



A Note on Insurance

According to Alaska State Statute, Sec. 21,36.150, “a person may not practice or permit unfair discrimination against a person who provides a service covered under a group disability policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a non-profit corporation, if the service is within the scope of the provider’s occupational license”.

In this subsection, “provider” includes services rendered by a licensed naturopath.

In other words, if you are covered by a group insurance policy, then any and all claims submitted for you by our clinic should be honored by your insurance company, depending on your policy. This does not include federal programs (such as Blue Cross Blue Shield Federal, Medicare, Medicaid, Denali Kid Care, and most unions). It is your responsibility to contact your insurance company prior to treatment if you are unsure about coverage for naturopathic medicine.

If you have more than one insurance company, we will file to all of them for you, if the insurance company sends us the Explanation of Benefits (EOB). If the EOB goes to the patient, the patient can either bring the EOB in to the clinic and we will file to the secondary insurance company, or the patient can file the claim directly.

If for some reason you do not want the clinic to file your claim, please be sure to tell the receptionist when you check in.

Payment: We request that all insurance companies reimburse directly to the patient, if the patient’s balance with the clinic is zero. However, some companies continually send the reimbursement checks to us. If this should happen we try to refund the patient within a 24 hour period of time (check sent by mail).

You may keep this information for your records



222 Front Street, Fairbanks, AK, 99701 Tel: 907 451-7100 Fax: 907-451-7168

Optional Information

The following additional information will assist us in better serving your health needs.
Please list your present health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Are you currently working with other doctors or health care practitioners?

Please list current vitamins, herbs, and other nutritional supplements with dosages:

Blood type (please circle one): O A B AB Don't know

Lifestyle History:

Spiritual practice? Yes / No

Rate your stress level (5 being most stressful): **1** **2** **3** **4** **5**

Rate your energy level (5 being most energetic): **1** **2** **3** **4** **5**

Average hours of sleep per night: _____

Difficulty falling asleep? Yes / No

I wake up _____ times per night

Rested in a.m.? Yes / No

Exercise activities:

Diet History:

Please check all that apply

____ Std. American ____ Reduced red meat ____ Chicken/Turkey/Fish

____ Vegetarian

____ Vegan ____ No wheat ____ No dairy

Reactions or allergies to specific foods? Yes / No If yes, please list below:

PF-1000

Notice of Privacy Practices -Holistic Medical Clinic-

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **Holistic Medical Clinic**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Fund raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

[] Please do not use my information for fund raising purposes.

Individual Rights You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information.
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information

- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed (such an accounting will not include disclosures for treatment, payment, health care operations and disclosures made based upon an authorization).
- the right to receive a printed copy of this notice

Holistic Medical Clinic Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **Receptionist** or **Office Manager**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Office Manager
Holistic Medical Clinic
222 Front St.
Fairbanks, AK
(907) 451-7100**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

**Office Manager
Holistic Medical Clinic
222 Front St.
Fairbanks, AK
(907) 451-7100**

Effective Date

This Notice is effective on or after **April 14, 2003**.



PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

Holistic Medical Clinic reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Holistic Medical Clinic**.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient



Financial Policy

Welcome to the Holistic Medical Clinic. Our clinic is operated on a payment-at-time-of-service basis. We request that payment be made at the time of each visit. For your convenience, we will immediately file your insurance for you. This will help to insure a turn around time for payment of three to six weeks. The insurance company should pay you directly. However, if they pay us, we will issue a reimbursement check within 48 hours of receipt. If there is any information that the insurance company may need to help pay the claim, we will be more than willing to help.

The charge for the initial visit, which will include a consultation and/or treatment, is between \$160.00 and \$220.00. This charge does not reflect the cost for any lab work, supplements or vitamins the doctor may recommend. Follow-up visits range from \$92.00 - \$134.00.

Payment for Holistic Medical Clinic fees shall be expected within thirty (30) days of receipt of invoice. Holistic Medical Clinic shall be entitled to a surcharge of one and one-half percent (1.5%) per month on any outstanding invoice amounts overdue.

Our clinic has a twenty four hour cancellation policy. A \$50.00 charge may be assigned for appointments that are not cancelled twenty -four hours or more in advance.

I agree to the above conditions and am aware that I am responsible for any charges that are accrued.

Signature (Parent or guardian if the patient is a minor)

Date