FEDERAL WAY NATUROPATHY
Rooted in Your Well Being

18 & Older Patient Consent and HIPAA Release Packet

Legal Name:_____ Birth Date: _____
Last First MI

Name I prefer to be called:_____ Former name, if any: _____

Gender:_____ Personal pronouns: _____ Legal Gender: _____

Street address:_____ Home phone: _____

City:_____ State:_____ Zip Code:_____ Cell phone: _____

Email address:_____ Work phone: _____

I authorize Federal Way Naturopathy to leave voice mail messages concerning health information at the following numbers:

_____***Home***_____***Cell***_____***Work*** *(check all that apply)*

As a component of my care, I understand and agree that Federal Way Naturopathy may contact me using automated calls, emails and text messaging sent to my landline and mobile device. These communications may notify me of scheduled appointments, preventive care, test results, treatment recommendations, outstanding balances, or any other communications from Federal Way Naturopathy I may opt out at any time by calling Federal Way Naturopathy at (253) 942-3301 or by accessing my notification settings on my patient portal. By my signature, I authorize Federal Way Naturopathy to contact me by____email____phone____SMS text. *(Check all that apply)*

_____
(Patient or legal guardian signature)

GUARANTOR

Person responsible for bill: _____ Phone: _____

Relationship to patient: _____ Is this person a patient here? ___Yes__ No Birth date: _____

Address (if different than above): _____

Other family members seen here: _____

IN CASE OF EMERGENCY

Name of local friend or relative: _____

Relationship to patient: _____ Home/Cell phone: _____ Work phone:_____

AUTHORIZATIONS

I_____give permission for Federal Way Naturopathy to give me medical treatment._____*(Initial)*

I understand I have the right to refuse any procedure or treatment. I understand I have the right to discuss all medical treatments with my clinician._____*(Initial)*

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Federal Way Naturopathy or my insurance company to release any information required to process my claims._____*(Initial)*

_____***Signature of patient*** _____***Date***

Acknowledgment of Receipt of Privacy Practices

By my signature below I,_____, acknowledge that I received a copy of the Notice of Privacy Practices for Federal Way Naturopathy. *The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at fwnmedical.com or on request from our staff.*

_____ _____
Signature of patient (or personal representative) Date

FEDERAL WAY NATUROPATHY
Rooted in Your Well Being

HIPAA Release and Consent Form

I understand and acknowledge that by being 18 years of age or older, my parents and/or guardians no longer have access to my medical records, personal information, providers, or appointment status without my specific written consent, under Federal and State Notice of Privacy Practices regulations. Federal Way Naturopathy may not speak with my parents and/or guardians to schedule appointments, fill or refill prescriptions, or release personal and/or medical information to my parents without my written consent as indicated in this document.

_____**I DO NOT** grant access to my parents and/or guardians. **No medical record information, personal information or appointment information may be discussed or released.** I understand that I will schedule all of my appointments with Federal Way Naturopathy and contact Federal Way Naturopathy to update my personal information and/or request prescriptions and/or prescription refills.

_____**I DO WISH TO** grant my below listed parents and/or guardians' access to my healthcare providers and/or medical information as follows:

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____
(Print Name of the parent or guardian; indicate his/her relationship to you.)

_____I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Federal Way Naturopathy to schedule appointments, request prescriptions and/or prescription refills, discuss my healthcare, and access my complete medical record. **I understand this gives the listed parents and/or guardians full access to my Protected Health Information (PHI), as outlined in the Health Insurance Portability and Accountability Act (HIPAA).**

I understand that my records may contain information regarding the diagnosis and/or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE The following information from the records released:

☐ HIV/AIDS ☐ Sexually transmitted infection ☐ Psychiatric disorders/mental health ☐ Drug/alcohol use

_____I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Federal Way Naturopathy for the **sole purpose of scheduling an appointment on my behalf**. NO access to my medical record, personal information, or information regarding my care may be provided or disclosed.

_____I give the above named individual(s) permission **to only request refills and pick up my prescriptions on my behalf.** NO access to my medical record, personal information, or my care may not be provided or disclosed.

_____ _____
Patient Printed Name Patient Birth Date

_____ _____
Patient Signature HIPAA Signature Date

This consent is valid for one year from the date signed. I understand that I have the right to withdraw my signed consent at any time by providing Federal Way Naturopathy with written notice indicating the changes in access.

I understand that this consent has no impact on whether or not I am covered under my parent/guardian's healthcare plan. Charges for my services are still billable to my parent/guardian's healthcare plan without their access to my PHI.

FEDERAL WAY NATUROPATHY
Rooted in Your Well Being

Federal Way Naturopathy's Financial Policy

Health insurance is a contract between the patient and their insurance carrier. The insurance policy lists a package of medical benefits such as treatment services, tests, office visits and therapies. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are your covered services. Your policy also lists the kinds of services that are not covered by your insurance company. These are your exclusions. You must pay for any uncovered medical care that you receive.

Medical necessity is not the same as a medical benefit. A medical necessity is something that your doctor has decided is necessary. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy. Insurance companies determine what tests, therapies, and services they will cover. Your insurance company's choices may mean that the test, therapy, or service you need isn't covered by your policy. You may still obtain the treatment your doctor recommended, but you will have to pay for it yourself.

By understanding your insurance coverage, you can help your doctor recommend care that is covered in your plan. Federal Way Naturopathy will try to be familiar with your insurance coverage so we can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor to know the specific details of each plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get tested or fill a prescription. Some kinds of care may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Your insurance company, not your doctor, makes decisions about what will be paid and what will not.
- Your physician, not your insurance company, makes medical decisions and recommendations about what will benefit your health.

Some services, tests or therapies recommended by your provider may not be covered by your insurance policy. When you have a test or treatment that isn't covered, your insurance company won't pay the bill. You can still obtain the treatment your doctor recommended, but you will have to pay for it yourself. Claims may not be resubmitted with different codes if they have been denied for lack of coverage.

Preventive office visits

Well-child exams, annual gynecological exams, and routine physicals are coded differently from standard office visits and are based on the age of the patient and whether you are a new or established patient. Your preventive benefits only cover services provided in the absence of illness or complaints. Legally we are not permitted to resubmit claims with a new diagnosis or procedure code if the claim was accurately submitted as a non-preventive visit. If there are additional concerns brought up at a preventive office visit, there will be an additional brief medical office visit fee.

Billing:

If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Labs and other ancillary services – i.e., lab testing, medical imaging, etc. are not part of our practice. Please call the number(s) listed on those statements for assistance.

FEDERAL WAY NATUROPATHY
Rooted in Your Well Being

It is the policy of Federal Way Naturopathy to collect all payments or insurance information at the time services are rendered. For your convenience, we accept cash, check, Visa, or MasterCard.
We will submit your insurance claims directly to any insurance your doctor is contracted with, provided the information we have obtained from you is accurate and complete, however the patient assumes responsibility for all unpaid balances, co-payments, and deductibles due, as well as any non-covered service by the insurance company, including cost of collection. It is the patient's responsibility to provide the most current insurance information to our office at the time services are rendered.

It is your responsibility to know the limits and exclusions to your insurance coverage.

VIRTUAL & DIGITAL VISITS: We are happy to offer you the option of a virtual and/or digital health visit from the comfort of your own home. These visits are billable, please ask for our complete virtual health visit policy letter for more information. This information is also available at fwnmedical.com
AUTOMOBILE ACCIDENT PATIENTS: We do treat automobile accident patients, and we will bill the patient's insurance only. We are unable to monitor long term accounts and we will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.
WORK RELATED ACCIDENTS: Federal Way Naturopathy does not accept L&I claims. Contact your case manager to find an in-network provider.
DISPENSARY: All dispensary products will be paid for at the time of pickup. If products are mailed, a Visa or MasterCard number will be required for billing. Shipping and handling charges will be added to the bill.
SELF-PAY PATIENTS: If you have no insurance coverage for our services, we offer a **20%** discount on office visits and procedures. Payment in full is due at the time of service.
NSF: All checks returned for non-sufficient funds will result in a **$25.00** service charge to be collected at the next visit, or within 30 days (whichever comes first).
UNPAID STATEMENTS: A **$5.00** rebilling fee will be charged each month on any outstanding balance. If no payment is received on an account after 90 days, the account will be sent to the collection agency.
REPORTS, FORMS & LETTERS: A fee of **$16.50** for the first page and **$5.00** p/ea. additional page will be charged for forms, reports and/or letter requests for military, work, personal or other reasons.
An itemized receipt is provided to the patient at each office visit for dispensary purchases. A patient contract is also provided at each visit and will serve as a letter of medical necessity for HSA & FSA accounts if needed. A fee of **$5.00 per receipt** will be charged when reprints are requested.
PAGER: A fee of **$55.00** will be charged for a non-emergent page to the physician. Please note that your pager call may result in a billable visit.

A fee of $50 will be charged for cancellations made less than 24 hours from your scheduled appointment.
A no show fee of $100 will be assessed for patients that fail to show up for a scheduled appointment.

By signing this form:

- I understand and agree that my health insurance is an arrangement between my insurance carrier and myself; that all services furnished to me are charged directly to me and that I am personally responsible for payment of all services._____(Initial)
- I authorize treatment and agree to pay all charges. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing._____(Initial)
- It is agreed that payment will not be delayed or withheld because of any insurance coverage or pendency of the claims thereon._____(Initial)
- I agree to pay for any missed appointments that were not canceled or rescheduled at least 24 hours in advance._____(Initial)

Federal Way Naturopathy firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at 253) 942- 3301.

Signature _____ Date _____

Print Name _____

900 South 336th St, Federal Way, WA 98003
Phone (253) 942-3301 Fax (253) 237-0606 fwnmedical.com