Raising Sages
Integrative Pediatrics

Please note that all of the below consents must be signed and dated. We will return copies of these forms to you at your first appointment. Please make sure you read the information carefully prior to signing. Please PRINT CLEARLY!

PATIENT NAME: _____

PATIENT BIRTHDATE: _____

PATIENT GENDER: ***MALE*** ***FEMALE***

PATIENT ADDRESS: _____

_____

BEST CONTACT PHONE **#**: _____

EMAIL ADDRESS: _____

PRIMARY HEALTH INSURANCE: _____

PRIMARY HEALTH INSURED NAME: _____

INSURED ADDRESS **(IF DIFFERENT FROM PATIENT)**: ***SAME ADDRESS***

_____

_____

INSURED BIRTHDATE: _____

SECONDARY INSURANCE **(IF APPLICABLE)**: ***NONE***

_____

SECONDARY INSURED NAME, ADDRESS AND DOB: _____

_____

Authorization & Consent for Medical Treatment of a Minor Child

AUTHORIZATION

I consent to the care and treatment of the below named individual by the physicians of RAISING SAGES INTEGRATIVE PEDIATRICS, as may be prescribed by the same and/or dictated by professional standards of practice for my/their illness or condition. My consent for any procedures in the office is implied as well as documented under written agreement of my own faculties under the Authorizations and Consent for Medical Treatment. I will ask prior to any procedure or treatment plan for clarification on anything I do not understand. This document is a binding contract setting forth the obligations I assume in consideration for the medical care and treatment of my child. I, as the patient's parent agree to be bound by its terms.

FREE WILL

I am here with my child of my own free will, representing no official agency or other organization, voluntarily requesting services for me and/or my dependents. I understand that all requests for information by official agencies or other organizations must be done in writing.

INTRODUCTION

I have specifically sought out the services and perspective of the providers of RAISING SAGES INTEGRATIVE PEDIATRICS for their Integrative approach to medicine, drawing on Traditional and Complementary/Alternative Medicine methods. I have sought out my provider because I know that he/she is knowledgeable in both conventional and nonconventional methods of treating illnesses and draws upon this experience and expertise to individualize and customize a treatment plan for each patient depending on the presentation. I understand that I will be presented with treatment options that include traditional and alternative approaches, and that ultimately, I will make the final decision on which method of treatment is right for me and my family.

RIGHT OF CHOICE

I have been fully informed that there are different schools of medical theory and that medicine is an evolving science. I am aware that in this evolving science, medical providers sometimes differ on their approaches to diagnosis or treatment of illness or problems. I have had the opportunity to consider different approaches or schools of medical thought and ask questions of my provider. I understand that I have the right to accept or refuse medical care, based upon my personal judgment. Complementary and Alternative Medicine, like any other treatment or medication, may or may not alleviate or cure the condition(s) for which it is offered. Likewise, I acknowledge that in any medical procedure or treatment that there are certain complications reported in medical journals and/or studies that are due to the procedure or treatment and unexpected adverse effects that may result. As part of the consideration I am giving to my provider in turn for treating me, I make a binding promise to notify the provider if I believe that my child is suffering from any unexpected adverse effect(s).

If I fail to notify my provider within a reasonable time of the onset of such unexpected adverse effect(s), I agree that any claim that I may have resulting from such adverse effect will be barred, waived and released. I further make a binding promise to notify the provider if I believe that my child is suffering from any complication(s).

It is important that you read and understand the information contained in this form so that you can make an informed choice about being treated at RAISING SAGES INTEGRATIVE PEDIATRICS by its agents, and your provider, specifically. If after reading this form, you have any concerns or questions regarding the care your child will receive, you should talk to your provider.

Acknowledgement of the Use of an Integrative Approach to Medical Care

I have read the above and/or it has been explained to me. I acknowledge that I have been given the opportunity to ask my provider about any treatments which I am consenting to receive now and in the future, including alternative forms of treatment, testing and the risks of such treatment, with the understanding that the ultimate decision lies with me regarding which treatment approach I desire. I

understand that the doctors at RAISING SAGES INTEGRATIVE PEDIATRICS will use the most evidence based care whenever possible. However, I also understand that that there may be a paucity of specific scientific research into some integrative therapies, especially in regards to children. In these cases, I understand that the doctors at RAISING SAGES INTEGRATIVE PEDIATRICS will make all attempts to only select those with a strong record of being safe and effective in the literature or using the best available evidence as possible.

Testing and/or treatments that may be offered or recommended by your provider at RAISING SAGES INTEGRATIVE PEDIATRICS may include, but are not limited to: nutritional support and/or testing, allergy testing and control, detoxification evaluation and support, individualized vaccination schedule, Vitamin/Mineral/Amino Acid supplementation, elimination and rotation diets for specific allergens, Comprehensive Stool Analysis, General laboratory screening, vision and hearing assessment, along with other routine procedures or testing performed in general pediatrics.

I acknowledge that the specific risks and complications of any treatment program requested will be discussed fully with my provider and I will have the opportunity to ask questions. I understand this is a general consent form to treat, accepting that the providers at RAISING SAGES INTEGRATIVE PEDIATRICS use alternative and traditional approaches to medicine. I realize that I may leave RAISING SAGES INTEGRATIVE PEDIATRICS at any time. In doing so, I may be requested to sign a form acknowledging this decision. However, if I decide to revoke my consent to treatment, the consent shall remain applicable for any treatment and procedures rendered prior to any such revocation.

It was my independent choice whether to see a provider at RAISING SAGES INTEGRATIVE PEDIATRICS and it is always my choice whether to continue medical care with RAISING SAGES INTEGRATIVE PEDIATRICS. I also understand that the providers of RAISING SAGES INTEGRATIVE PEDIATRICS reserves the right, at any time and without cause, to discharge any patient due to poor compliance with the recommended program or treatment plan and/or for any other reason.

I have read this form that serves as an informed consent document and an authorization to treat my child and have been given the opportunity to ask questions. If I have questions later, I understand I may contact a provider at RAISING SAGES INTEGRATIVE PEDIATRICS. I will be given a signed copy of this document for my records. The risks and benefits to me have been explained and I am encouraged to and will have the chance to ask questions.

BY COMPLETING AND SUBMITTING THIS FORM, I AGREE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT, MY RIGHTS AND RESPONSIBILITIES, AND HEREBY GIVE CONSENT TO UNDERGO TREATMENT AT "RAISING SAGES INTEGRATIVE PEDIATRICS" INFORMATION ABOUT ME AND MY CHILD'S RECORDS WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.

Print Patient's Name

Patient's Signature or Signature of Legal Guardian, if applicable Date

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and your child may be used and disclosed and how you can get access to this information. Please read it carefully.

Raising Sages Integrative Pediatrics is committed to maintaining patient confidentiality while complying with all state and federal regulations in regards to protected health information. This policy was put in place as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) federal laws that went into effect April 2003. The new laws were designed to protect and enhance rights of consumers by providing you with access to your health information and controlling the inappropriate use of that information.

STATEMENT OF USES AND DISCLOSURES

Protected Health Information (PHI) is covered by state and federal laws. Therefore, the release of this information is carried out under strict guidelines. As a patient of this health care facility a consent form is obtained for the release of medical information for the purpose of payment, treatment, and health care operations. This consent is obtained on the first date of service, and updated every year thereafter. The disclosure of health information requires an authorization signed by the patient for the following purposes. The authorization is revocable in writing 90 days from the date signed.

A. Life and Health Insurance Applications
B. Selection of a new physician
C. Release of information to attorneys
D. Release of information to Patient/ Legal Guardian

We may use or disclose identifiable health information without your authorization for the following purposes: public health reporting, auditing purposes, research studies, workers' compensation, and emergency care.

STATEMENT OF INDIVIDUAL RIGHTS
Under HIPPA regulations patients have virtually unlimited access to their own health care information. Patient rights include:

a. Consent to the use and disclosure of protected health information to carry out treatment, payment, or health care operations
b. Receive notice of privacy practices as part of the required consent form or process
c. Access protected health information
d. Receive an accounting of how their protected health information has been disclosed outside normal patient care channels
e. Agree or object to certain disclosures
f. Request amendment or correction to protected health information
g. Request restrictions on use of protected health information for treatment, payment, or health care operations

Federal and State laws require Raising Sages Integrative Pediatrics to maintain the privacy of confidential information, and to provide our patients with notice of legal duties and privacy practices. We are required to abide by this Notice currently if effect. We reserve the right to change the terms of this Notice and to provide our patients with the revised copy immediately.

Any concerns or questions regarding this Notice may be directed to the Staff at Raising Sages Integrative Pediatrics at 949-788-1111.

Printed Name_____

Signature_____

Date_____

PARENTAL REFUSAL TO VACCINATE LIABILITY WAIVER

The staff and physician(s) at *Raising Sages Integrative Pediatrics* respect and honor the right of the parent to choose what they feel is best for their child in regards to vaccinations. It is our policy that the decision is one that must be made in regards to the norms of informed consent according to the American Medical Association. Our policy is that all children, regardless of the decision to vaccinate or not by their parents, still deserve the best medical care possible and therefore we are happy to care for your child regardless of the family's decision whether to vaccinate or not.

Nevertheless, it must also be acknowledged that the standard of medical care is to vaccinate fully according to the CDC/ACIP Guidelines, and in that regard, for medical, legal and ethical purposes the official policy of the practice is that the family should vaccinate according to the recommended schedule. If the family elects to not follow this schedule, then the staff and doctor(s) will have an open, honest and non-judgmental discussion with the family about the various risks/benefits of vaccinating vs not vaccinating their child to help them make the best decision for their individual situation. The family is aware that the CDC VIS sheets are available for download from the website as well as the package inserts of the vaccine products used in the practice for their perusal according to their interest. Our staff will be happy to discuss them with you as needed.

Your signature below acknowledges that the decision to not vaccinate your child could result in their becoming infected by the respective-vaccine preventable diseases with the potential for serious complications, as well as passing the disease to others who are not protected against the disease for various reasons. Your signature also waives ALL medical, legal and financial responsibility for your decision for *Raising Sages Integrative Pediatrics, Inc.,* the individual physician(s), staff and all associated parties. We are providing care for your child in good faith that both parents are in agreement with this decision. If both parents do not agree with this decision, then they must also be involved with this decision and will not hold this practice responsible for the disagreement of the parent presenting to the practice.

Printed Name **Signature**

Patient Financial Responsibilities

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care.
• We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information **about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.**
• Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
• If you do not agree with the EoB/outcome from the insurance company, *the insured must contact the insurance company directly to contest this.* It is not our responsibility to do this for you**. It is your responsibility to pay the amount due as stated by the insurance company and is payable upon receipt of statement or at time of visit.**
• Payment is *due at time of service or within 30 days of receipt of their statement* and for your convenience, we accept cash, check, and most major credit cards at our office. We also keep credit cards on file and will bill your card after the EoB is processed automatically.
• Patients that do not pay their bills in a timely fashion or are sent to collections may be discharged from the practice and/or we will not be able to continue to see your child until all balances are reconciled.
• Patients may incur, and are responsible for the payment of additional charges at the discretion of the owner/physician. These charges may include (but are not limited to):

- **o Charge for returned checks ($25)**
- **o Charge for missed appointments without 24 hours advance notice ($50 or Co-Pay)-- we send reminders to you as a courtesy but the *ultimate responsibility for remembering your appointment is yours.* You will be charged for the No-show whether or not you receive a reminder!**
- **o Charge for after-hours phone calls requiring diagnosis, treatment, or prescriptions ($20/call)**
- **o Charge for the copying and distribution of patient medical records ($25/child)**
- **o Charge for review and interpretation of integrative/extensive lab tests ($50)**
- **o Charge for school/camp/medicine forms ($10)**
- **o Charge for letters written by doctor for schools, agencies, etc ($40)**
- **o Any costs associated with collection of patient balances (Collection agency fees, etc)**

I have read, understand and agree to the above financial responsibility information. I agree to the above terms and consent to my credit card being kept on file and charged for the above fees as needed.

Signature

Waiver of Liability for Non-Covered Services

Your health plan will only pay for services that it determines reasonable and necessary. These services are outlined in the *explanations of benefits* provided by your insurance carrier under your benefit plan. If your health plan determines that a particular service, although deemed important to you by your Physician and yourself, is not reasonable and necessary under your health plan standards, your health plan will deny payment for that service. I understand that it is my responsibility to contact the insurance company to determine whether coverage is available. If coverage is not available and I choose to obtain the uncovered service(s), I agree to pay personally for them and will not hold Raising Sages Integrative Pediatrics responsible for payment of said service.

NON-COVERED SERVICES:

- **VACCINE CONSULTS/ VACCINE EXEMPTION CONSULTATIONS**
- **HEALTH COACHING**
- **FUNCTIONAL/INTEGRATIVE LAB TESTING AND INTERPRETATION BY M.D.**
- **NEWBORN HOME VISITS**
- **AFTER HOURS PHONE CALLS**
- **FORMS, LETTERS, ETC as outlined on financial responsibility consent**

Signature_____

Integrative Medicine Laboratory Testing Informed Consent

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician or insurance company may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctor. Additionally, you understand that the ultimate financial responsibility for these tests is yours—the practice will do its best to code and order appropriately, but takes no responsibility for the coverage/denial from your insurance.

I have read and understand the above:

_____

Signature **Date**

Selling Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at *Raising Sages Integrative Pediatrics*

You are under no obligation to purchase nutritional supplements at our office!

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I have read and understand the above statement.

_____
Signature