East Valley Naturopaths

11673 N. Saguaro Blvd, Fountain Hills, AZ 85268, (480)836-4411
1757 E. Baseline Rd. Building 10, suite #140, Gilbert, AZ

Authorization for Treatment and Informed Consent

Patient Name:
Date:

I, the undersigned, Authorize and understand Naturopathic Medicine, as licensed in Arizona allows Dr. Carol Jamison, N.D. to evaluate, diagnose, and treat with the following, but is not limited to:

- Interview, discuss my health (physical, mental, emotional, spiritual) at length.
- Perform physical examination
- Perform common diagnostic procedures (imagine, laboratory evaluation of blood, saliva, urine, and stool).
- Initiate treatments such as diet and behavior modification, nutritional supplementation, Botanical and/or homeopathic (highly diluted energetic substances) products, nutritional intravenous and intramuscular injections, Acupuncture (stainless steel one time use sterilized needles inserted at specific locations through skin and underlying tissues), Biopuncture (injection of homeopathic products into skin and underlying tissues, at specific locations), hydrotherapy, massage, reiki or other energetic modalities.
- Medications may be prescribed over the counter, or through a pharmacy in the form of plant, mineral, animal, or pharmaceutical preparations, as pills, capsules, creams, lozenges, patches, teas, powders, suppositories or tinctures (may contain alcohol).
- These conventional and alternative therapies are considered medically necessary on the basis of findings during the course of said treatment.
- I hereby certify that I fully understand the authorization for naturopathic treatments, its advantages and possible complications, if any, as well as possible alternative modes of treatment. Some of the risks/benefits are as follows but not limited to:
    - Potential risks: pain, discomfort, minor bruising from Acupuncture, Biopuncture or injections; allergic reaction to prescribed botanicals, supplements, prescription medications; an aggravation of pre-existing symptoms.
    - Potential Benefits: restoration of the body's maximal functioning capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery and prevention of disease or its progression.
    - Notice to women: All female patients must alert the provider if they know or suspect that they are pregnant or if they are on medications to prevent pregnancy, since some of the therapies could present a potential risk to the pregnancy or reduce the effectiveness of pregnancy prevention.
- I also certify that no guarantee or assurance has been made as to the results that may be obtained.

I, the undersigned, hereby authorize the release of information to insurance companies, for purposes of diagnostic and treatment payment. I also authorize my insurance benefits to be paid directly to the doctor. I acknowledge that I am fully responsible for my bill at the time of services.

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of East Valley Naturopaths' Notice of Privacy Practices.

Clinic Policy requires payment at time of services.

Signatures

Patient's Signature	***Parent or Guardian's Signature***	***Date***

East Valley Naturopaths

Confidential Patient Information

Today's Date:_____

Patient Demographics

Name:_____ _____ _____/___/_____
(Last) *(First)* *(M)* *(Date of birth)*

Perm. Address: _____ City: _____ State: _____ Zip: _____

Temp. Address: _____ City: _____ State: _____ Zip: _____

Phone Perm: (_____) _____ Cell Phone: (____) _____ Phone Work: (_____) _____

Email Address: _____

How did you hear of us?
Presentation: ___ **Sign/Brochure:** ___ **Phone book :** ___ **family/friend :** ___ **Other:** _____

Referring Person's Name: _____

Additional Patient Information

Other Physicians: _____

Employer: _____ Occupation: _____

Marital Status (circle) Single Married Separated Divorced With Partner Widow(er)

Name of Spouse (or parent for minor child): _____

Whom may we contact in case of an emergency: _____ Relationship to you: _____

Emergency Contact #: (____) _____

Insurance Information

Insurance Company: _____ Phone: (____) _____

Name of Insured: _____ Relationship to the Insured: _____

S.S. #: ____/____/_____ Policy #: _____ Group #: _____

Insurance Information

I understand and agree that health and accident insurance policies are an arrangement between an insurance company and me. I hereby authorize the undersigned physician to furnish medical information to my insurance carriers concerning this illness or accident. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Clinic Policy requires payment at time of services.

Signatures

_____ _____ ____/____/____

Patient's Signature ***Parent or Guardian's Signature*** ***Date***