

Carol Bobovski, N.D.
15613 Bel-Red Road, STE B.
Bellevue, WA. 98008
P: 425-947-1970 / F: 425-947-1971

Office Visit Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Informed Consent for Naturopathic Care

I, the undersigned, hereby request and consent to the naturopathic medical care provided by Docere Natural Health, designed to improve the quality of my health and condition.

I authorize Dr. Bobovski to provide physical examination, diagnostic procedures (i.e.: venipuncture, pap smear, urine analysis), and minor office procedures (wound cleansing and dressing, ear cleansing, eye washes).

I understand that Dr. Bobovski provides naturopathic treatments that include botanical medications (teas, tinctures, capsulations, suppositories, tablets, creams or gels), homeopathic medications (creams, pellets, liquids), nutraceuticals (nutrient supplementation, intramuscular injection), lifestyle counseling, contraception recommendations and fittings, and metabolic cleansing.

I understand that Dr. Bobovski provides naturopathic physical modalities that include massage, cranial-sacral therapy, hot-cold applications, muscle energy stretching and therapeutic stretching.

I have had an opportunity to question Dr. Bobovski regarding the nature and purpose of naturopathic care. I understand and have been informed that there are benefits and potential risks in naturopathic medicine that may include, but are not limited to: an allergic reaction or side effects to a botanical medication, supplement or injection, injury from injections, venipuncture or a physical medicine modality. I am also aware that there is potential for a nutrient-drug or botanical-drug interaction. I will notify Dr. Bobovski of all medications (prescribed and OTC), supplements, and botanicals that I take to improve the quality of my health, and will notify her if there are any changes in those medications during my care in her office. **I am aware that there is a potential risk to a developing fetus if certain medications, botanicals, and nutrients are taken during a pregnancy.** I will therefore, notify Dr. Bobovski if I am trying to become pregnant or suspect that I am pregnant.

I acknowledge that that there is no guarantee, expressed or implied, concerning the outcome of any of the procedures used in the course of my care. I understand that results from treatments vary, and that compliance with the diet and lifestyle recommendations, supplements and medications may increase the effectiveness of my care.

I understand that a referral to another physician, specialist, or emergency room may be necessary under certain circumstances and in my best interest. I understand that should I experience a medical emergency I am to dial 911.

I voluntarily consent to the above procedures and treatment and understand that I am free to withdraw my consent and discontinue care at any time. I understand that my health record is confidential, but that I am able to review it at any time during office hours, and can request a copy (at cost).

I have read or have had read to me the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient or Legal Guardian

Date

Print

Witness

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Financial Policy

1. Payment: As a patient of Docere Natural Health, LLC you are directly responsible for all charges incurred while under treatment unless you are eligible for insurance reimbursement with an insurance carrier the doctor is credentialed with. Payments are due at the time of service, supplies received, or laboratory tests ordered. If the doctor is credentialed with your insurance carrier, all deductibles, co-payments and balances that are the patient's responsibility are due at the time of service.

Accepted methods of payment are: cash, personal checks, debit and Visa/ Mastercard credit cards.

2. Insurance: If the doctor is contracted with your insurance carrier (Regence Plans: PPO, Preferred and limited coverage with Selections; Lifewise; Premera BlueCross and Uniform Medical) we will bill your insurance directly. **You will need to verify your benefits and eligibility, and ensure your referral status prior to your office visit. It is your responsibility to keep track of your network status, deductible, maximum benefit, or other liabilities specific to your plan's coverage.** Please use the form below to assist you with your verification process.

Docere Natural Health is not responsible for payment discrepancies that might occur once the reimbursement check is received. If Docere Natural Health is not contracted with your carrier, and you think that your insurance will cover naturopathic care, at your request we will provide you with an insurance billing form that you can submit to receive payment from your insurance company. Fertility and Weight loss programs are not usually covered by insurance.

3. Seniors: Due to state and Federal regulations, we **cannot** process medical coupons or Medicare/ Medicaid claims.

4. Cancellations: Please give us 24 hours advanced notice of an appointment cancellation. If less than 24 hours notice is received the amount of the scheduled visit will be charged to you (except in emergency situations).

5. Late Fee: Accounts over 90 days outstanding are overdue and may be acted on for collection. Collection costs are added to your account. A late fee of \$5.00 per month will be charged on overdue accounts. There is a \$10.00 charge for returned checks and payment is due in the amount of the check plus the returned check fee within 14 working days.

I have read and had the opportunity to ask questions regarding the financial policy. I agree to abide by its terms.

(Signature)

Print

Date

Witness

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Eligibility Verification Form

Please call your insurance carrier to verify your naturopathic and laboratory coverage prior to your visit. The number is located on the back of your insurance card.

1. Date of Call: _____
2. With whom you spoke: _____
3. Effective Date: _____
4. Yearly Deductible: _____
Amount met to date: _____

Naturopathic Coverage:

1. % Covered: _____
2. Co-payment Amount: _____
3. Number of Visits allowed yearly: _____
4. Do you need a referral: YES* NO
5. Is an Annual Physical Exam a covered benefit? YES NO*

**If your insurance requires that you receive a referral or prior authorization, please obtain this prior to your visit at Docere Natural Health, LLC. Otherwise, you will be responsible for the cost of the visit and any labwork. I am happy to write or call your referring practitioner to keep them updated on the care receive in my office.*

6. Does your insurance require you to choose a primary care provider (PCP)?
 YES NO
If yes, who did you choose: _____

Please bring this form to your office visit, along with your insurance card.

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Notice of Privacy Practices

I acknowledge that I have been informed of the laws pertaining my privacy rights, per the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that my health information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in treatment directly and indirectly.
- Obtain payment from third party payers, your insurance company, or with business associates (i.e.: a billing service, with whom I am contracted)
- Conduct normal medical office operations, written mailings, and phoning for scheduling and follow up. If you do not answer the phone a message will be let on your machine or with the person who answers the phone. In the case of an emergency, we may disclose your health information to a family member (or your emergency contact) for the benefit of your health.

I understand that I can revoke the clinics right to disclose my contact/health information in the methods described above if I provide that request in writing to the clinic. Dr. Bobovski will let me know if that request can be honored. I also understand that some or all of my healthcare information may be disclosed if required by law. I understand that I have a right to review/copy my health records. I have been informed that a written notice is required regarding the information I wish to see, and that reasonable fee may be required for copying my chart.

I understand that I will be notified via writing, should the details of this notice change in any way. Should I have further questions or concerns regarding my privacy rights I will call Docere Natural Health at 425-821-1800 for assistance.

I acknowledge that I have received this notice regarding my privacy rights.

Signed: _____ Date: _____
Printed: _____

Name of Patient if signed by guardian or parent: _____