Kathleen Flewelling, ND
A Natural Path Integrated Healthcare Services
503-738-5859

Rights and Responsibilities

Records Release and Assignment of Insurance Benefits
The undersigned hereby authorizes the Release of Information relating to claims for benefits submitted. I agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim.
Initial____________

Records Release and Assignment of Personal Health Representative
I give permission to the following designated family member or friend to review my health records. I also give my permission to Dr. Flewelling to discuss my health records with this person. I know that I have the right to revoke this permission in writing at any time.
Personal Health Representative: Name:_____________________________Phone:________________________

__________I don't wish to authorize a Personal Health Representative.

Notice of Privacy Practices – HIPAA
I understand a copy of this clinic's privacy practices is available upon request. My signature below acknowledges that I have had the opportunity to review the privacy practices regarding my protected health information.
Initial____________

I understand that all forms of communication including mobile phones, voicemail, email and fax may be compromised so I will be careful about the information that I send.
Initial____________

I understand that anything I see or overhear while in the clinic about another patient is confidential.
Initial____________

Consent Form and Agreement
It is our policy to inform you about your condition and the recommended procedures/medications that are used to treat this condition as well as any risks or benefits of these treatments. We make every effort to educate you so that you may make an informed decision to give or withhold your consent for the treatment or procedure recommended.
I, the patient, understand that no warranty or guarantee for a specific cure or result has been made to me as to the result of care. I understand that reactions to treatment can be minimized when the doctor is informed about all medications and supplements that I take as well as all diagnoses I have and symptoms I experience. I also understand that there is some risk of reaction to treatment that cannot be predetermined, and I will contact the doctor immediately if a reaction occurs in order to remedy the situation as soon as possible.
Initial__________I have read the policies above and understand them.

Initial__________I agree to promptly pay all fees and charges for treatment provided to me and/or my family.

Initial_________I acknowledge my financial responsibility for all charges, regardless of my insurance coverage.

Initial_________I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

____ ______________________________
Signature of patient (or parent/guardian of minor) **Date**

(Flip form over)