



Wellness Consultation Policies

Cancellation Policy: There is a \$50 charge for cancellations of less than 24 hours or failure to show up for a scheduled appointment.

Email Policy: Email may be used for answering brief clarifying questions at your practitioner's discretion. If you are emailing about a new or more detailed concern, you will be asked to schedule a phone or office consultation to ensure effective communication and comprehensive care.

Costs of any laboratory tests are paid directly to the lab and do not include the fee for follow-up consultation to discuss the results.

Consultation Fees:

Practitioner	90 minutes	60 minutes	30 minutes	15 minutes
PharmD, DC, or ND	\$195	\$145	\$85	\$30
Classical Homeopath, CCN, L.Ac., MS, RD, or RN	N/A	\$110	\$75	N/A
ACN, Ayurvedic, Certified Herbalist, NA, or LMT	N/A	\$85	\$55	N/A
Chiropractic Adjustment	\$40 per visit			



HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health care plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may also call you by name in the waiting room when

your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.



Privacy Notice Acknowledgement Form

The Federal Health Insurance and Portability and Accountability Act (HIPAA) regulates how health care providers may use and disclose health information, and also requires that patients be notified of the provider's privacy practices.

I, _____ (Printed Name of Patient or Patient's Representative), acknowledge receipt of the "Privacy Notice Acknowledgement Form" and "Wellness Consultation Policies".

Signature (Patient or Patient's Representative)

Date



Wellness Consultation Consent Form

I hereby understand, agree, and attest to the following:

1. I fully understand that the Wellness Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.
2. Since the Wellness Consultant is not a medical doctor or primary care physician, it is recommended that I continue services with my primary care physician.
3. The services offered by the Wellness Consultant are at all times restricted to helping me gain a better understanding of 'health' (not disease), so that I will have greater self-awareness and be able to use a self-care plan for daily living.
4. The wellness plan offered (which may include discussion and or sale of nutritional supplements, nutrition and lifestyle modifications, homeopathic remedies, vitamins, minerals, food grade herbs, and other dietary supplements) pertains to the whole body concept of nutrition rather than addressing a specific ailment or condition.
5. The Wellness Consultant does not provide emergency or after-hours care. In the event of an emergency, I will dial 911 or proceed to the nearest emergency room.
6. Laboratory testing may be conducted for screening purposes only and does not constitute a diagnosis of any medical condition. It is my responsibility to follow up with a medical doctor if any of the lab results are abnormal.
7. Women who are pregnant or planning pregnancy must inform their Wellness Consultant, as this will likely alter the recommendations that are made.
8. Since they are not prescribing physicians, the Wellness Consultants will not be able to advise me to discontinue or change doses of my medications. I am advised to consult with my prescribing physician concerning any modifications of my pharmaceutical medications.
9. Potential benefits of following a wellness plan include health optimization, symptomatic relief, and disease prevention. Potential risks include rare allergic reactions, paradoxical reactions to supplements (example: valerian is a relaxing herb for most people, but it is stimulating in some people), and drug-supplement interactions. Although there is a growing body of information regarding such interactions, I understand that not all drug-supplement interactions are known at this time.
10. There are wide individual differences in response to a wellness plan, and no guarantees are made that I will gain any benefit nor suffer any adverse consequences.
11. While I may experience immediate benefits from the wellness plan, I understand that the most effective results will occur when I make a long-term commitment to rebuild my health, which will likely involve some lifestyle modifications.

Signature of Client or Client's Representative:

Printed Name of Client or Client's Representative:

Phone Number:(_____)_____-_____

Date: _____

Referred By: _____

Acceptance Application

Name:

Email:

Phone:

Address:

Occupation:

Age:

Family (significant other, children and ages):

What would you like to accomplish?

What have you tried already?

What are your strengths?

What are your greatest accomplishments?

What do you consider your weaknesses or challenges?

What have you done to overcome your challenges?

Are you being treated for any conditions? If so, what is the condition and treatment, including medications?

Acceptance Agreement: I _____ declare that I am of sound mind and agree to fully disclose all information requested. I understand that this program is designed to promote educational information and I take full responsibility for my learning of it, my actions, as well as the results of this program. I do not hold anyone affiliated with this program liable for my results.

Signature and Date _____

Client Prep Form

In order to get the most out of your coaching experience and prepare for your session, you'll want to do the following:

1. Think about what you want to get out of the session(s). Write your intention

here: _____

2. What are your strengths? _____

3. What challenges you? _____

4. If there were no limits and you could not fail, what would you do?

5. What have you done that empowers you, provides results and works for you?

6. What other information do you feel would be helpful for your coach to know?

7. Spend a few minutes clearing your mind, getting present and grounded before our session. I recommend doing a visualization/grounding meditation. See "Meditations" on my website www.BrendaYoung.com.