Be Well Medical
5510 W Chandler Blvd, Suite 3
Chandler, Arizona, US - 85226

Be Well Consent to Treatment and HIPAA Privacy Practices

The following document is comprised of two sections: 1) THE HIPAA PRIVACY POLICY and 2) CONSENT TO TREATMENT.

Please read this notice carefully. The Health Insurance Portability and Accountability Act (HIPPA) describes how medical information about you is protected, and circumstances under which your protected heath information may be disclosed. You have the right to obtain a paper copy of this notice upon request, even if you have agreed to accept this notice electronically.

1. HIPPA NOTICE OF PRIVACY PRACTICES

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

We are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Be Well Medical Center would only disclose your protected health information to individuals who you designate below, to coordinate your health care with other clinicians involved in your care, or if required by law. *

☐ I understand

I give permission for my relative/ other party to have access to my medical records, to have personal details held by Be Well Medical Center, and for staff to discuss this with my relative/ other party listed below. Please list below any parties who can have access to your healthcare information.

☐ Yes ☐ No

Names and relationship to you (you may designate multiple people)

2. INFORMED CONSENT AND REQUEST FOR MEDICAL EVALUATION

I consent to being treated at Be Well Medical. I understand that my care as a patient at Be Well Medical is directed by licensed naturopathic physicians. I consent to services rendered and provided to me by the physician participating or consulting about my care.

Be Well Medical
5510 W Chandler Blvd, Suite 3
Chandler, Arizona, US - 85226

I, (your name), hereby request and consent to consultation and treatment with Be Well Medical clinical team. * ____________________

Notice to pregnant women: Please alert your provider of confirmed or suspect pregnancy, as some of the therapies prescribed could present a risk to the pregnancy.

☐ I understand ☐ N/A

Notice to individuals with bleeding disorders, or who are currently taking blood thinning medications. For your safety it is vital to alert your provider of these conditions. *

☐ I understand ☐ N/A

I understand the US Food and Drug Administration has not approved nutritional and herbal supplement prescriptions for specific disorders and symptoms. Treatment plans involving herbal and dietary supplements are recommendations, not prescriptions. Recommendations are made on the basis of evidence based medicine from cumulative scientific studies and time-honored clinical practices from around the world to maximize benefit and minimize risk to myself, the patient. *

☐ I understand

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Be Well Medial Center, and will comply with them in all respects. I acknowledge that I have received the HIPAA Notice of Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to evaluation and treatment, which applies to the entire course of care for my present condition and any future conditions for which I seek treatment with Be Well Medical Center.

PATIENT SIGNATURE * ____________________

Name of Guardian (if applicable): ____________________

Today's date: * ____________________