Functional and Integrative Medicine of Idaho

CONSENT FOR TREATMENT

I request and authorize health care services at Functional and Integrative Medicine of McCall that my provider may deem advisable and in my best interest. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent.

Printed Patient Name:_____

Signature of Patient, or Parent/Guardian if applicable:_____

HIPAA POLICY

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Functional and Integrative Medicine of McCall has developed privacy practices based on HIPAA. These practices are outlined in our Notice of Privacy Practices (NPP) that provides an explanation of your individual rights with respect to your personal health information. Please take a few minutes to review our NPP.

_____Please initial here that you have been provided with access to my Notice of Privacy Practices.

If you wish to disclose your health information, please designate those individuals below:

□ I choose to disclose all of my financial and billing information with the following persons:

_____

□ I choose to disclose all of my medical information with the following persons:

_____

□ Other: _____

Printed Patient Name:_____Date:_____

Signature of Patient, or Parent/Guardian:_____

□ Consent received by_____on _____□ Consent refused by patient, and treatment refused as permitted.