Amy Nelson, ND
955 Carrillo Dr. Suite #105
Los Angeles, CA 90048
Phone: 323.470.0511
www.AmyNelsonND.com

# Informed Consent for Treatment

Please read and sign the following in order to completely understand the risks and benefits of your care.

I, _____, hereby authorize Amy Nelson, ND to perform the following specific procedures as necessary to facilitate my healthcare:

- Common diagnostic procedures, i.e. laboratory, physical exam, diagnostic imaging
- Medical use nutrition: therapeutic nutrition, nutritional supplementation
- Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories
- Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing process
- Psychological counseling
- Lifestyle and hygiene counseling: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress management and balancing of work and social activities
- Therapeutic Massage
- Hydrotherapy
- Equine therapy

I recognize the potential risks and benefits of the procedures as described below:

- Potential risks: allergic reactions to prescribed herbs, supplementations and medications, side effects of natural medication, inconvenience of lifestyle changes, emotional release, emotional distress, healing crisis.
- Potential benefits: restoration of health and body's maximal functional capacity and optimal wellness, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- Notice to pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant. Some therapies used could present risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that Amy Nelson, ND has given no guarantees to me regarding cure or improvement of my condition. I understand that I agree to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that any questions I have will be answered by my provider to the best of her ability. I realize I play an integral role in my healing process and in order to produce results, I must take responsibility for my health. By making the appointment for a visit with Amy Nelson, ND I am making an investment in my health.

I understand that I am expected to have a local primary care physician if I am conducting my appointments with Amy Nelson, ND by phone, Skype, or any other electronic means.

_____ Date:_____/_____/_____
Patient/Guardian Signature

_____
Parent/Guardian Printed Name

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# Your Health Information and Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers, it is our responsibility to keep your information safe and secure. In order to provide you with service that best meets your privacy needs, please tell us if there are any ways you do not want us to attempt to reach you. Please check all that apply:

I understand that

- ☐ a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless specifically directed by myself or representative unless it is required by law.
- ☐ my information may be shared:
  - For coordination of care; multiple health care providers may be involved in my treatment directly and indirectly.
  - With other clinic members or students under their tutelage
  - With family, friends, relatives, or others that are specifically identified on this form as being involved my health care or health care bills.
  - To protect the public's health, such as reporting when the flu is in the area.
  - To make required reports to the police (i.e. gunshot wounds).
  - To obtain payment from third party payers (i.e. insurance companies)
- ☐ I may look at my health record or request a copy of it at any time.
- ☐ My health records will be kept for a minimum of seven years after the date of my last visit.
- ☐ This health clinic follows strict HIPPA guidelines to protect my health information.
- ☐ I am entitled to receive updates upon request if Amy Nelson, ND amends or changes its Notice of Privacy Practices in a material way.

In order to provide you with service that best meets your privacy needs, please tell us if there are any ways you do not want us to attempt to reach you. Please check all that apply:

- ☐ Please do not phone me at home. Use this alternate phone number: _____
- ☐ Please do not phone me at work. Use this alternate phone number: _____
- ☐ Please do not leave messages on my answering machine.
- ☐ Please do not contact me by email.
- ☐ Please send mail, including my bills, to this alternate address:_____
  _____

List those with whom you are willing to have us share your health information and discuss your treatment: _____

_____

Other request (please describe): _____

_____

I, _____, hereby acknowledge that Amy Nelson, ND has provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used, disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact Amy Nelson, ND.

_____ Date:_______________
Patient Signature

_____ Date: _______________
Patient Name (Please Print. Include parent/guardian name if patient is a minor)