# Informed Consent and Request for Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether to undergo care with Integrative Healthcare of Colorado, having had the opportunity to discuss the potential benefits and/or risks.

I, _____, hereby request and consent to examination and treatment with Integrative Healthcare of Colorado and all Practitioners and staff hereafter called IHC. These treatments at IHC include herbs, homeopathy, Prolozone, Ozone Therapy, IV therapies and nutrients, Vibe Plate, Bio Mat, Alpha Stim, Wellness Pro, supplements, massage (lymphatic), nutritional advice, lifestyle advice, and more.

I understand that I have the right to ask questions and discuss to my satisfaction with IHC regarding:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

I understand that an evaluation and treatment at IHC may include, but are not limited to:

- Physical exam
- Common diagnostic procedures including venipuncture, imaging, laboratory
- Evaluation of blood, urine, stool and saliva
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Counseling (including but not limited to visualization for improved lifestyle strategies)
- Over the counter and prescription medications
- Dietary advice
- Herbs (use of herbal formulas in the form of teas, powders, tinctures, which may be taken internally or used externally as a wash. Formulas may include shells, minerals and animal materials).

**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, aggravation of preexisting symptoms.

**Notice to pregnant women or women of child bearing age:** 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. It is the responsibility of the patient to notify the office if there is a chance of pregnancy.

**Notice to patients with bleeding disorders, pace makers, and/or cancer:** For your safety, it is vital to alert your provider at The Practice of these conditions. Please INITIAL the following: I understand that physicians at IHC will only prescribe medications if he/she believes that they are in my best interest.

_____I understand the US Food and Drug Administration have not approved some of the services provided at IHC as well as nutritional, herbal and homeopathic substances.

_____ I understand the possible side effects, complications, and problems associated with the services I am requesting.

_____ I understand and state that no promises or assurances of definite improvement or resolution have been made by the healing partners or staff.

_____I understand that I can discontinue my chosen approaches at any time and my practitioner will not be prejudiced against me in any way. I believe the risks of my chosen service(s) to be less than the risks of conventional treatment for my condition.

I do not expect IHC 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 practitioners at IHC to explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the results intended from any treatment provided to me. By signing below, I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Integrative
Healthcare of Colorado

**Ozone Therapy Consent**

Ozone Therapy, including Prolozone and Major Autohemotherapy (MAH), although not typically used in conventional medicine and unapproved by insurance companies has a strong track record of safety and efficacy. However, the safety and efficacy of this therapy is not recognized or approved by the Food and Drug Administration.

I understand that should I currently be in any of the following conditions, one or more of these therapies may not be appropriate for me: Pregnancy, Thyrotoxicosis, Hemophilia, Porphyria, and extremely low platelet count.

Other alternatives to Ozone Therapy have been discussed with me and include:

- Various pharmaceuticals, antimicrobials, NSAIDS, pain medications including narcotics, immune stimulators
- IV therapies without ozone

I understand that Elizabeth Kirt, FNP-C and/or any representative of Integrative Healthcare of Colorado, LLC make no warranties or guarantees about these therapies with respect to my condition. I do, however, understand the broad application to these therapies to sub-optimal oxygenation states, which is the underlying abnormality in many chronic conditions. I further acknowledge that it is my right to cease activated oxygen therapy at any time. Finally, I understand that my insurance carrier will likely not pay for activated oxygen therapies. With full awareness of the above facts and considerations,

I _____, give full consent to Elizabeth Kirt, FNP-C and/or anyone representing Integrative Healthcare of Colorado for giving me one or multiple treatments of activated oxygen therapies including Major Autohemotherapy (MAH) and Prolozone injections.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

## Wellness Pro Consent

I _____, understand that the Wellness Pro is a transcutaneous electrical nerve simulation (TENS) therapy that uses low-voltage electrical current for pain relief. Two electrodes are placed on my skin, often in the area of pain, creating a circuit of electrical impulses that travel along the nerve fiber, this helps to reduce my painful symptoms. The TEN's machine can be used to treat several types of illnesses and conditions, but most commonly muscle, bone or joint problems, such as osteoarthritis, fibromyalgia, back pain, neck pain, tendinitis, or bursitis. The machine can be set to many different settings that will be altered by the practitioner to best suit my condition. The Wellness Pro is a non-invasive, FDA cleared device that is considered to be safe.

I _____, give full consent to Elizabeth Kirt, FNP-C and/or anyone representing Integrative Healthcare of Colorado for giving treatments using the Wellness Pro - TENS device.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

## BioMat Consent

The BioMat stimulates ion channels by producing negative ions that deliver energy to the cells of the body. The topmost layer of the BioMat is constructed of superconducting channels of pure amethyst, which allow the far infrared rays and negative ions to penetrate the body as far as seven inches. The professional-size BioMat was approved as a Class II medical device by the Food and Drug Administration (FDA) and is considered safe for use.

I _____ give full consent to Elizabeth Kirt, FNP-C and/or anyone representing Integrative Healthcare of Colorado for giving me one or multiple treatments using the BioMat.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Integrative
Healthcare of Colorado

**Alpha Stim Consent**

Alpha-Stim has been on the market as a pain and mental health solution for over 35 years and has more research than any other therapeutic MET or CES device. There are over 100 studies published to-date and over 20 currently underway. Alpha Stim is cleared by the FDA.

The Alpha-Stim AID utilizes cranial electrotherapy stimulation (CES) to deliver the only rigorously tested and patented waveform that is clinically proven to treat anxiety, insomnia, and depression. The Alpha-Stim M uses CES to treat mood and sleep disorders, plus microcurrent electrical therapy (MET) to treat pain.

I _____ give full consent to Elizabeth Kirt, FNP-C and/or anyone representing Integrative Healthcare of Colorado for giving me one or multiple treatments using the Alpha Stim.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

**Credit Card Authorization Form and Cancellation Policy**

Patient's Name: _____ Name on Credit Card: _____
Credit Card Number Ending: _____Expiration: _____

Credit Card Number Ending: _____Expiration: _____

Billing Address: _____

I authorize Integrative Healthcare of Colorado to keep my credit card on file and bill my credit card for payment of services, laboratory testing and/or supplements.

I certify that I am authorized to use this credit card.

**Explanation of Payment and Cancellation Policy:**

Payment is due at the time of service. We are an out-of-network provider, meaning we do not accept *any* insurance for payment for services. Upon request, you may receive an invoice that can be submitted to your insurance company as an out-of-network provider. We do not bill Medicare or Medicaid and neither service will reimburse you for your visit.

If it is necessary to cancel your scheduled appointment, we require that you call and email 24 hours + in advance. Failure to notify our office 24 hours in advance may results in a charge equal to the fee of the scheduled treatment.

Please be advised that any phone call or email/Charm message interaction between the provider and the patient that exceeds 15 minutes will be charged for the time necessary for the practitioner to research, review, and respond to your email/phone call. Your credit card on file will be charged for the service the following business day. Your practitioner may decide that email/Charm message communication is less efficient than an in-person or phone consultation. If your practitioner determines that your email/Charm message is too complex and requires an in-depth explanation, you will be asked to schedule a phone or in-person consultation with your provider so that your question(s) may be adequately and appropriately addressed. The phone calls are billed at the regular, in-office rate with payment due via credit card at the end of each call. I understand and agree to the terms of Integrative Healthcare of Colorado payment and cancellation policies.

**Our fees as related to Consultations:**

We schedule consultations as requested by the patient, and those are scheduled with our practitioners with the following format: 1-hour consultation is 45 minutes of face-to-face time, and 15 minutes for treatment planning or changes. Consultations fees are charged according to the fees listed on the website www.IntegrativeHealthColorado.com or you may call for an updated list or fees.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

**Notice of Information Practices**

*(Detailed Disclosure of Health Information)*

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.

**Understanding Your Health Record/Information**

When you arrive at IHC, a record of your care and treatment is initiated. Upon thorough examination and assessment, this record will typically contain your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

**Understanding what is your record and how your health information is used helps you to:**

ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

**Our Responsibilities**

**IHC is required to:**

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

*We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.*

We will not use or disclose your health information without your authorization, except as described in this notice.

**How We May Use or Disclose Your Health Information**

**(1) Treatment.** We will use your health information for treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your practitioner will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the practitioner will know how you are responding to treatment. We will also provide your practitioner or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from our facility.

**(2) Reimbursement.** We pledge our best efforts to provide you with the necessary forms and supportive information in a timely manner so as to optimize reimbursement to you. Any reimbursement from your insurance company should go directly to you. In this process, we will use your health information. For example, a bill may be sent to a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As a reminder, since nearly all of our services are considered alternative or non-standard, the only items we provide superbills for, typically, are, with appropriate diagnosis codes, Elizabeth Kirt's consultations, and TENS sessions; we do not provide superbills for other services. If you have questions about this, please speak to Elizabeth Kirt prior to your appointment.

**(3) Health care operations.** We will use your health information for regular health operations. For example, members of the medical staff, the interdisciplinary team, or consultants may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

**(4) Business associates.** There are some services provided in our organization through contacts with business associates. Examples include our accountants, consultants, and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

**(5) Notification.** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided us. e.g., on an answering machine.

**(6) Communication with family.** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**(7) Food and Drug Administration (FDA).** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**(8) Public health.** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We reserve the right to charge for forms as requested or records copied and supplied.

**(9) Law enforcement.** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

**(10) Reports**. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**Your Health Information Rights**

Although your health record is the physical property of IHC, the information in your health record belongs to you.

**You have the following rights:**

You may request that we not use or disclose your health information for a reason related to treatment, payment, IHC's general health care operations, and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing on a form provided by our facility. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it. For more information about this right, see 45 Code of Federal Regulations (C.F.R.) 164.524.

If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing and must provide a reason to support the amendment. We ask that you use the form provided by our facility to make such requests. For a request form, please contact our Practice Administrator. For more information about this right, see 45 C.F.R.164.526.

You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years). We ask that such requests be made in writing on a form provided by IHC. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health care operations; disclosures made to your or your legal representative, or any other individual involved with your care; disclosures to correctional institutions or law enforcement officials; and disclosures for national security purposes.

You have the right to obtain a paper copy of our Notice of Information Practices upon request.

You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

**For More Information or to Report a Problem**

If you have questions and would like additional information, please contact the Practice's Administrator.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing on a form provided by IHC. The complaint form may be obtained from the Practice Administrator, and when completed should be returned to the Administrator. You may also file a complaint with the secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint.