Confidential Patient Information Form

Legal Name (last, first ,m.):_____

Preferred Name _____MaidenName_____

Birth Date:_____ Age:_____ Gender: ☐Male ☐ Female

Marital Status:_____

Street Address:_____City:_____State:_____Zip:_____

Phone *Appointment reminders will be sent to 1st preference*

☐Home ☐Work ☐Cell (___)_____ Voicemail/Text/Email reminders **OK?** Yes___No_____

☐Home ☐Work ☐Cell (___)_____ Voicemail/Text/Email reminders **OK?** Yes___No_____

Employer:_____Occupation_____

Email Address: _____

Insurance Company: _____ID# _____ Group# _____

Emergency Contact

Name: _____ Phone:_____

Relationship: _____

Do you authorize Natural Life Medicine to release information to this person?

____ **Yes** ____ No (If no- we can not disclose any information)

Preferred Pharmacy

Name: _____ Address: _____

Primary Care Provider

Name: _____ Address:_____

By signing below I indicate the information above is complete and accurate to the best of my knowledge. I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I am subject to all terms of the financial consent form.

_____ _____

Patient signature. In case of minor, parent or guardian must sign. Date

History Intake

Last/First name:_____ DOB:_____

Allergies

Do you have any medication, food, or environmental allergies? ☐ Yes ☐ No
If yes, please explain any allergic reaction:

_____

Do you have an Epi Pen for severe allergic reactions: ☐ Yes ☐ No Exp date: _____

Supplements/Medications

List all medications and supplements you are taking. Please attach additional sheet if needed.

Medication/Supplement Name	Strength (mcg, Mg, IU, etc)	Directions (ex: 1 tab twice a day)

Social History

Do you consume alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____
Current or past tobacco use: #/packs per day: _____How long: _____ Quit date _____
Drug usage, past or present: _____
Do you exercise? ☐ Yes ☐ No Type/how often: _____
Do you have children: ☐ Yes ☐ No If yes, what are their ages: _____
Any chance you are currently pregnant: ☐ Yes ☐ No
# of pregnancies ____ # of live births ____ # of abortions ____ # Miscarriages _____

Please list any past medical history (surgeries, accidents, hospitalizations, etc).

Please list any family medical history.

Review of Systems Questionnaire

Please check any symptoms that apply. Please provide additional information if you have marked the answer yes.

Name:_____ **DOB:**_____ **Chief Complaint:**_____

General Health

- ☐ Fatigue
- ☐ Need to decrease/alter activities of daily living
- ☐ Night sweats
- ☐ Sweats easily
- ☐ General weakness
- ☐ Catches cold, easily
- ☐ Cold hands or feet
- ☐ Slow wound healing
- ☐ Chronic infections
- ☐ Allergies (food, mold, dander, pollen, other)
- ☐ Sensitivity to fumes, odors, chemicals, etc
- ☐ Feeling hot/flushed
- ☐ Chills
- ☐ Undesired weight loss, difficulty gaining weight
- ☐ Undesired weight gain, difficulty losing weight
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Frequent infections
- ☐ Low blood sugar
- ☐ High blood sugar
- ☐ Implants of any kind
  Kind:_____

Date of last health check up: _____
Please list any chemical, metal, dust, or fume exposure or any repeated exposure in the past: _____

Muscle and Joints

- ☐ pain, swelling, warmth, limited motion in joints
- ☐ Pain, swelling or weakness in muscle(s)
- ☐ Muscle cramps/spasms/tic/tremor
- ☐ Muscle weakness

Explain: _____
_____
_____

Neurological

- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Numbness and tingling
- ☐ Seizures, epilepsy
- ☐ Poor memory
- ☐ Difficulty processing information, confusion
- ☐ Difficulty with concentration
- ☐ Difficulty speaking or talking, slurred speech
- ☐ Headaches
- ☐ Learning difficulty, dyslexia
- ☐ Lightheaded, dizziness, or vertigo
- ☐ Hyperactivity

Respiratory and Cardiovascular

- ☐ Chest pain
- ☐ Chest tightness
- ☐ Pain in left arm &/or left side of body
- ☐ Rapid or pounding heartbeat/palpitation
- ☐ Irregular heartbeat
- ☐ Shortness of breath, difficulty breathing
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Varicose/spider veins
- ☐ Fainting
- ☐ Lung congestion, bronchitis
- ☐ Asthma, wheezing
- ☐ Phlegm
- ☐ Pneumonia
- ☐ High Cholesterol

Head, Eyes, Ears, Nose, Throat

- ☐ Vision change/blurriness
- ☐ Glaucoma, cataracts
- ☐ Watery, red, itchy, dry eyes
- ☐ Dark circles under eyes
- ☐ Concussion/traumatic brain injury
- ☐ Eye strain
- ☐ Floaters
- ☐ Eye pain near or behind eye
- ☐ Poor night vision, night blindness
- ☐ Ear ringing
- ☐ Ear pain
- ☐ Ear infections
- ☐ Discharge from ears
- ☐ Decrease or loss of hearing
- ☐ Sinus problems
- ☐ Nasal congestion
- ☐ Nosebleeding
- ☐ Nasal polyps
- ☐ Decreased sense of smell or taste
- ☐ Snoring
- ☐ Ulcer or sores in mouth or lips, oral herpes
- ☐ Sore throat
- ☐ Swollen glands
- ☐ Swollen or tender tongue or gums
- ☐ Teeth grinding/TMJ
- ☐ Excessive mucus production
- ☐ Hoarseness, loss of voice
- ☐ Lump in throat

Gastrointestinal

- ☐ Low or excessive appetite
- ☐ Difficulty chewing/swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loss of bowel control, incontinence
- ☐ Heartburn/acid reflux
- ☐ Ulcers
- ☐ Strong thirst
- ☐ Belching/hiccups
- ☐ Bloating/gas
- ☐ Dental/gum problems
- ☐ Abdominal pain/cramping
- ☐ Intestinal gas
- ☐ Gallbladder stones
- ☐ Hemorrhoids/rectal pain/itching
- ☐ Poor digestion, fullness after meal

Bowel Movements

- ☐ Frequency: _____
- ☐ Mucous in stool
- ☐ Blood in stool
- ☐ Incomplete feeling
- ☐ Unusually strong odor
- ☐ Undigested food
- ☐ Thin/small in shape
- ☐ Painful

Consistency: □ Well-formed □ Dry □ Hard □ Loose □ Soft □ Greasy/oily □ Alternates b/w loose & constipated

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Genitourinary

- ☐ Pain/burning on urination
- ☐ Discharge or blood in urine
- ☐ Urinary urgency
- ☐ Difficulty controlling urination, Incontinence
- ☐ Urinary retention
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Blood in urine
- ☐ Dribbling urination
- ☐ Kidney stones
- ☐ Profuse urination
- ☐ Decreased urination
- ☐ Bed wetting
- ☐ Urinary tract infection
- ☐ Change in sex drive
- ☐ Herpes
- ☐ Genital sores

Skin, Hair, and Nails

- ☐ Hair loss/thinning
- ☐ Dry skin
- ☐ Oily skin
- ☐ Wrinkles
- ☐ Stretch marks
- ☐ Itchy skin/hives
- ☐ Flushing
- ☐ Acne
- ☐ Rash/eczema
- ☐ Psoriasis
- ☐ Change in skin color and pigmentation
- ☐ Small bumps on back of the arms
- ☐ Excessive sweating
- ☐ Insufficient sweating when active or hot
- ☐ Tingling or crawling sensation
- ☐ Numbness
- ☐ Decrease in body or facial hair
- ☐ Decrease in head hair
- ☐ Weak or rigid fingernails
- ☐ Tanning bed usage
- ☐ Easy bruising

Sleep

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Excessive dreaming
- ☐ Nightmares
- ☐ Sleep talking/walking
- ☐ Tired upon waking
- ☐ Typical bedtime _____
- ☐ Typical Wakeup time _____
- ☐ Hours a night _____

Emotional and Social

- ☐ Depression, sadness
- ☐ Post partum
- ☐ Anxiety/panic attacks
- ☐ Irritability/anger
- ☐ Mania/elevated mood
- ☐ Nervousness
- ☐ Mood swings
- ☐ Stress
- ☐ Fear
- ☐ Frequent worry
- ☐ OCD
- ☐ Apathy, lack of interest
- ☐ Use of alcohol, drugs, herbs, etc to help manage stress
- ☐ Isolation, few friends, distant family
- ☐ Problems with: parents, family, friends, employers, coworkers
- ☐ Recurrent problems from childhood or past events
- ☐ Compulsive activities: gambling, sex, shopping, work, others?
- ☐ Diagnosed mental condition?
- ☐ Suicidal thoughts? □ Yes □ No

Women's Health- Genitals and Sexual Function

- ☐ Painful menses
- ☐ Pain between menses
- ☐ Irregular menses
- ☐ Bleeding between menses, excessive bleeding
- ☐ Missed menses
- ☐ Abnormal discharge
- ☐ Nipple discharge
- ☐ Breast lump
- ☐ Hot flashes
- ☐ Facial hair growth
- ☐ Vaginal sores
- ☐ Vaginal dryness, irritation, painful intercourse
- ☐ Yeast infections
- ☐ Painful, swollen, or fibrocystic breasts
- ☐ Low libido
- ☐ Infertility
- ☐ Pain during intercourse
- ☐ Difficulty reaching orgasm
- ☐ Ovarian cysts
- ☐ Uterine fibroids
- ☐ Polycystic ovarian disease (PCOS)
- ☐ Endometriosis

Premenstrual syndrome (PMS)

- ☐ Water retention
- ☐ Breast tenderness/swelling
- ☐ Mood swings
- ☐ Irritability
- ☐ Migraine/headache
- ☐ Acne
- ☐ Food cravings
- ☐ Change in bowel movements
- ☐ Abdominal cramps
- ☐ Low back pain

Are you currently using birth control □ Yes □ No

Name/type/how long: _____

Date of last pap smear, breast exam, checkup

_____

Any abnormal exams? □ Yes □ No

Any chance of pregnancy? □ Yes □ No

Menopausal symptoms? □ Yes □ No

(Describe if yes)_____

Menses

- ☐ Heavy bleeding
- ☐ Light bleeding
- ☐ Clots

Color: Bright red, dark red, or normal red (please circle)

First day of last menstrual period: _____

How many days of period _____

Duration of entire menstrual cycle _____

Men's Health - Genital and Sexual Function

- ☐ Pain or difficulty obtaining or mainting erection
- ☐ Pain or difficulty with ejaculation
- ☐ Pain or mass in testicles
- ☐ Slow stream of urine
- ☐ Frequent urination
- ☐ Undescended testis
- ☐ Low libido
- ☐ Excessive sex drive
- ☐ Premature ejactulation
- ☐ Nocturnal emissions
- ☐ Low sperm count
- ☐ Poor spam mobility
- ☐ Prostate disease
- ☐ Hernia
- ☐ Impotence

Additional Information:

Please write any addition information we should know or any symptoms that have occurred in the past:

_____

_____

_____

_____

_____

_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. USES AND DISCLOSURES:

TREATMENT – Your health information may be used by our providers and staff members or may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

PAYMENT – Your health information may be used to seek payment from your health plan, other sources of coverage such an automobile insurer or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS – Your health information may be used as necessary to support the day-to-day activities and management of Natural Life Integrative Health. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to ensure that our practice is meeting state and federal guidelines and laws designated to protect your health care information.Your health information will be used by our staff to call / send you appointment reminders.

LAW ENFORCEMENT – Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting. For example, any known or reasonably suspected cases of child abuse or neglect, any known or suspected intentions of harming oneself (suicide), and/or any known or suspected intentions of harming others.

PUBLIC HEALTH REPORTING – Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Washington Department of Health.

BUSINESS ASSOCIATES – The following companies may have access to your Protected Health Information for the purpose of carrying out Treatment, Payment, and/or Health Care Operations: OMNI Medical Billing Company, Inc, RingCentral, Inc., MedicalMine, Inc., Practice Fusion, Inc and NexTrust, Inc.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION – Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a disclosure or use of your information, you may submit a written revocation of the authorization. However, your decision to revoke your authorization will not affect or undo any disclosure or use that occurred before you notified this practice of your decision.

INFORMATION ABOUT TREATMENT – Your health information may be used to send you information on the treatment and management of your health condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

INDIVIDUAL RIGHTS - YOU HAVE CERTAIN RIGHTS UNDER THE FEDERAL PRIVACY STANDARDS. THESE INCLUDE:
The right to request restrictions on the disclosure and use of your protected health information; The right to receive confidential communications concerning your medical condition and treatment; The right to inspect and copy your protected health information; The right to request an amendment or to submit corrections to your protected health information; The right to receive an accounting of how and to whom your protected health information has been disclosed; The right to receive a printed copy of this notice.

PROVIDER / OFFICE DUTIES – We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES – As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice at your next office visit. These revised policies and practices will be applied to all protected health information we maintain.

RIGHT TO INSPECT PROTECTED HEALTH INFORMATION – As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting your individual practitioner or the front office. If you request a copy of your records, the following fees will be assessed: $26 Clerical fee, $1.09 per page fee for the first 30 pages and then $0.82 per page for any pages 31 and over. This fee must be paid prior to the copies being released.

COMPLAINTS AND CONTACT PERSON – If you would like to submit a comment or complaint about our privacy practices or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

OR YOU MAY ALSO CONTACT: Office for Civil Rights-U.S. Dept of Health and Human Services
701 Fifth Avenue, Suite 1600, MS – 11, Seattle, WA 98104 Phone (800) 368-1019 FAX (206) 615-2297

Please sign to acknowledge receipt of our Privacy Policy.*

Signature:_____**Date:**_____

Financial Policy

Natural Life Medicine (NLM)

INSURANCE VERIFICATIONS - Before the initial visit, it is your responsibility to verify your benefits.

The information received is not a guarantee of your actual benefits and is subject to final processing by your insurance company. *You are responsible for all fees not covered by the insurance company.*

We do accept limited Medicare Plans Please contact your Insurance Co. to verify benefits

PAYMENT ARRANGEMENTS – Should you need to make special payment arrangements, please speak with my billing company by calling (206) 219-5310. Payment arrangements are based on the total balance due. Alternative payment arrangements may also be available.

PRIVATE BILLINGS - For patients without insurance, full payment is due at time of service. All patients are quoted a fee for the office visit and are expected to pay at the time of the appointment.

LAB BILLING – You are responsible for all fees associated with lab tests, NLM does not know what these fees will be. Naturopathic physicians are not able to order labs for patients with Medicare, therefore, patients with Medicare must expect to pay for all labs.

FORMS OF PAYMENT – In addition to cash or check, we kindly accept Visa, MasterCard, and Discovery for payment of services. There will be a $35.00 fee for checks returned for insufficient funds.

COLLECTION NOTICE – I understand that any and all accounts that become 90 days delinquent are subject to collections.

Insurance Company:_____ **ID#:**_____

Relation to insured(circle one): Self Spouse Dependent **Group#:**_____

_____**I certify that I am eligible for benefits under my prepaid health benefit plan. In the event that I am later found to be ineligible or in consideration of being treated without proof of eligibility, I agree to pay for any and all services provided by my individual practitioner based upon regular fees then in effect.**

_____**I understand that all Co-pays, co-insurances, deductibles and non-covered services will be due at the time of service unless other payment arrangements are made with the provider or billing company directly.**

_____**I grant permission to OMNI Medical Billing Co., Inc. to submit claims on my behalf to my insurance carrier for services provided by Natural Life Medicine.**

_____**I authorize the release of any medical or other information necessary to process my claims.**

_____**I authorize payment of medical benefits to NLM directly from my insurance carrier.**

First Office Visit		Follow Up Visits	
Naturopathic Physician	$250	Naturopathic Physician	$175
Acupuncture	$150	Acupuncture	$110
Acupuncture prepay 4 visits	$390		
Manual Manipulation	$100	Manual Manipulation	$50

SERVICES NOT COVERED BY INSURANCE

Returned check fee, plus original amount due	**$35.00**
***No show/late cancellations**	**50% of your appointment fee**
Sauna Sessions	**$25 per 30 minute session**
Phlebotomy Convenience Fee	**$20**
Cupping or Gua Sha	**$50**
IV Therapy Administration	**$150 plus cost of supplies**
Nutrient or Medication Injections	**Cost Varies, please inquire**
Trigger Point Injections	**Cost Varies, please inquire**

Emergency Prescription refill fee (without appointment)

- **Within 5 business days** **$15**
- **Same day** **$50**
- **If practitioner needs to be contacted on time off** **$100**

Please note if you are more than 10 minutes late to an appointment, we will have to charge a late fee and reschedule your appointment. Follow-ups are only 30 minutes, therefore it's important the doctor can go over all that is needed in the full amount of time provided.

I have read and understood the above information and have been provided with a copy at my request.

_____ _____

Patient Signature or Parent/Guardian (if under 18 years of age) **DATE**

_____ _____

Patient Name **Patient D.O.B.**

Consent to Treatment

The following information is provided to establish a common understanding of our roles and rights in a professional therapeutic relationship. Please read this document and sign indicating you have understood and agree to the following. If you have any questions or require clarification, please call the office and we will be happy to provide you with any other information.

1. At Natural Life Medicine, each practitioner holds an active license in Washington state. We agree to provide you with services that are within the scope of practice of the license.

2. We reserve the right to refuse service to anyone at anytime without explanation.

3. NLM requires **24 business hour notice** when cancelling an appointment. Monday appointments must be cancelled on the Friday before. This is done so appointments can be offered to those in need. If you do not cancel your appointment in a timely manner, you may be charged a cancellation fee that is **50% of our Time of Service Rates** for that appointment. If two or more appointments are not cancelled in a timely manner we may cancel all future appointments until we collect payment of said fees.

4. Any information you provide during consultations or sessions is confidential. The information contained within your record will not be disclosed unless as directed by you through written consent or if the authorities or law compels us to do so. The only exceptions to this confidentiality are information you provide me indicating intention to harm yourself or others. (Please see Notice of Privacy Practices).

5. Each and every procedure or treatment carries with it both risks and benefits. There may be additional or alternate treatments/procedures available. Your treatment plan is thoroughly researched and customized to you and your health status and goals. However, no guarantees can be assured regarding the outcome of any procedure(s) or treatment(s).

6. Ongoing relationships with other physicians and healthcare providers need not be discontinued. Please let us know if you are being treated by other healthcare providers. Consult your prescribing physician before you discontinue any medications. It is your responsibility to inform us of any changes in your condition, contact information or treatments between visits.

7. We are not available on a 24 hour basis at all times. We urge you to maintain a relationship with another doctor with whom you can consult with in the event of an emergency or urgent problem. If a serious or urgent health problem should arise, you should immediately call your other doctor(s), call 911, or have someone drive you to the nearest hospital emergency department. If you notice an adverse effect from one of the components of your treatment plan, you should discontinue it and immediately inform us of the situation.

8. Lastly, we encourage you to ask questions about any health-related topic and take an active role in your health care. We use a team-based approach and we strive to work hand-in-hand with you to help you achieve your short and long term health related goals so you may attain the highest level of wellness possible.

It is our sincere honor and pleasure to participate as part of your healthcare team.

The contact information, health history and other information I provide on my intake forms are complete and accurate and I consent to treatment. I understand and agree to the information on this document. My questions, if any, were answered to my satisfaction.

Patient name: _____

Signature: _____ Date _____
(In case of minor, parent or guardian must sign)

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in telemedicine consultations with the following Naturopathic Physician:

Natural Life Medicine Providers

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1. **Washington State Residence**. Residence within Washington State is required for telemedicine consultations with the providers at NLM. Verification of residence will be conducted prior to scheduling an appointment.

a. **Primary Care Services**: Establishment of primary care services are available for patients within a 50 mile radius of the physical location where Natural Life Medicine practices in Puyallup, WA, if allowed by your insurance plan (if applicable).

i. **Primary Care Services**: Examples of primary care services include Well Child Checks, Well Adult Exams, referrals to specialists, lab reviews, Gastrointestinal complaints, Thyroid management, etc.

ii. **In-person visits**: In-person visits are required at least once per year by providers if primary care services are established.

2. **Definition.** Advances in technology have resulted in new approaches in the delivery of medical care, including those in which the physician and patient are not in the same physical location, but interact using technology. These new approaches are referred to as Telemedicine.

a. **Synchronous/Live Communication:** Live real-time audio/video communication through interactive technology that enables a patient and a doctor who are separated by distance to interact simultaneously.

b. **Doctor-Patient Relationship**: The relationship between a provider of naturopathic medical services (Doctor) and a receiver of naturopathic medical services (Patient) based on mutual understanding of their shared responsibility for the patient's health care.

i. The relationship is established when the Doctor agrees to undertake diagnosis and/or treatment of the Patient and the Patient agrees that the Doctor will diagnose and/or treat, whether or not there has been or is an in-person encounter between the parties.

ii. Not all patient situations will be appropriate for Telemedicine.

c. **Risks, Consequences, Emergency Plan.** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the telemedicine consultation, your Doctor may recommend a visit to a hospital, urgent care, etc.

d. **Benefits.** Benefits of telemedicine include: facilitating care to patients unable to attend office visits in person, reducing the expenses of traveling to see a physician/specialist, and expanding patients' accessibility to healthcare services, among other benefits.

e. **Originating Site / Location of Patient for Telemedicine Services:** Some states or insurances place restrictions on where the patient can receive virtual care. Washington Medicaid, for example, does limit where the patient can be at the time of care, but offers more flexibility by including the patient's home. Here's the full list of eligible patient locations allowed by WA Medicaid:

i. Clinics

ii. Community mental health/chemical dependency settings

iii. Dental offices

iv. Federally qualified health center (FQHC)
v. Home or any location determined appropriate by the individual receiving service
vi. Hospitals (inpatient and outpatient)
vii. Neurodevelopmental centers
viii.Physician or other health professional's office
ix. Rural health clinics (RHC)
x. Schools
xi. Skilled nursing facilities

3.**Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Washington State law apply to information disclosed during this telemedicine consultation.

a. **HIPAA Compliance:**

i. HIPAA (Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding Protected Health Information (PHI).

ii. Medical professionals who wish to comply with the HIPAA guidelines on telemedicine must adhere to rigorous standards for such communications to be deemed compliant.

iii. The HIPAA guidelines on telemedicine are contained within the HIPAA Security Rule and stipulate:

a) Only authorized users should have access to electronic Protected Health Information (ePHI).

b) A system of secure communication should be implemented to protect the integrity of ePHI.

c) A system of monitoring communications containing ePHI should be implemented to prevent accidental or malicious breaches.

iv. The electronic health record (EHR) system and videoconferencing platform that are used are HIPAA-compliant.

b. **Medical Information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4.Rights. You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any insurance program benefits to which you would otherwise be entitled.

5.**Nature of Telemedicine Consultation:** During the telemedicine consultation:

a. Details of you and/or your child's medical history, examinations, imaging results, and/or lab tests will be discussed through the use of interactive video, audio and telecommunications technology.

b. Physical examination of you or your child may take place.

c. Non-medical technical personnel may be present in the telemedicine location to aid in video transmission or physical exam if origination location of patient is in a medical facility.

d. Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

e. Individualized, integrative treatment plan is discussed.

6. **Prescriptions.** Washington providers who prescribe medications via a Telemedicine encounter have to follow the same guidelines as for in-person care. This means conducting a patient evaluation, gathering their history and any other information needed to make a diagnosis.

a. The Providers at NLM has limited prescribing rights in Washington State and are able to

prescribe the following:

i. “Legend drugs” as defined under RCW **69.41.010** with the exception of Botulinum Toxin (commonly known as, among other names, Botox, Vistabel, Dysport, or Neurobloc) and inert substances used for cosmetic purposes; and

ii. Controlled substance prescription are limited to testosterone and codeine containing substances in Schedules III-V only with a DEA license, which the providers at NLM obtain

7.**Financial Agreement.** You and/or your insurance company will be billed for this visit. Please see the separate Billing Policies.

I have been advised of some of the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I understand the written information provided above.

Patient Name: _____

Date of Birth: _____

Signature: _____

Patient (or person authorized to give consent)

Date and time: _____