NaturaMed
NATURAL FAMILY MEDICINE

8130 North Lake Blvd
P.O. Box 368
Kings Beach, CA 96143
PH: 530-546-0400
Fax: 530-546-0401

Confidential Patient Information

Please fill in all portions of this form printing clearly and legibly to ensure accuracy.

Today's Date: _____

Patient name: _____ Age: _____ Marital Status: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Birthdate____/____/____AGE:_____ Email:_____

Occupation: _____Employer: _____ Referred by: _____

Work Address: _____ City: _____ State _____ Zip _____

Name of nearest relative not living with you: _____ Phone # _____

Name of spouse (or parent for minor child) _____ SS# _____

Occupation _____ Employer _____ Work # _____

Emergency contact: _____ Relationship _____ Phone: _____

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. *Furthermore, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance*. Permission is hereby given for any medical treatment and any diagnostic procedures required for my health care; or (when a patient is a minor child) for the health care of my minor child.

Examination Policy

This office specializes in the diagnosis and treatment of acute and chronic internal, hormonal, and nutritional conditions. Evaluation is done to determine the nature and extent of your problem. In addition to our in-office evaluation, out-of-office laboratory and/or x-ray evaluation may also be recommended, depending on what is necessary in your case. Your Doctor will explain what tests are necessary or recommended during your consultation with her.

CLINIC POLICY REQUIRES PAYMENT AT THE TIME OF SERVICES. PAYMENT TODAY WILL BE BY:

CASH _____ CHECK _____ VISA/MC_____

We require 24 hours advance notification of cancellations or changes in appointments, and we reserve the right to charge if sufficient notice is not given.

Patient's signature _____ Date _____

OR:

Printed: _____Signed: _____

(Guardian/Parent signature authorizing care for minor child)

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Patient's Name (please print):_____

We are a cash-based practice. At this time we are not able to accept, nor do we bill, insurance for any of our in-house services. Full payment of all charges is required at the time of service. We accept payment by cash, check, and credit card (MasterCard/Visa). Checks denied for insufficient funds will incur a fee of $35.00. We are not contracted with any insurance providers, and our services are generally not covered by insurance in California. Please see "**An Explanation of Our Financial Policy**" on our website or available by email or in person at the front desk.

TELEPHONE/EMAIL POLICY

Phone Consultations: Charged accordingly with in-office visits. The phone consultation fee is not charged if you are calling for clarification of an on-going medical therapy, or when the doctor has specifically requested you call with a treatment status. The practitioners have full schedules and are generally not available for unscheduled phone conversations. The front desk staff is instructed to take detailed messages from our patients if an answer from the doctor or practitioner is required. Be respectful of their time and be concise. They will get back to you with a response in 24-48 hours.

I understand that if any questions require a phone call from the Doctor or practitioner, any telephone conversation over 5 minutes will be billed at the same consultation rate as in-person visits. If you have any questions or concerns regarding this charge, feel free to ask at the time of your call

Emails: At this time we do not conduct patient communication via email. By sending an email, I acknowledge and agree that a prompt reply is NOT required, expected or contemplated. I acknowledge that I will not use email communication to deal with emergencies or other time-sensitive issues. I understand that email communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that NaturaMed Natural Family Medicine may keep copies of email communications and that such messages may be included in my or my child's medical record. If I choose to send an email which requires *the doctor or practitioner* to spend over 5 minutes to read and reply to it I will be billed at the in-person consultation rate.

Pleases initial here to indicate you have read and accept the terms of this section: _____

FINANCIAL POLICY

Payment is expected for all services at the time care is provided. We are unable to carry open balances for our patients for either services or supplements. If an open balance is accrued, any open balance over $200 will result in termination of services and supplements until such time as the open balance is paid in full. In cases of financial hardship, special circumstances for payment may be considered. Such arrangements must be made in advance with the front desk. We participate in MedLoan Finance, a company that specializes in 0% interest loans for medical services. Our front desk is happy to assist you with an application.

We are not contracted with any insurance providers, and our services are not generally covered by insurance in California or Nevada. Upon request we can provide a services only receipt for you, it is your responsibility to submit it to your insurance company for reimbursement. Any questions you may have about reimbursement for our services should be directed to your insurance company. If you will be requesting a services receipt for submission, you must notify the front desk PRIOR to your appointment with the doctor. We are not able to provide these for services previously rendered, nor can we recreate these forms if you misplace them. Coding and billing for insurance company reimbursement is a full time job for a billing specialist and we do not offer this service. *Please see "An Explanation of our Financial Policy" for further information regarding this.*

Please note: As a rule, most insurance companies consider nutritional evaluation and treatment to be "preventative" health care and will not reimburse for these services. Most insurance companies do not cover "Alternative Medical" procedures. This includes but is not limited to:

- Vitamin Injections
- Intravenous Nutrition and Metabolic Therapy
- Nutritional Counseling
- Nutritional Supplements
- Functional Laboratory Assessment
- SpectraVision Bio-Feedback Body Balancing

Clearly, we do not share this view. We will print all of your charges, whether billable to your insurance or not, on a receipt. For clarification of our financial policy, please refer to our "An Explanation of our Financial Policy" available on our website or from the front desk.
We currently accept payment by cash, check, MasterCard or Visa.
Please initial here to indicate you have read and accept the terms of this section: _____

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CANCELLATION POLICY

NaturaMed has a 24 hour cancelation policy. Our doctors and therapists have very busy schedules and many patients that would like to see them. If you do not give 24 hour notice NaturaMed has the right to bill you for the price of a complete office visit. If you "no-show/no call" for your appointment, NaturaMed has the right to bill you for a complete office visit.

All returned checks will be assessed a $35.00 charge in addition to the payment fees covered by that check. Returned check fees and service fees for that check are payable by cash, money order, credit card or cashier's check. If need be NaturaMed will turn delinquent accounts over to a collections agency and *any charges, fees or court costs incurred as a result of collection efforts will be added to the account balance*.

Please initial here to indicate you have read and accept the terms of this section: _____

At the time of your first visit, a credit card will be taken and kept securely in your file. We will contact you prior to any charges being placed on the credit card on file, however, by initialing the above statements and by signing below, you are agreeing to our financial policy as outlined, including charges for telephone and email communication as well as appointment cancellations without 24 hours notice and acknowledging that you have read and understand "An Explanation of Our Financial Policy".

By signing below, I acknowledge that I have read, understand and agree to comply with the above listed policies of NaturaMed LLC as stated above.

Patients Printed Name: _____

Patients Signature:_____
(or signature of responsible adult if patient is a minor)

Date: _____

Office Staff Witness Signature: _____

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INFORMED CONSENT FOR CARE

I hereby request Naturopathic/functional medicine treatment and therapies, including nutritional consultations, and other procedures including various modes of physiotherapy, nutritional therapy (including IV and or IM injections if indicated) and diagnostic procedures including laboratory testing, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Naturopathic Medicine (Dr. Ann Manby Sura) and/or licensed doctors of Naturopathic Medicine who now or in the future treat me while employed by, working or associated with or serving as back-up doctor in the offices of NaturaMed LLC or for the Doctor of Naturopathic Medicine named here, including those working at the clinic or office. I also understand that Naturopathic Interns working under the doctor's direct supervision or the RN employed by the doctor may be directed by the doctor to perform certain diagnostic or therapeutic procedures on me during any time of my care.

I understand and am informed that in the practice of Naturopathic Medicine, some therapies and modalities of treatment are considered "investigational", "experimental", or "alternative" by the conventional medical community and that there are some risks to treatment. I also understand that most insurance companies do not cover these procedures which include but are not limited to:

SpectraVision Body Scanning
Vitamin Injections
Intravenous Nutrition and Metabolic Therapy
Nutritional &/or Lifestyle Counseling
Nutritional Supplements

Infra Red Sauna Therapy
Homeopathic Medicine
Botanical medicine(s)

Functional medicine testing including:
Salivary or other hormone testing
Nutritional Status Testing
Gastrointestinal function testing
Heavy Metal Testing
Genomic SNP testing

I do not expect the Doctor to be able to anticipate and explain *all* the risks and complications and I wish to rely on the Doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Some of the potential risks and benefits of these procedures include:
Potential Risks include but are not limited to: allergic reactions and other side effects to prescribed herbs and supplements; aggravation of pre-existing symptoms discomfort, pain, infection, burns, nausea, light headedness; inconvenience of lifestyle changes, injury from injections, venipuncture or other procedures. Please notify NaturaMed Natural Family Medicine if you experience any symptoms which may be secondary to the above procedures.

Potential benefits include but are not limited to: restoration of health and the body's maximal functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease, assistance in injury and disease recovery; and prevention of disease or its progression.

I agree that I am accepting or rejecting this care on my own free will and choice. I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all of the conditions I may have. I also understand that it is inherent in the practice of Naturopathic medicine that the patient is ultimately responsible for the choices made, whether to follow the Doctors advise and guidance or not. "There is nothing the Doctor can do that will overcome what the patient will not".

I am not an agent of any private, local, county, state or federal agency attempting to gather information without so stating my intentions.

I have read and/or have had read to me, the above consent. With this knowledge, I voluntarily consent to Naturopathic medical treatment, realizing that no guarantees have been given to me by NaturaMed Natural Family Medicine or any of its personnel, regarding cure or improvement of my condition. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions for which I seek treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. 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 so directed by myself or my representative or unless required by law

_____ _____
Printed name of patient Patients Signature/or Guardian of minor

_____/_____/_____ _____
Date Office Staff Witness Signature

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PLEASE LIST ALL CURRENT **PRESCRIPTION MEDICATIONS** AND DOSAGES BELOW:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

PLEASE LIST ALL CURRENT **OVER THE COUNTER MEDICATIONS** AND DOSAGES (ie: aspirin, allergy medications, stomach medications etc)

1) _____

2) _____

3) _____

4) _____

PLEASE LIST ALL CURRENT **NUTRITIONAL, HERBAL OR HOMEOPATHIC SUPPLEMENTS** AND DOSAGES (ie: vitamins, anti-oxidants, hormone balancers) Include brand name. Use the back of the page if additional room is needed.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

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Confidential Pediatric Intake Form

*PLEASE **PRINT** CLEARLY AND LEGIBLY TO ASSURE ACCURACY*

Today's Date: _____

Patient name: _____ Age: _____ M or F

Birthdate____/____/____ Grade in School: _____ School Attending: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Physical Address: _____ City: _____ State: ____ Zip: _____

Mother's Name and occupation:_____

Father's Name and occupation:_____

Parents are (circle): Married Separated Divorced Living Together Other_____

Home phone: _____Mom's Cell Phone: _____Dad's Cell phone: _____

Best number for messages:_____ Contact Email:_____

Sibling(s) names and ages: _____
Besides the mother and father, does anyone else take care of the child? No Yes

Who? _____ How often? _____

Primary Care Doctor: _____ Referred by: _____

Has the child seen a dentist? Yes No Dentist's name? _____Last visit? _____

How would you rate this child's health in general? Excellent Good Fair Poor

Reason for Today's Office Visit: _____

Has child been seen by any other doctor(s) or professionals for this complaint? Yes No

Has child had any blood work or other tests done? If yes, please list what:

_____

_____

_____

Present Health Concerns

Please list most important health concerns in order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	

Please list any operations or hospitalizations, reasons and year occurred:
1. _____
2. _____
3. _____
4. _____
Please list any allergies to medication or life threatening allergies and reaction:_____
_____
_____

Any other allergies – environmental, animal, food? _____
_____

Previous Medical History

Yes *indicates the child gets the problem regularly;* ***No*** *indicates the child never had the problem;* ***P****ast indicates the child had the problem in the past but not recently. Please circle the correct one for your child.*

Ear Infections? Yes No Past
*If has had, how many total?*_____
If yes or past, how were they treated? _____
Colds? Yes No Past
*If has had, how many total?*_____
If yes or past, how were they usually treated? _____
Strep throat? Yes No Past
If has had, how many total?
If yes or past, how was it treated? _____
Eczema, Psoriasis? Yes No Past
If yes or past, how was it treated? _____
Anemia? Yes No Past
Seizures? Yes No Past
Broken bones? Yes No Past
Asthma? Yes No Past
Frequent urination or bed wetting? Yes No Past

How many times has the child taken antibiotics?_____

What other medicine has the child taken? How often?
1. _____
2. _____
3. _____
4. _____

Hearing tests Normal: Yes No Not Tested
Vision Tests Normal: Yes No Not Tested
Any speech impediments: Yes No Past
Learning impediments: Yes No Don't know

Vaccination History: ***Yes****, has had;* ***No****, has not;* ***Some****, did not finish all shots or on alternate schedule*

Hep B	Yes	No	Some	Influenza	Yes	No	Some
RotaVirus	Yes	No	Some	MMR	Yes	No	Some
DPT:	Yes	No	Some	Varicella (chkpox)	Yes	No	Some
Hib:	Yes	No	Some	Hep A	Yes	No	Some
Pneumococcal	Yes	No	Some	Meningococcal	Yes	No	Some
Polio (inactivated)	Yes	No	Some	Other: _____			

Any reactions to vaccinations? If so, please explain:_____
Date of last physical/annual exam: _____

Please check the 'yes' box next to each condition that applies to the child's mother, father or other family members. Please note whether the condition is in the past or currently by denoting 'P' for past, or 'C' for current. Indicate who had/has the condition in the 'relation' column.

	YES	Relation	Date Resolved Past (P) Current (C)		YES	Relation	Date Resolved Past (P) Current (C)
Alcoholism/Drug Addiction				High Blood Pressure			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				Headaches/migraines			
Asthma				Kidney Disease			
Cancer (type?)				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema/Psoriasis				Other			

Mother's Pregnancy history

Age at conception:_____Have other children already? Yes No

Prenatal Care during pregnancy? _____

Health During Pregnancy:

Smoking: Yes No
Coffee: Yes No
Recreational drugs: Yes No
Preeclampsia: Yes No
Vaginal birth: Yes No

Diabetes: Yes No
Nausea/Vomiting: Yes No
Emotional Stress: Yes No
Length of Labor:_____
Traumatic birth: Yes No

If the birth was difficult, please explain: _____

_____

_____

_____

Health of baby at birth: _____

_____

APGAR Score: _____

Child breastfed: Yes No
When put on formula:_____
When was child put on solid food:_____
When did child Walk:_____
Develop Teeth:_____

For how long:_____
What formula was used:_____
Talk:_____

Health History of Child

Jaundice as baby: Yes No
Cradle cap: Yes No
Eczema or psoriasis: Yes No
Diarrhea: Yes No
Constipation: Yes No
Finicky eating: Yes No
Poor teeth: Yes No
Chronic sniffles: Yes No
Bad foot odor: Yes No
Very sweaty baby/child: Yes No
Hyperactivity: Yes No
Growing pains: Yes No

Colic: Yes No
Anemia: Yes No
Asthma: Yes No
Warts: Yes No
Nightmares: Yes No
Bed-wetting: Yes No
Tantrums: Yes No
Disobedient: Yes No
Fears/Phobia: Yes No
Diaper Rash: Yes No
Early Puberty: Yes No
Stomach aches: Yes No

Any particular household stressors child has witnessed or gone through:
1._____
2._____
3._____

Typical Day's Diet and approximate times.
Breakfast:_____
Snack:_____
Lunch:_____
Snack:_____
Supper:_____
Snack:_____

Do you follow any particular dietary regimens or restrictions? If yes, Please describe:
_____
How much water does the child drink? _____ Tap, bottled, filtered, other
How much juice does the child drink? _____ What type? _____
Other fluids (such as GatorAde, Vitamin Water, soda pop etc) _____

Family Health Habits:
How often does your child use a seatbelt or car seat? Never Rarely Sometimes Often Always
How often does your child wear a helmet when participating in sports such as bike riding, skiing, skateboarding, etc? Never Rarely sometimes Often Always
Does your home have smoke detectors? Yes No
Does your home have carbon monoxide detectors? Yes No
Does anyone in the household smoke? Yes No Explain: _____
Do you feel that you live in a safe place? Yes No Explain: _____

Toxin Exposure:
Has the child ever lived near a refinery or other highly polluted area?_____
Has the child ever lived in a house with lead paint?_____
Has the child ever lived in a house that had new paint, cabinets, carpeting installed, or a new mattress and did that seem to affect their health at all?_____
Do you spray pesticides or herbicides around the house or use other toxic chemicals?_____
_____
Does the child seem particularly sensitive to perfumes or other vapors? Yes No Explain_____
_____
Does the child have any cavities or fillings? Yes No if Yes, what type of fillings? _____

Is there anything else you'd like to share with us about your child or your child's health?
_____
_____
_____
_____
_____

Thank you for taking the time to fill this out thoughtfully, thoroughly and legibly. It will assist us in giving your child the best care possible.

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Notice of Privacy Practices Consent Form

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, herby acknowledge that NaturaMed, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr Ann Sura
530-546-0400

I also understand that I am entitled to receive updates upon request if NaturaMed, LLC amends or changes its Notice of Privacy Practices in a material way.

_____
Printed Name

_____ _____
Signature Date

_____
Relationship to Patient, if signed by someone other than patient.

THIS SECTION IS TO BE COMPLETED BY NATURAMED, LLC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement

[ ] Other (specify): _____

_____ _____
Name and title of employee Date

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An Explanation of Our Financial Policy

As doctors and staff, we are passionate about what we do, and we feel that we have a calling to provide as many people as possible with the highest quality natural health care possible. Just as our services are unique, our financial policies set us apart from mainstream/conventional medicine. We have prepared this handout to answer questions you or your family members may have about the rationale for our financial policies. If, after reading this, you still have questions, feel free to speak with our staff.

Why We Do Not Accept Insurance Assignment

Many people who have contacted our office for our services have asked us why we do not bill insurance directly, when other medical providers do. We fully understand the financial challenge this presents to some patients and we wish there were a way for us to bill your insurance company. Unfortunately, at this time, there is not. Here is why:

When clinics bill health insurance companies directly, the doctors are required to become participating providers. The doctors must sign a contract that allows the insurance company to determine which services the doctor and clinic will and will not provide, and how much they can charge for those services. In general, insurance companies are not focused on any preventative or wellness services. They are heavily invested in the conventional model of health care that too often relies on drugs and surgery – often thought of as disease management rather than health care. We are committed to our Naturopathic and functional medicine model that addresses the underlying causes of your symptoms with specific nutritional and lifestyle recommendations.

A participating provider must agree to accept the fees the insurance company establishes, regardless of whether the fees are reasonable or applicable to that practice. In general, these established fees cover the actual cost of the briefest (and we believe the lowest quality) care. Doctors who are participating providers are required to accept discounted fees for their services, and they cannot bill the patient for the difference between their fee and what the insurance company will pay. Therefore, the clinic must write off the difference, often as much as 50% or more of the doctor's fee for service. At the same time, the participating provider's office overhead costs have increased dramatically because of the staff, time, and equipment necessary for processing and tracking claims.

In today's health care environment, the actual cost for doctors to provide services continues to rise, while the percentage of reasonable fees that insurance payments cover is declining. At the same time, the profits of health insurance companies and the salaries of their top executives continue to rise to record levels.

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Most doctors and clinics cope with the requirements of being participating providers by keeping their office visits very brief, so that they can see many patients within a given timeframe. When their clinic becomes unprofitable, it must be supported by another institution. Most primary care medical clinics are not self-sustaining financially, and have had to merge with hospitals whose expensive high-tech surgical and diagnostic procedures are priced to keep the clinics afloat financially. Ironically, some of our patients complain about their extremely brief and unsatisfactory office visits in other medical practices, while at the same time expressing frustration that we do not accept insurance. Unfortunately, we have found that we cannot be participating providers in the insurance networks and provide the time-intensive, well-researched, expert intensive care that we do.

Why Our Doctors Must Charge For Your Follow-Up Visits, Telephone Consultations, custom written protocol's and Email correspondence

Some patients have asked why we charge for follow-up consultations regarding lab results and exams, as well as for telephone consultations, or in the event a patient cannot return to the office to review their lab results in person, a "custom protocol" fee when other doctors do not. Our doctors are not salaried, as are doctors who are employed in large clinics and hospitals and whose salaries are partially subsidized by the hospital system they are associated with. Our doctors' pay is based solely on the time and services they provide. Like all non-salaried professionals, including lawyers and accountants, our doctors must charge for their time so we can afford to provide you with care and remain in business. In general, we only charge for our time spent directly communicating with you or working on your case. Our doctors spend considerable non-reimbursed time each week consulting with each other and other providers regarding your care, reviewing your records, and meeting with staff to improve the quality of our services.

In follow-up visits, our doctors spend time discussing your results with you. For example, it is relatively simple to inform a patient that her mammogram is negative; but it is entirely different to discuss the results of more complex functional evaluations and to recommend practical lifestyle and dietary strategies that may help to prevent breast cancer. Patients often complain that conventional doctors do little to nothing in the way of truly preventative medicine. We want you to understand that preventative health care takes considerable time and expertise on the part of the doctor, and someone has to pay for that time and expertise.

About the Charges for Our Doctors' Services

Some patients may have the mistaken impression that our doctors take home the majority of the fees we charge for their services, and that the doctors have a great deal of leeway to offer discounts for those fees. In fact, our doctors take home only a fraction of the fees collected for their services. This is

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because a clinic like ours requires highly trained staff and extensive, expensive professional continuing education. The majority of our fees support the overall mission of providing high quality natural health care, not the doctors' paychecks. Our doctors have chosen this work because it is their passion and their calling, and certainly not because it is a way to make a lucrative income. In fact, most Naturopathic medical doctors who choose private practice know that their income will be substantially lower than it would be if they were practicing in a more conventional manner that is fully supported by the health care reimbursement system.

Why We Sell Nutritional Supplements and How We Price Them

We recommend nutritional supplements as an adjunct to dietary and lifestyle modification. This approach is central to the well-researched and science-based practice of functional medicine, which all of our professional staff have studied. We sell therapeutic quality nutritional supplements as a service to our patients. With a few exceptions, we do not sell nutritional products of similar quality to those that are widely available over the counter. We purchase highquality nutritional products from the top nutritional research laboratories in North America and Europe and we price them to cover our costs of providing them. Since we have very limited space in our clinic to stock the variety of nutritional supplements our patients are prescribed for various health conditions, we drop ship prescribed supplements to our patients. This ensures that each patient gets exactly what they need of the highest quality professional line supplements available delivered directly to their door. Shipping times vary from 1 to 7 days depending upon the supplier so patients should call the office at least 1 full week before running out of supplements to have refills sent to them.

For more information on our nutritional supplement policy, please read our "Informed Consent Regarding Nutritional and Herbal Supplements," which is available on our website or at the front desk.

We hope you have found this explanation helpful. If you have any further questions, do not hesitate to speak with Bertha or Paoloa at the front desk.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways Dr. Ann Sura, ND and NaturaMed, LLC may collect, store, use and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

Federal and state laws require us to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is still in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

Uses and Disclosures of Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are illustrations of the different types of uses and disclosures that we may make without obtaining your authorization.

- **Payment.** We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **Treatment**. We may use and disclose your protected health information to assist your other health care providers in your diagnosis and treatment.
- **Health Care Operations**. We may use and disclose your protected health information in order to perform various operational activities.
- **Enrolled Dependents and Family Members**. We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for you.

Other Permitted or Required Disclosures

- **As Required by Law**. We must disclose protected health information about you when required to do so by law.
- **Public Health Activities**. We may disclose your protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence**. We may disclose your protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities**. We may disclose protected health information to government oversight agencies (e.g. state insurance departments) for activities authorized by law.
- **Judicial and Administrative Proceedings**. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement**. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

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- **Coroners or Funeral Directors**. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties.
- **Research**. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety**. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions**. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation**. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures With an Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding your Protected Health Information

You may have certain rights regarding protected health information that Dr. Ann Sura,ND maintains about you.

- **Right To Access Your Protected Health Information**. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right to Amend Your Protected Health Information**. If you feel that your protected health information maintained by Dr. Ann Sura is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request, if for example, you ask us to amend information that was not created by Dr. Ann Sura, or you ask us to amend a record that is already accurate and complete. If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronically). For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right to Request Restrictions on the Use and Disclosure of YourProtected Health Information**. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a

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restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications**. You have the right to request that we use a certain method to communicate with you or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights**. You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

Health Information Security

NaturaMed, LLC requires its employees to follow its security policies and procedures that limit access to health information about patients to those employees who need it to perform their job responsibilities. In addition, Dr. Ann Sura, ND maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any other information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may file a complaint with us by contacting the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.
If you have any questions or complaints, please contact:

Dr Ann Sura
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