EDGEWATER
NATURAL FAMILY MEDICINE

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Consent to Naturopathic Treatment and Notice of Privacy Policies –

Dr. Lee Aberle, ND, IFMCP and Dr. Carly Erickson, ND, MSM, IFMCP

I. Consent for Treatment

Naturopathic medicine's therapeutic procedures are considered safe and effective methods of care. However, any procedure intended to help may have complications. Complications with prescription medications are generally more likely than with nature-cure alone. It is the policy of this clinic to inform patients of the risks, benefits and alternative treatments available to any procedure or medication.

By signing below, I acknowledge that treatment offered to me by Dr. Lee Aberle and Dr. Carly Erickson may be different from those offered by another licensed health care provider, and that I am at liberty at any time to seek or continue medical care from another health care provider, including a physician, surgeon or other type of provider.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a specific cure or result. By signing here, I agree to these policies and I give permission to Dr. Lee Aberle and Dr. Carly Erickson to treat me.

Signature _____ **Date** _____

II. HIPAA Notice of Privacy Practices and Consent

I hereby consent to the use and disclosure of my protected health information by Dr. Lee Aberle and Dr. Carly Erickson for the purposes of treatment, payment and health care operations, or as otherwise required by law.

I understand that all information provided during office visits, charted notes and lab reports are confidential. Information will not be released outside of the facility without a patient's written and signed request. All clients have the right to access this information.

I understand that it is the policy of Edgewater Natural Family Medicine, Dr. Lee Aberle and Dr. Carly Erickson to provide copies of laboratory reports during follow up visits.

I understand that I may request a written copy of Edgewater Natural Family Medicine's Notice of Privacy Practices.

I have read and understand the above statements regarding privacy. By signing here, I agree to these policies.

Signature _____ **Date** _____

III. Statement of Financial Responsibility

Full payment for all services and products is due at the time of service. It is preferred that you keep a credit card on file, and is required for some services. If you are unable to keep an appointment, we require notice at least 48 hours prior to my scheduled appointment. A fee of half the rate for the scheduled time will be charged to the patient for missed appointments and late cancellations at the discretion of the clinic. A fee of half the rate for the scheduled time will be charged to the patient if their paperwork is not filled out before their appointment at the discretion of the clinic. This policy is subject to change.

I have read and understand the payment and cancellation policy above. By signing here, I agree to these policies.

Signature _____ **Date** _____