Heidi Peterson, ND
7005 NE Glisan St, Suite A
Portland, OR 97213
Tel: 503-546-7663 ~ Fax: 503-505-7672
Website: doctorheidi.com

PATIENT INFORMATION

Name_____Age:_____Date of Birth:_____

Gender: M F Other_____ Preferred Pronoun:_____ Email Address:_____

Address:_____City_____State_____ZIP_____

Patient Phone #:_____ OK to leave messages? YES or NO

Emergency Contact Name:_____ Contact Phone:_____

If you would like to authorize a partner or other person to be able to discuss your health or billing information with us, please list them below.

Name_____ Relationship_____

Whom may I thank for this referral?_____

AUTHORIZATION TO TREAT (*Please initial below*)

_____I authorize Heidi Peterson, ND to examine and treat me.

_____I understand that treatment and therapies recommended by Heidi Peterson ND may be different than those offered by other licensed health care providers and I am at liberty to seek other care.

COMMUNICATION WITH DR. PETERSON:
You will be given access to a **patient portal through Elation Passport.** This is a direct, HIPAA compliant communication for you and your doctor. *Please do not send regular emails.*

APPOINTMENT REMINDERS AND CANCELLATION POLICY :
I ask that cancellations be made at least 48 hours before your appointment- not including weekends
Appointment reminders are sent via email or text 2-3 days before your appointment from the Elation scheduling system. *Appointments missed or canceled in less that 48 hours prior to their scheduled time will incur a* ***$100 fee*** *that cannot be billed to your insurance company.* Last minute cancellations of scheduled appointments are difficult to fill and costly. Exceptions to this policy may be made for emergency situations on a case by case basis.

PRESCRIPTION REFILLS:
It is quite time consuming for Dr. Peterson to refill regular prescriptions. Please take this into consideration when it is time for a refill. Call your pharmacy for refills and have them fax over the request to us. **Please give Dr. Peterson at least one week to fill your refill requests.** You are required to see Dr. Peterson at least once a year for her to continue prescribing medications. There may be a *$15 fee for any urgent refill reques*t to tide you over until your scheduled appointment.

MAIL ORDERS:
If you require supplements or lab kits to be mailed to you a *minimum shipping fee of $15* will be charged.

FORMS:
If you need a FMLA form or another type of form filled out there is a **$30 charge** for this. It will require a short visit with Telemedicine or in person with Dr. Peterson.

RETURNED CHECK FEE:
Returned checks will incur a fee of **$45.00**.

LABORATORY CHARGES: I understand that all charges will be submitted to my insurance company by the lab company and the reimbursement of payment is determined by my insurance company, not Dr. Peterson's office.
I understand that labs will be sent to QUEST Laboratory as a default. By choice, you can check with your insurance company which lab would be considered in-network and let us know where to send them. You can request us to send labs to any of the following labs – Quest, LabCorp, Legacy or Providence. (Pacific Source Ins is sent to Legacy Lab as default and Providence Ins sent to Providence Lab as default)

I agree to pay a $30 Lab Processing fee to Dr. Heidi Peterson that will not be submitted to my insurance company.

******Most lab fees go towards the deductible these days***. We do offer a lower-cost lab alternative that can be paid for at the time of service that will not be run through insurance. Please let us know *at the time of the appointment* if this is your choice.

INSURANCE BILLING POLICY:
We are currently OUT OF NETWORK with ALL insurance companies. All fees are due at the time of service or upon receipt of your invoice through our online payment system. We will not be submitting your claim but we can provide you with the necessary information in order for you to submit this to them or your HSA for reimbursement.

OFFICE VISITS:
In person and telemedicine appointments are available and can be schedule through our online scheduling system at https://app.elationemr.com/book/9396640088068drheidipeterson

TELEMEDICINE DISCLOSURES: Telemedicine involves the use of electronic communications to enable health care for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education. Live two-way audio and video will be used through

https://zoom.us/j/3509151410?pwd=aHY0VlUybUNXNEpFQTNvd205NktjZz09

Security-Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits- Improved access to medical care by enabling a patient to remain at a remote site • More efficient medical evaluation and management• Obtaining expertise of a distant specialist• Maintaining patient safety during a pandemic or declared state/federal emergency

Possible Risks -As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (ie. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment

I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with Dr. Peterson in person for any necessary physical examinations.I understand that telemedicine has its limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with Dr. Peterson in person for any necessary physical examinations.

NOTICE OF HIPAA PRIVACY PRACTICES POLICY INCLUDING TELEMEDICINE

WE ARE REQUIRED BY LAW TO PROTECT THE PRIVACY OF YOUR MEDICAL INFORMATION AND TO PROVIDE YOU WITH A DETAILED WRITTEN NOTICE DESCRIBING HOW THIS CLINIC MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN OBTAIN OR CORRECT THIS INFORMATION.

Here is a brief summary:

We may use your medical information or disclose it to others in order to provide or arrange for your health care, to arrange payment or reimbursement for the care that we provide to you, or to carry out administrative activities related to or supporting your treatment.

We may be required or permitted by certain state or federal laws, regulations, or legal circumstances to use or disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights regarding your medical information in this clinic. You have the right to inspect, copy, amend or correct that information, obtain an accounting of disclosures of your medical information, request that we communicate with you confidentially and request that we restrict certain uses and disclosures of your health information. We have a procedure for filing a complaint if you think your rights have been violated.

We will provide a copy of this NOTICE OF PRIVACY PRACTICES to you, which explain your rights and our obligations under the law, at your request.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge having read this or been offered a copy of this office's Notice of Privacy Practices.

I certify that I have read this form and that I fully understand its content, including risks and benefits of Telemedicine. I hereby authorize Heidi Peterson ND to use Telemedicine in the course of my diagnosis and treatment. I have been given ample opportunity to ask questions regarding the content of the consent form above and all questions have been answered to my satisfaction. I agree to accept full responsibility for payment of services.

Printed Patient Name_____

Signature_____ Date_____