporates one or more of these procedures, services or supplies into your treatment program, you must pay for them at time of service and not seek reimbursement from your insurance company. If Heart Spring Health is billing your plan for office visits on your behalf, your plan contract may stipulate a visit Copay/CoInsurance payment in addition to these service charges.

This is not a complete list of non-covered services, as your insurance company may designate other services and supplies as non-covered without providing notice to Heart Spring Health.

97140: Manual Therapy

97014: Electrical Stimulation

97035: Therapeutic Ultrasound

97810: Initial 15 minutes Acupuncture

97811: Additional 15 minutes Acupuncture

99354, 99355: Prolonged Services

99358: Additional Research Outside of Office Visit

If you have any questions or concerns regarding coverage of services that are beneficial for your healthcare needs, please speak directly with your provider. A decline of these treatments must be acknowledged in writing prior to the service being performed.

Lab Services Acknowledgement & Consent

I understand and agree to the following:

I am responsible to pay a nominal service fee for blood draws and other lab services at HSH

Heart Spring Health does NOT bill lab claims or service fees to insurance. Lab requests and samples are sent to lab companies who process and then bill to your insurance accordingly. All bills for lab work come form the lab company, NOT Heart Spring Health.

Email/Text Communication Consent

Before sending Email/Text to Heart Spring Health Providers, please read and agree to the following information regarding the risks and conditions of Email/Test use:

1. Risks Associated with Using Email/Text

Heart Spring Health offers patients the opportunity to communicate by Email/Text. 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/Text can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email/Text can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- Email/Text senders can easily misaddress an Email/Text.
- Email/Text is easier to falsify than handwritten or signed documents.

- Backup copies of Email/Text may exist even after sender or recipients have deleted their copy.
- Employers and on-line services have a right to archive and inspect Emails/Texts transmitted through their systems.
- Email/Text can be intercepted, altered, forwarded, or used without authorization or detection.
- Email/Text can be used as evidence in court.

2. Conditions for the Use of Email/Text

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

- Although Heart Spring Health will endeavor to read and respond properly to an Email/Text, Heart Spring Health cannot guarantee that any particular Email/Text 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/Texts sent to providers must be sent to their respective Email/Text addresses.
- Providers will likewise respond to all patient Emails/Texts from their respective Email/Text address.
- All Emails/Text to or from Heart Spring Health patients concerning 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/Texts.
- Heart Spring Health may forward Emails/Texts internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Heart Spring Health will not, however, forward Emails/Texts to independent third parties without the patient's prior written consent, except as authorized or required by law.
- If the individual's Email/Text required or invites a response from Heart Spring Health, and the individual has not received a response in a timely manner or within a business week, it is the individual's responsibility to follow up by telephone to determine whether the intended recipient received the Email/Text and when the recipient will respond.
- Individuals should not use Email/Text 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 Heart Spring Health of any types of information that they desire not to be sent by Email/Text, 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/Text. Heart Spring Health is not liable for breaches of confidentiality caused by the individual or any third party.
- Heart Spring Health shall not engage in Email/Text communication that is unlawfully practicing medicine across state lines.
- It is the individual's responsibility to follow up and/or schedule an appointment it warranted.

3. Communication by Email/Text

To communicate by Email/Text, patients shall:

- Limit or avoid the use of his/her employer's computer.
- Inform Heart Spring Health of changes in his/her Email/Text address.
- Put the patient's name in the body of the Email/Text.
- Review the Email/Text to make sure it is clear and that all relevant information is provided before sending to Heart Spring Health.
- Take precautions to preserve the confidentiality of Email/Text, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by Email/Text l or written communication to Heart Spring Health.

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 also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. 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 treat 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 and 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 decided 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 issue 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 of 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 must submit a formal letter of intention. Effective as of the date of first professional services.
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.
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.

Acknowledgement and Agreement

I acknowledge that I have read and fully understood this consent form. I understand and consent to the risks associated with Email/Text communication between Heart Spring Health and me as well as the risks and other conditions outlined in this document. In addition, I agree to the instructions for communication outlined here, as well as any other instructions in this document or that Heart Spring Health may impose.

Once you have read this document to completion, please visit the reception desk at Heart Spring Health to sign the electronic copy of this release packet.