

SEVEN CIRCLES NATURAL MEDICINE

Patient Procedure Contract and Acknowledgement

We ask that every patient read and sign to indicate their agreement to the following information. You will receive a copy for your records.

- Please be prepared to provide insurance card (if applicable) at the time of each visit.
- **Each patient is responsible for knowing the terms and coverage of your insurance plan.** If you have insurance that the practitioner “accepts,” it does not guarantee payment will be made from your insurance company. You will be personally responsible for the bill. Please note; Medicare and any supplemental plans will not cover any acupuncture or naturopathic care unless you also have a secondary plan. Patients are responsible for all deductible payments, co-pays and co-insurance.
- **A minimum of 24 hours notice is required for appointment cancellations** except in legitimate emergencies as determined by the doctor. Cancellations made less than 24 hours from the appointment **may be charged a \$50 fee** for the first absence and the full amount of the visit for all missed appointments thereafter. If patient takes first available appointment fee will be waived.
- Payments for dispensary items and/or copays are due at the time of service; cash check, credit or debit cards are accepted.
- Though medical advise or treatment recommendations may be declined, neither Dr. Marleen Haverty, Turtle, Susanna Niveen Farahat, nor Seven Circles Natural Medicine will be held accountable for anything that may happen as a result of your refusal.
- You may authorize that medical information be communicated via voicemail or email by indicating and initialing here:
Phone for voicemail: _____ Initials: _____
Email: _____ Initials: _____

We discourage texting however understand the convenience. If you'd like to discuss in more detail please send an email to 7circlesportland@gmail.com.

By signing below you acknowledge your understanding of the terms and conditions listed above and agree to adhere to the policies of the clinic and physician.

Patient signature or signature of legal guardian

Printed name

Date

New Patient Registration

Full Legal Name: _____

Preferred Name: _____ Pronoun(s): _____

Sex (as designated on your insurance): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Email: _____

Date of Birth: _____ SSN: _____

Responsible Party/Emergency Contact: _____

Emergency Contact Phone (if different than above): (____) _____

Address (if different than above): _____

Primary Insurance

Insurance Carrier: _____ Insurance Phone: (____) _____

ID Number: _____ Group Number: _____

Co-Pay: _____ Relationship to Patient: _____

If you wrote "Self" in Relationship to Patient you may leave the following blank.

Subscriber Name (if not patient): _____

Date of Birth: _____ SSN: _____

Phone: (____) _____ Address: _____

Secondary Insurance

Insurance Carrier: _____ Insurance Phone: (____) _____

ID Number: _____ Group Number: _____

Co-Pay: _____ Relationship to Patient: _____

Subscriber Name (if not patient): _____

Date of Birth: _____ SSN: _____

Phone: (____) _____ Address: _____

Is this visit injury related? Yes No If yes, is the injury work related? Yes No If yes,
is the injury from a motor vehicle accident? Yes No State: _____

Employer: _____ Injury Date: _____

By signing I agree that all the information provided above is complete and correct.

Signature

Date

Seven Circles Natural Medicine

Informed Consent for Treatment

I, the undersigned, hereby authorize Seven Circles Natural Medicine to perform the following specific procedures necessary to facilitate my diagnosis and treatment. Medical treatments and procedures not within the scope of our licensed practice will be referred to an appropriate provider.

Diagnosis and Treatment

- Common Diagnostic Procedures: venipuncture, pap smears, laboratory, and physical exam, etc.
- Minor Office Procedure: dressing a wound, ear lavage, etc.
- Botanical Medicine: granulation teas, alcohol-based tinctures, capsules, tablets, creams, poultices, compresses, suppositories, etc.
- Homeopathic Medicine: the use of high quality dilute quantities of naturally occurring plants, animals, and minerals to gently stimulate the body's healing responses.
- Lifestyle Counseling and Hygiene: nutrition therapy and promotion of wellness, including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.
- Psychological Counseling
- Contraception: oral birth control pill, diaphragm.
- Acupuncture: insertion of specialized sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.
- Cupping: a technique to relieve symptoms with cups made of glass, bamboo, or other materials, which are placed on the skin to create a vacuum with heat or other device.
- Gua Sha: a rubbing technique on areas of the body with a round instrument.
- Moxa: an indirect warming technique on an acupuncture point using an herbal stick, string, or ball moxa.
- Tuina: an ancient massage used to treat a wide variety of common disharmonies.
- Legend substances: pharmaceutical agents approved for prescription by naturopathic physicians.

Potential Risks: discomfort, pain, infection, blistering, and temporary discoloration of the skin at the site of procedure, an aggravation of symptoms existing prior to treatment, allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from needle insertion, injections, venipuncture, or other procedures.

Notice regarding pregnancy: All patients must alert the doctor immediately if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that Seven Circles Natural Medicine has given me no guarantees regarding cure or improvement of my condition. I hereby release Seven Circles Natural Medicine from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I acknowledge that Seven Circles Natural Medicine is not responsible for patient compliance and will not be held responsible for outcomes due to patient non-compliance. I understand that I am free to withdraw my consent and to discontinue participation in the above procedures at any time.

I understand that a record will be kept of all health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself, or unless required by law. I understand that I may look at my medical record and request a copy of it. I understand that my medical record will be kept no longer than ten years after the date of my last treatment. I understand that my practitioner will answer any questions I have.

By signing I agree that I have read and understand the above and consent to treatment.

Signature

Date

Seven Circles Natural Medicine

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Seven Circles Natural Medicine's Notice of Privacy Practices effective

_____.

Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Seven Circles Natural Medicines Notice of Privacy Practices effective

_____.

Name (please print): _____

Relationship to patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____