Patient Payment, Email Policy and HIPAA Form

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ Work # (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_ Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­

**Please read and sign below:**

All payments are required at time of service. This keeps our healing services accessible to all.

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments. It is the patient’s responsibility to ensure that their specific health insurance plan will cover Naturopathic care and if a referral is required. If your plan does not cover ND care, you will be expected to remit payment for the visit/s.

**Phone and Email Policy**

Questions? Phone calls and emails are free if they pertain to **brief clarification of existing treatment plans**. You will be charged at the normal hourly rate ($170/hr) for phone calls or emails when:

1. The questions involves more than essentially a yes/no answer or involves discussion.
2. The question pertains to new problems or treatment. This is essential for your safety.
3. The questions asks for any opinion greater than yes/no.
4. It has been more than 14 days since your last visit. This is essential for your safety.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient / Parent / Guardian)

**HIPAA Release Form**

Dr. Elizabeth R. Yori and Heritage Natural Health are concerned about the privacy of our patients’ health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for: **Dr. Elizabeth Yori, N.D.**

Name of Patient (PRINT)

Signature of Patient or Authorized Representative