ADULT MEDICAL HISTORY, INFORMED CONSENT, OFFICE POLICIES

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The Northwest Center for Homeopathic Medicine

Please email a jpg photo to drbobullman@gmail.com or drreichenberg@gmail.com.

Name : Age and Date of Birth:
Address:
City, State, Zip, Country:
E-mail:
Phone: Home: Cell: Skype:
Occupation: Spouse/Significant Other:
In case of emergency, notify:

Referred by:

Main health concerns:

Significant life traumas or stresses:

Significant past health problems, accidents, hospitalizations or surgeries? (include dates)

Family history of serious illnesses? (Include condition and which family member)

Current medications and nutritional supplements (include dosages):

Contact information for primary care physician:

Any upcoming diagnostic testing or medical or dental treatment?

INFORMED CONSENT TO HOMEOPATHIC AND NATUROPATHIC TREATMENT

AND OFFICE POLICIES

I (name) _____ consent to be treated by Dr. _____, a licensed naturopathic physician in the State of Washington. Description of treatment: Homeopathic medicine uses dilute, natural substances to treat the whole person. Naturopathic medicine utilizes various natural therapies including herbs, vitamins and minerals, nutritional recommendations, manipulation, and psychological counseling. Although many scientific studies and years of clinical experience have shown these procedures to be safe and effective, they are still recognized by some individuals and groups as "experimental." I recognize the potential risks and benefits of homeopathic and naturopathic medicine.

Potential risks: Adverse reactions to homeopathic medicines, herbs, vitamins, minerals, nutritional recommendations, manipulation, or other prescribed treatments. Potential benefits: Improved health that may lead to prevention or relief of symptoms and elimination of problems.

Release: Fully understanding the above-described information and potential risks, I voluntarily consent to treatment, realizing that, as with any medical treatment, no guarantees are possible and none have been given to me by my doctor or his/her staff regarding any cure or improvement in my condition. I hereby release Dr. Ullman's and Dr. Reichenberg-Ullman's clinic and staff from any and all liability that may arise as a result of my diagnosis and/or treatment. I understand that any of my questions regarding treatment will be answered by the doctor and that I am free to withdraw my consent and to discontinue treatment at any time. Medical records: I authorize the utilization of clinical or other information contained in my medical records for research, teaching, or publication in an article or book, so long as my identity is not disclosed. Information regarding my case may be shared with other health professionals or with attorneys, with my permission.

Payment: I have been informed about the doctors' fees and acknowledge that I am directly responsible for payment of all charges incurred while I am under the care of Drs. Ullman or Reichenberg-Ullman. I understand that all payments are due at the time of service. I will pay for all pharmacy items and books when I received them. I understand that $20 will be charged for any returned checks. I agree to pay for any costs of collection and/or attorney fees or costs incurred by any delinquent unpaid balances on my or my child's account. Insurance: I will pay all fees directly to The Northwest Center for Homeopathic Medicine (NCHM) at the time of each visit and, if appropriate. I may seek reimbursement from my insurance provider. I am aware that this is a cash practice, that the doctors do not contract with any insurance providers, and that telephone consultations may not be covered by insurance.

Cancellations and Missed Appointments:
If I must cancel my first appointment, I will call or email the office at nchmclinic@gmail.com no less than 48 hours in advance. In this case, I will receive a full refund minus a $50 administrative fee. Without sufficient notice, no refund will be possible. If I need to cancel subsequent appointments, except in the case of true emergency, I will call or email nchmclinic@gmail.com no less than 48 hours in advance to avoid a missed appointment charge. Appointments cancelled between 48 and 24 hours before my scheduled appointment will be charged half the appointment fee. For appointments cancelled less than 24 hours in advance, or missed, I understand that I will be charged the full appointment fee.

Special Payment: If I am over 65, I qualify for a 10% discount on office visits. If I have a financial hardship, I may inquire about special arrangements prior to my appointment.

I HAVE READ AND UNDERSTAND THIS AGREEMENT AND AGREE TO ALL OF THE ABOVE PROVISIONS.

_____
(Signature of patient or of person authorized to consent for patient) (Date)