A Family Wellness Center
Donna L. Beck N.D.

330 NE 102nd Ave. Portland, OR 97220 Telephone (503) 252-9181 Fax (503)252-6161

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. All HIPPA Policies are effective April 14th, 2003

Please direct any questions, concerns or complaints regarding HIPPA policies and procedures to Rachelle Franke at (503) 252-9181.

Consent for Treatment

Naturopathic Medical Consent: I consent to services rendered and treatment provided by Dr. Beck at A Family Wellness Center. I recognize that Dr. Beck is a licensed Naturopathic Physician. I have the right to refuse any treatment suggested that I am uncomfortable with. I have the right to ask questions to my satisfaction. Dr. Beck has the right to treat me within the scope of her practice. Dr. Beck has the right to refuse treatment or to make referrals to outside physicians if she feels that she can not be of service to my case.

Patient Name: ____

Patient/ Guardian Signature:____

Relationship to Patient: ____

Date: __________________________