

LiveWell Center
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DISCLOSURES AND INFORMED CONSENT

WELCOME/SERVICES. Welcome to The LiveWell Center; we are honored to be part of your journey to better health. Naturopathic Medicine is a branch of the healing arts that includes the prevention, evaluation, diagnosis, and treatment of injuries, diseases, and conditions through education, nutrition, naturopathic preparations, natural medicines, physical medicine, physical agents, and other therapies and modalities designed to support the body's natural healing processes. Our Naturopathic Doctors (NDs) are registered under Colorado's Naturopathic Doctor Act. They are not Doctors of Chiropractic (DC), Doctors of Nursing (DNP), Doctors of Osteopathy (DO), or Medical Doctors (MD), who are licensed under separate practice acts. In Colorado, Naturopathic Doctors do not prescribe, dispense, administer, or inject controlled substances (including general or spinal anesthetics) or practice medicine (including performing surgery, obstetrics, or administering ionizing radiation therapy). The only adjustments, manipulations, and mobilizations we perform are naturopathic manual therapies. We cannot recommend against a course of care recommended or prescribed by a licensed provider in another branch of the healing arts. Our office does not provide naturopathic treatment to children less than nine years old and recommend that our pediatric patients follow the CDC immunization schedule and have a relationship with a licensed pediatric health care provider.

ALTERNATIVES AND COLLABORATION: Alternatives to Naturopathic Medicine include declining such care and consulting with others such as an MD, DO, DC, or DNP. Naturopathic Medicine is not a substitute for other types of health care and we encourage you to seek second opinions, have a relationship with an MD or DO, to communicate with all your providers about the care recommended in our office, and to authorize us to attempt to collaborate with your other providers. **ONLY IF YOU WANT TO.**

Provider: _____ Phone: _____

RISKS: Naturopathic Medicine is generally considered safe but may involve some risks including, without limit: all of the risks disclosed with any preparations or medicines; allergic reaction; infection; pain or discomfort; weakness, fainting, or nausea; skin irritation, discoloration, or scarring; aggravation of symptoms; mood changes; and rarely, neurological injury and pneumothorax. Naturopathic Medicine may adversely interact with specific drugs and may be inappropriate during pregnancy. Naturopathic manual therapies involve risks including, without limit, fractures, disc injuries, dislocations, and sprains. Additionally, hidden conditions may exist that are not detectable through examination. This may include spinal tumors, weak or occluded arteries, and aneurysms. Accordingly, some people are at risk for stroke or vascular injuries as a result of manual therapies.

EMERGENCIES: If you are having a medical emergency, do not wait to seek care. Call 911.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Our fees are described in the intake paperwork. Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. You may terminate care at any time. Prorated fees for unused, prepaid services will be refunded; however, no refunds are available for product purchases.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!

I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

Patient or Person with Authority to Consent

Date

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

This notice describes how your health information may be used and disclosed. Please review it carefully.

YOUR RIGHTS

You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say “no,” but if we do, we’ll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree, and we may say “no.” If, however, you pay for a services or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- Obtaining a list (accounting) of those with whom we’ve shared your information for six years prior to the request and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We’ll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive it electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint about a violation of your rights by contacting: Dr. Daenell, 303-399-8050, patientsupport@drdaenell.com; or US Dept. of Health & Human Services for Civil Rights, 200 Independence Ave, S.W., Washington, DC 20201, www.hhs.gov/ocr/privacy/hipaa/complaints, 1-877-696-6775. We will not retaliate against anyone for filing a complaint.

YOUR CHOICES

- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster situation; or include your information in a directory.
- We will not sell your information or share it for marketing unless you give us written permission. We may, however, contact you for fundraising efforts, but you can tell us not to contact you again.
- We will not share psychotherapy notes for unless you give us written permission.

If you are not able to choose, we may share information if we believe it is in your best interest. We may also share information when needed to lessen a serious and imminent threat to health or safety.

OUR USES AND DISCLOSURES

- We can use your health information and share it with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.
- We are also allowed or required to share your information in other ways, such as:
 - Providing you with information related to your health;
 - Contacting you regarding appointments, treatment alternatives, or other health related services;
 - Incidental uses or disclosures (e.g., listing your name on a sign-in sheet, etc.);
 - Legal compliance (including reports of adverse reactions, suspected abuse, neglect or violence);

- Providing information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or for organ procurement;
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative orders, subpoenas, discovery requests or lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to disaster relief agencies;
- Providing information for workers' compensation claims; or
- Informing a family member, other relative, or close personal friend when:
 - Information is relevant to the individual's involvement with your care;
 - Notification of your location, general condition or death;
 - To assist in your care (pick-up prescriptions or documents, follow-up care instructions, etc.).
- Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

OUR RESPONSIBILITIES

- We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise such privacy or security.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This Notice is effective September 23, 2013.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

PATIENT ACKNOWLEDGEMENT

I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

Signature of Patient/Legal Guardian

Date

Print Patient Name (required)

Print Legal Guardian Name (if necessary)

INTERNAL PRACTICE USE ONLY: _____ refused to sign.

Signature of Practice Representative

Date

RECORDING AGREEMENT

I _____ ("Participant") requested services, or more information about the services, offered through LiveWell. LiveWell has agreed to provide such information or services in group and individual meetings, both in person and by videoconference. LiveWell does not permit any video or audio recording. In consideration of LiveWell's willingness to provide information and/or services, Participant agree not to record, by any manner whatsoever, any LiveWell provider, staff member, patient or potential patient, or LiveWell facilities or seminars. Participant agrees that any recordings made in violation of this agreement shall become the sole and exclusive property of LiveWell and shall not be used or disseminated to anyone outside of LiveWell.

In the event of a breach of this Agreement, LiveWell may apply to any Court of competent jurisdiction to enjoin any further use or disclosure of a recording made in violation of this Agreement. This right shall be in addition to any other remedy provided by this Agreement or by law. Participant also agrees to pay LiveWell damages for breach of this Agreement. Because damages would be costly to prove, Participant agrees to pay, upon demand, liquidated damages in the amount of \$10,000 per violation for breach of any provision of this Agreement. Participant expressly agrees that the liquidated damages outlined in this Agreement are reasonable estimates of the losses LiveWell would incur as a result of a breach. Participant agrees to pay all reasonable attorneys' fees, expert witness fees, costs of investigation and proof of facts, costs, and other expenses incurred by LiveWell or its providers to enforce the terms of this Agreement.

PARTICIPANT

Name

date