Synergistic Healthcare, PLLC
1100 N San Francisco Street, Ste A,
Flagstaff, AZ 86001

A Consent to Treatment, Office Policies, and Privacy.

Dear New Patient,

Welcome to Synergistic Healthcare!
Dr. Poulos looks forward to addressing your healthcare needs. We encourage your questions and participation in all aspects of your healthcare.
This following document is comprised of three sections: 1) Office policies and financial agreement, 2) HIPPA privacy policy, and 3) Consent to treatment. Please make sure to read through this document in its entirety, mark each box appropriately, and insert your signature at the bottom.

1. OFFICE POLICIES & FINANCIAL AGREEMENT

Office hours & Appointments:

The office is open Monday,Tuesday, Wednesday and Friday, by appointment only.	☐ I understand
Payment for all services and dispensary items is due at the time of the visit.	☐ I understand
You will be charged a Missed Appointment fee of $25.00 for any missed appointments or late cancellations (less than 24 hours notice).	☐ I understand
I give permission for the Doctor or staff to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.	☐ I understand
I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain services, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance. *	☐ I understand

2. HIPPA NOTICE OF PRIVACY PRACTICES

Please review this notice carefully. It describes how medical information about you may be used
and disclosed and how you can get access to this information. Please check each box appropriately.

USES AND DISCLOSURES 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.

☐ I understand

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 or 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 care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

☐ I understand

Payment:

Payment is due at time of service. *

☐ I understand

Fee schedule is as follows:
New patient 90 min: $185
Followup 10 min: $55
Followup 20 min: $65
Followup 30 min: $85
Followup 40 min: $95
Followup 50 min: $110 *

☐ I understand
☐ Others _____

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 plan to obtain approval for the hospital admission.

☐ I undertstand

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 indicate 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.

☐ I understand

Use required by law:

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.

☐ I understand

YOUR RIGHTS

The 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. ☐ I understand

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. ☐ I understand

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. ☐ I understand

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. ☐ I understand

You may have the right to have your physician amend your protected health information:

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 electronically. ☐ I understand

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. ☐ I understand

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 HIPAACompliance Officer of your complaint. We will not retaliate against you for filing a complaint. ☐ I understand

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 HIPAACompliance Officer in person or by phone at our main phone number. ☐ I understand

3. INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE

I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved.

I, (your name), hereby request and consent to examination and treatment with licensed naturopathic physicians, or licensed acupuncturists who may serve as substitutes for one another in cases of my primary provider's absence, hereafter called allied health care providers. _____

I understand that as part of the practice of naturopathic medicine evaluation and treatment may include, but are not limited to:

Physical exams (e.g. general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)

Common diagnostic procedures (e.g. venipuncture, pap smears, diagnostic imaging, laboratory evaluation of
blood, urine, stool and saliva)

Pharmaceutical (e.g. prescribed medications may be warranted depending on diagnosed condition)

Soft tissue and osseous manipulation (e.g. naturopathic/osseous manipulation of the spine and extremities)

Physiotherapeutic treatments (e.g. therapeutic ultrasound, interferential, Pulsed Electromagnetic Frequency - PEMF)

Dietary advice/therapeutic nutrition (e.f. use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)

Trigger point injection therapy with vitamin substances

Botanical/ herbal medicines, prescribing of various therapeutic substances including plant, mineral, and animal
materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures (which may contain
alcohol), suppositories, tropical creams, pastes, plasters, washes, or other forms

Homeopathic remedies (highly diluted quantities of naturally occurring substances)

Counseling (including but not limited to visualization for improved lifestyle strategies)

Over the counter or prescription medications, consistent with the California Board of Naturopathic Physicians'
Formulary

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression. ☐ I understand

Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching; loss of consciousness and deep tissue injury from needle insertions, pneumothorax, allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulations; aggravation of pre-existing symptoms. ☐ I understand

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some of the therapies prescribed could present a risk to the pregnancy. ☐ I understand

Notice to individuals with bleeding disorders, pace makers, and/ or cancer. For your safety it is vital to alert your providers of these conditions. ☐ I understand

Naturopathic doctors will only prescribe medications if they believe that they are in the best interest of myself, the patient. ☐ I understand

I understand the US Food and Drug Administration has not approved nutritional, herbal and homeopathic substances; however these have been used widely in Europe, China and the USA for years. ☐ I understand

Naturopathic doctors are not psychologists or psychiatrists. Counseling services are provided for the support of improved lifestyle strategies. I do not expect the naturopathic physicians, and/or any allied healthcare providers to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that the doctor explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me.

☐ I understand

Please submit your digital signature below.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Synergistic Healthcare, PLLC, and will comply with them in all respects. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Name of Patient: * _____

Name of Guardian (if applicable): _____

Today's date: * _____