Carrie Miller, ND

16840 Bothell Way NE

Lake Forest Park, Wa 98155

www.drcarriemiller.com

Email: info@drcarriemiller.com

Phone: 206-487-3180

Fax: 844-364-5361

Naturopathic Medical Treatment

I,(print name) _____ request care from Dr. Carrie Miller, ND, a Washington State Licensed Naturopathic Physician. I have sought health care of my own free will and hereby authorize the performance of diagnostic procedures and treatments as recommended by my physician. My physician will appropriately educate me and answer all my questions with regards to all recommended treatments/procedures. I will be informed of the nature and character, anticipated results, recognized alternative forms, recognized serious possible risks and complications, anticipated date and time of all proposed treatments/procedures. I understand that I can refuse consent to all proposed treatments/procedures at any time. I understand that each person reacts differently to treatments/procedures, therefore, the expected results of said treatment cannot be guaranteed. I have been advised of all estimated costs of said treatments/procedures.

Naturopathic Medicine utilizes natural therapies in order to restore one's health and natural balance. These therapies include the following: Blood Draw, Physical/GYN Exam, Specialized Injections, Specialized testing through urine, blood or stool specimens, Homeopathy, Herbal Medicine, Nutrition Counseling, Vitamin Supplements, Prescriptions and Natural Hormone Therapy.

Regarding cancer supportive therapies, our physicians are not to be mistaken for traditional oncological treatment. These supportive therapies utilize advanced naturopathic medicine. For conventional/traditional oncological treatment, I understand that I must consult my M.D. Oncologist.

I understand that some therapy is not considered a covered benefit and it can be an out of pocket medical expense. If I decide to seek reimbursement from the medical insurance on my own, I assume the full risk of the insurance not covering the treatment. Carrie Miller,ND will not refund for any treatment received that the medical insurance denies or accepts at a lower reimbursement rate and not considered within the treatment guidelines of Carrie Miller, ND

With this knowledge, I voluntarily consent to treatment by Carrie Miller, ND.

I have read and understood all of the above.

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

Signature of Person Giving Consent **Date Signed**

Carrie Miller, ND

16840 Bothell Way NE

Lake Forest Park, Wa 98155

www.drcarriemiller.com

Email: info@drcarriemiller.com

Phone: 206-487-3180

Fax: 844-364-5361

Notice of Privacy Practices (HIPPA Compliance)

Protecting your personal and health information

Carrie Miller, ND is committed to protecting the privacy of your personal information. I am required by law to maintain the privacy of your personal and health care information. Personal health information means any information that is identifiable to you as your personal information, including information regarding your health care and treatment, identifiable factors including your name, age, address, income or other financial information.

What kind of information would I collect from you?

The personal information I collect from you includes copies of your previous medical records or health care treatment, such as: lab reports, progress notes and treatment notes. The reason for collecting this information would be so that I can review it and better determine how I may assist you in your health care needs as well as get a better understanding of your past medical history so I can be productive and appropriate in my treatment administration.

How do I collect your personal information?

I collect your personal information through your previous health care providers. However, I will not do this without your written consent for release of your information. I have a specific records release form that I will present to you for your signature of authorization. Upon receiving that, I send it to your previous health care provider, hospitals or clinics that have provided services to you. Carrie Miller, ND, will then review these records and file them in your chart.

You are the one who will tell me in written form what records you want released and what records you want kept confidential.

Never at any time can I attempt to collect your personal information without your full knowledge and written consent.

How do we protect your personal information?

*I treat all your personal information as confidential

*I will only disclose your personal information as it is necessary for another physician, specialist, hospital or clinic to use on your behalf with regards to your health care, and only with your permission.

You have the right to review and receive a copy of your personal information.

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

Signature of patient: **Date:**

Carrie Miller, ND
16840 Bothell Way NE
Lake Forest Park, Wa 98155
www.drcarriemiller.com
Email: info@drcarriemiller.com
Phone: 206-487-3180
Fax: 844-364-5361

Notice of Insurance Accountability

I, (print name) _____ have given all of my insurance information to Carrie Miller, ND. I understand that it is my responsibility to verify with my insurance company that my insurance plan covers Naturopathic Treatment and accepts Carrie Miller, ND. I understand that it is my responsibility to know if my deductible is met and if it is not, that insurance will not cover and I am responsible for any bills. I understand that all my office consultations with Carrie Miller, ND will be billed to my insurance company, and that I am responsible to pay my copay at the time of my visit. I understand that I am responsible to pay for all charges the insurance does not honor, does not cover, or denies. I understand that Carrie Miller, ND is not responsible to pay for any of my insurance charges, nor is responsible for any additional charges incurred for treatment. I understand that Carrie Miller, ND has been given an estimation of my coverage and that complete determination of my benefits cannot be known or made until my visit claim is sent in to the insurance company for review and processing. I understand that I have the right to bill insurance myself if Carrie Miller, ND does not accept my insurance, however Carrie Miller, ND is not responsible for my reimbursement.

I have read and understood the above information. I agree to all the above and will be responsible to pay for any charges that I am billed for.

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

Signature of Patient **Date**

Carrie Miller, ND
16840 Bothell Way NE
Lake Forest Park, Wa 98155
www.drcarriemiller.com
Email: info@drcarriemiller.com
Phone: 206-487-3180
Fax: 844-364-5361

Notice of Lab/ Imaging Accountability

I, (print name) _____ understand that it is my responsibility to verify with my insurance company that my insurance plan covers lab work and diagnostic imaging. I understand that I will be billed separately by a laboratory for any lab work or imaging requested by my physician. I understand that I am responsible to pay for all charges the insurance does not honor, does not cover, or denies. I understand that Carrie Miller, ND is not responsible to pay for any of my lab fees, they are not included in the office visit fees, nor is Carrie Miller, ND responsible for any additional charges incurred from lab work ordered on my behalf. Your physician will order diagnostic tests and diagnostic imaging only necessary for clinical evaluation. Once I have left the office, I must assume that my lab samples have been picked up by the lab and it is too late to make any changes. The charges for the full lab work and full imaging requested will be my complete responsibility. Any questions regarding a laboratory test bill must be directed to the laboratory directly.

I have read and understood the above information. I agree to all the above and will be responsible to pay for any charges that I am billed for.

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

Signature of Patient **Date**

Carrie Miller, ND
16840 Bothell Way NE
Lake Forest Park, Wa 98155
www.drcarriemiller.com
Email: info@drcarriemiller.com
Phone: 206-487-3180
Fax: 844-364-5361

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Carrie Miller, ND at 206-487-3180

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a copy of our Privacy Practices for your own records.

I authorize Carrie Miller, ND's office to disclose my records and its contents with:

Print Name _____ Relationship _____

Print Name _____ Relationship _____

Additionally:

May we leave messages regarding your health information on your answering machine or voicemail at home? ◯ NO ◯ YES

May we discuss your medical care with anyone that answers the telephone at your home? ◯ NO ◯ YES

Are there any members of your family or household with whom we should NOT discuss any of your health care issues? ◯ NO ◯ YES Please specify _____

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

_____

Patient or legally authorized individual signature **Date**

_____

Print name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

Carrie Miller, ND
16840 Bothell Way NE
Lake Forest Park, Wa 98155
www.drcarriemiller.com
Email: info@drcarriemiller.com
Phone: 206-487-3180
Fax: 844-364-5361

Authorization to release healthcare information

Patient Name:

Patient DOB:

Daytime Phone:

I hereby request and authorize the following release of information:

Information to be release by office:
Name:
Address:
Phone #:
Fax #:

Information to be released to:
Carrie Miller, ND
PO Box 82493
Kenmore, Wa 98028
Phone: 206-487-3180
Fax: 844-364-5361

Date range for records release: From **To**

I want to release the following (check all that apply):
- ☐ **Lab/hospital/radiology records**
- ☐ **Treatment notes and plan**
- ☐ **Complete Chart Records**

DISCLAIMER: By typing your name below, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature.

Signature of patient or authorized rep **Relationship if not patient** **Date**

Special Consent (check all that apply):
By signing below, I am authorizing the release of testing, diagnosis and treatment for:
☐ **HIV/Aids** ☐ **Sexually transmitted Infections** ☐ **Mental Health** ☐ **Alcohol/drug abuse**

Signature of patient or authorized rep **Relationship if not patient** **Date**