



LIM General Consent 2026

Dear Patient,
Welcome to our clinic!

The providers at LIM look forward to addressing all of your health needs. We encourage your questions and participation in all aspects of your health care. This following document is comprised of three sections: 1) office policies and financial agreement, 2) HIPAA privacy policy, and 3) consent to treatment. Please make sure to read through this document in its entirety and insert your signature at the end of the final section.

Office Policies and Financial Agreement

Office hours & Appointments:

Current office hours are Monday, Tuesday & Thursday 9am-5pm, Wednesday 9am-2pm, and Friday 9-4pm. We close for lunch 12-1.

Appointments can be made at 509-881-0722 and also online through the patient portal using CHARM PHR or via our website: www.leavenworthintegrativemedicine.com

I give permission for the Doctor or staff to contact me via telephone, SMS/text, Charm or email and leave a message that may contain appointment or medical information.

Pharmacy Refills and Laboratory Services:

Some or all of your lab work may be referred to an outside laboratory for testing. You will be billed directly by the laboratory for these tests. Sample drop offs to our office may incur a specimen processing fee of 10.00 that is NOT covered by insurance.

Pharmacy refills MUST be initiated at your pharmacy. No early refills will be allowed. Please allow 4-5 business days for refill authorizations. Appointments for refills MUST be made at least one week in advance of prescription expiration. No refill authorizations will be made on weekends.

Office Visit Fees

Fees are determined after the visit has taken place and depends on the complexity of the health concern, which procedures are performed, and the amount of time spent with the patient. We will bill your insurance as a courtesy. All non-insurance visit fees will be collected at the time of the visit.

Insurance Billing



Our office bills your insurance as a courtesy and bills only those insurance companies for which each doctor is a contracted provider. It is the patient's responsibility to clarify the details of your health insurance coverage with your insurance company. Not all insurance plans cover naturopathic medicine. Occasionally extended visit codes will be billed based on time that goes well over standard visit increments. Insurance sometimes denies these codes and they are the responsibility of the patient.

Insurance does not cover the following fees:

Email consultations (some companies do cover)

NCS fees for Dr. Bridges

Specialty lab costs

Office use Injections (Some are covered)

Specimen processing fees (sample drops offs)

Blood draw "only" visits (cash pay only)

Some procedures including PRP, Pellets

Supplements

Late cancelation fee: We require notification 24 hours in advance if you cannot keep your appointment. There is a \$50 fee for cancellations with less than 24 hours notice (\$25 for emails/phone call visits). If no advance notice is received, you will be charged the full fee of \$50 for your scheduled appointment to the credit card on file the day of the cancelation/no show. This fee is waived for all NCS monthly and yearly members.

Payment Policy

Full payment for co-pays, past patient balances due, nutritional supplements and lab fees must be rendered at the time of service. We accept payment by cash, checks, VISA/MasterCard. Checks or credit card payments that are denied for lack of funds will incur a fee of \$35.

A minimum billing fee of \$5.00/month is added to any unpaid balances over 60 days. Patient will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance after EOB received will be billed to the patient and/or the CC on file. After one billing cycle, the credit card on file will be run for unpaid invoices due (>\$150/invoice or >\$250 for combined invoices due will receive a call from our front office). Patients may re-submit receipts for paid claims directly with their insurance in these instances. Insurance coverage is a contract between you and your insurance carrier. The patient is responsible for negotiating a disputed claim.

We reserve the right to change our fees as we deem necessary.



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.

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.

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 plan to obtain approval for the hospital admission.

Request for personal medical records incur a charge of \$.25 per page (\$28.00 max fee). We require a 7 day notice for requested medical records to be processed.

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 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.

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.

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.

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 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.

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.

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 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 HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

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.

Informed Consent for Naturopathic 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 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, minor office procedures including biopsy)

Soft tissue and osseous manipulation (e.g. therapeutic massage, deep tissue massage, neuromuscular technique, naturopathic/osseous manipulation of the spine and extremities).

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

Minor office procedures including: Trigger point injections, Prolotherapy, IV therapy, PRP, Pellet placement, or Nutrient/Medication Injections



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, topical creams, pastes, plasters, washes, or other forms

Hormone replacement therapy

Homeopathic remedies (highly diluted quantities of naturally occurring substances)

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

Over the counter or prescription medications, consistent with the Washington 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.

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.

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.

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

Naturopathic doctors will only prescribe medications if they believe that they are in the best interest of the patient.

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.



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.

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 Leavenworth Integrative Medicine, 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.

I, (your name), hereby request and consent to examination and treatment with my LIM licensed naturopathic physician(s).

**PATIENT or GUARDIAN SIGNATURE
and DATE ***
