Amber Wellness Group

1944 NE 45th Ave Portland, OR 97213
Phone: 971.319.0045 Fax: 503.296.5712

Clinic Policies and HIPPA Notice

HIPAA Notice of Privacy Practices

I hereby consent to the use and disclosure of my protected health information by the physicians of Amber Wellness Group for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

I understand that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Amber Wellness Group 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 understand that I have the right to request restrictions to the usage and disclosure of my protected health information.

I understand that 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 also understand that revocations will be honored as of the date they are received, in writing, by Amber Wellness Group at 1944 NE 45th Ave Portland, OR 97213.

I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Amber Wellness Group by phone at: 971-319-0045.

I understand that Amber Wellness Group 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, Amber Wellness Group will make available a revised Notice of Privacy Practice for my review.

I understand that in compliance with state and federal guidelines, the physicians of Amber Wellness Group do require a copy of the front and back of your state driver‘s license and will be kept on file for medical and billing purposes.

I understand that in order to provide the best care possible, we may need to discuss your case with other healthcare professionals and facilities. I authorize the physicians of Amber Wellness Group to release my medical records, via a separate medical release consent, to my primary care physician and other healthcare providers. I also authorize the physicians of Amber Wellness Group to request pertinent medical records, via a separate medical request consent, from these professionals and facilities.

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. And while we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

- I understand 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, tests and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my health care, such as: shipping and handling, emails and phone calls to the provider or clinic wherein medical advice is provided.
- I understand that emails, phone consults and research that require practitioners time will be billed in minute increments.
- I understand that I am responsible for full payment of all services if any of the information I have provided is incorrect, falsified, or not given in a timely manner and has resulted in Amber Wellness Group being unable to directly bill for and/or receive reimbursement from my insurance carrier.
- I understand that I am responsible for all charges. If my account becomes delinquent, a 5% service fee will be added on a monthly basis to any balances past 30 days. If it becomes necessary to effect collections, Amber Wellness Group is authorized to release my name, address and amount due (including service fees) to a collection agency or district court to secure payment. I agree to pay for all costs and expenses associated with this action, including reasonable attorney fees. My signature on this consent agrees to both provisions.
- I understand that I may forfeit the privilege of Amber Wellness Group 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 Amber Wellness Group. This release applies to support of the insurance billing processes only. Separate authorization may be required for other entity requests.
- Fees are due at the time of service, Amber Wellness Group accepts cash, check and all major credit cards. The fees for payment at time of service for patients without insurance benefits covering Naturopathic Medicine, or who opt to pay out of pocket, are

given a 20% discount.

- I understand that there will be a $120 fee for any appointment not cancelled within 48 hours of the scheduled appointment or missed entirely. I also understand insurance companies can not be billed for missed appointments and that I am responsible for the charges in full. Fees are adjusted periodically and therefore may increase during the term of our engagement.
- I understand that there is a $25 fee for returned checks.

Insurance Billing

The physicians of Amber Wellness Group are contracted providers with several insurance companies. If they are a contracted provider with your insurance carrier, then they will be billed for you. If the physician is not a contracted provider, appointment fees will be due at the time of service and we will provide you with documentation that you can use to submit to your insurance company for reimbursement.

- I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.
- I understand that I am responsible for filling out the insurance verification form in its entirety provided by Amber Wellness Group and to be aware of any coverage benefits and exclusions.
- I understand that I am responsible for full and timely payment of all insurance co-pays, deductibles, and coinsurance balances due, including any and all services not covered or paid for by my insurance carrier (subject to individual provider insurance contract provisions).
- I understand that Amber Wellness Group 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.
- I understand that treatment/services such as hydrotherapy, energy work, injections, IV therapy, phone consults and email correspondence, 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).
- I understand that the benefit of seeing an integrative provider in that I get to spend more time with them. This will be billed as an office visit and often times as an extended time visit and/or a specific modality visit. These codes may incur an extra charge in addition to my copay.
- I understand that Amber Wellness Group 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 understand that 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 if I am requesting services that may not be covered by Medicare, Medicaid or my insurance company, I will be responsible for those services and will promptly pay any balance unpaid by insurance after I have been billed.. I also understand that if I suspend or terminate my insurance, any fees for professional services rendered to me will become my responsibility and are immediately due and payable Many insurers require a deductible, copay or coinsurance to be paid by the client. Reimbursement rates vary by carrier. Many plans have visit limits or yearly maximum benefits. Co-pay is due at the time of service. Coinsurance and deductibles will be billed to you, by us, after insurance filing and is immediately due and payable.. It is my responsibility, as the patient, to keep up to date on my plan benefits. 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 hereby give authorization for Amber Wellness Group physicians to provide medical services to me, as deemed appropriate and collect payments from my insurance company. It is my full financial responsibility to pay for any charges previously covered/paid by my insurance carrier to Amber Wellness Group which is later deemed by my insurance carrier to not be medically necessary and has resulted in a partial or full refund request by my insurance carrier from the physicians of Amber Wellness Group.

Non-covered Services

The following services are not covered under our contract with your insurance carrier and cannot be billed to your insurance carrier on your behalf. Therefore, it will be your full financial responsibility should you choose at any time to receive any of these non-covered services:

- Physical Medicine – including, but not limited to massage, hydrotherapy, physical therapy, acupuncture, hot/cold pack, etc. (You many have coverage for massage and PT, please refer to your insurance verification form for your plans benefits.)
- Minor Surgery - including, but not limited to, biopsy, cryotherapy, dermatological procedures/treatments, etc.)
- Labs – Out of network labs/lab tests, including but not limited to, hormone panels, allergy profiles, etc, as well as some lab draw and handling fees
- IV therapy, IV drips, B12 injections

Medicare and Medicaid

- I understand that it is my full responsibility to inform staff and the physicians of Amber Wellness Group that I am a Medicare and/or Medicaid member **prior** to scheduling an appointment or receiving services.
- I understand that Medicare currently does not recognize, contract with or cover Naturopathic physician providers; any services provided to me or charges incurred by me as a Medicare member are my full financial responsibility.
- Amber Wellness Group 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 both a Medicare and Medicaid member and choose to receive services from Amber Wellness Group, I am fully aware that payments for any services, supplements, supplies, etc. are my full financial responsibility and these charges cannot be billed by Amber Wellness Group to Medicare or Medicaid.

Roles and Responsibilities for Provider and Patient

- I understand that the naturopathic physicians are not licensed to prescribe any controlled substances.
- I understand that the physicians will only prescribe medications if it is believed that they are in the best interest of myself, the patient. Appropriate referrals will 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 and the USA for years.
- I understand that the physicians of Amber Wellness Group are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies.
- I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent
- I have informed the physicians of Amber Wellness Group of all my known physical conditions, medical conditions and medications, and will keep the doctor updated of any changes. I understand that there shall be no liability of the physicians of Amber Wellness Group in part due to my forgetting to relay any pertinent information.

- I do not expect the physicians of Amber Wellness Group to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the physicians of Amber Wellness Group explain therapies and procedures to my satisfaction. I further

acknowledge that no guarantee of services has been made to me concerning the results intended from any treatment provided to me.

General Information

During the process of becoming well there might be significant changes in your body's function, known as "Healing Reactions". This may include a temporary worsening of previous or existing conditions or new symptoms. Typically, this occurs within 24 hours of a treatment and then the symptoms improve. If this is not the case, please let the office know by calling 971-319-0045, go to an urgent care clinic or call 911. We assure you that the services rendered by the physicians of Amber Wellness Group will be delivered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your therapeutic goals. However, together we will work to achieve the best possible results for you.

- **Labs Review** Our policy is that all lab results, ordered by a physician at Amber Wellness Group, requires a follow up appointment. This is to go over and interpret the results for an effective treatment plan and optimal health. Lab results will not be emailed or given over the phone prior to the return appointment
- **Prescription Refill Policy** Please call your pharmacy and request any refills for medication prescribed by physicians at Amber Wellness Group -this will expedite the turnaround time. Let the pharmacy know 48 business hours prior to needing the prescription to be filled
- **Supplements** Please give Amber Wellness Group 48-72 business hours to complete a supplement order, either for pick up in clinic or to be mailed. You can email or call the clinic for this. The clinic does make every effort fulfill your request as soon as possible. There will be a shipping and handling fee for all supplements that are mailed to you. All supplements, supplies, herbs, homeopathics, tinctures and formulas, etc. prescribed by the providers and purchased from Amber Wellness Group are your full financial responsibility with payment to be made at the time of purchase. No products can be returned to the clinic for a refund under any circumstances.
- **Cancellation Policy** Failure to give 48 business hour notice or not coming to a scheduled appointment will result in $120 fee billed for the session. Monday appointments need to be cancelled on Friday. Insurance companies cannot be billed for missed appointments, therefore the fee is entirely out of pocket. In the instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care.
- **E-mail Policy** E-mail is inherently an insecure manner of communication and they typically travel through many other computers and servers before arriving at their destination. At any point along this pathway these messages can be intercepted and read by a third party. Additionally, if you share your computer with members of your family or friends, or you use a professional email account that could be accessed by your

employer or colleague, then transmitted information might not be confidential. Therefore, the confidentiality of the messages that are sent and/or returned cannot be guaranteed. Your e-mail address is utilized only for patient care. No one else beside the physicians/nurses or office staff of Amber Wellness Group has access to your e-mail account. Without your consent, your email address will never be provided to a third party not affiliated with our private practice. Correspondence should be brief, concise and related to your current treatment plan only. Please include your full name in all correspondence so that your identity may be verified. The practitioners of Amber Wellness Group will not be able to respond to complex questions, give a lengthy response or address things not pertinent to your current treatment plan. There is a fee charged for doctor replies that are in excess of 3 minutes. Most inquiries as well as, non-medical questions, billing questions, supplement orders, etc should be directed to the main office for a timely response. Unless otherwise noted in an auto-reply message to you, Amber Wellness Group will reply to your e-mail within 72 business hours. If you do not receive a reply within that time frame, please call the clinic You should not utilize e-mail for urgent messages or any matter that requires immediate attention. Any urgent issue should be conveyed via phone to the office directly. The office phone is 971-319-0045 The office email is frontdesk@amberwellnessgroup.com Our medical assistant can be reached at MA@amberwellnessgroup.com All e-mail correspondence will be incorporated into your permanent medical record. After this has been done, Amber Wellness Group will delete all correspondence from their computer and from the server that is utilized. Amber Wellness Group is not responsible for any e-mail or information lost due to technical failures.

Patient Information

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with one or any of the practitioners at Amber Wellness Group. I have had the opportunity to discuss the potential benefits, risks and hazards involved.

I hereby request and consent to examination and treatment with Amber Wellness Group. I can request that students and preceptors not be included in my evaluation and treatment.
I understand that I have the right to ask questions and discuss to my satisfaction with Amber Wellness Group:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success

- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done I understand that evaluation and treatment may include, but is not limited to:
- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments).
- Common diagnostic procedures (including venipuncture, pap smears, physical therapy examinations, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva).
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements vitamin injections), IV Therapy and Trigger point injection therapy with vitamin substances.
- Botanical/ herbal medicines (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, topical creams, pastes, plasters, washes or other forms).
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water).
- Soft tissue and osseous manipulation (including therapeutic massage, deep tissue massage, neuromuscular technique, naturopathic/osseous manipulation of the spine and extremities, pregnancy massage (to relieve muscular discomfort associated with pregnancy), muscle energy technique and craniosacral therapy).
- 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). By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Notice to individuals with bleeding disorders, pacemakers, and/or cancer. For your safety it is vital to alert your provider of these conditions.