Consent Forms

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IMPORTANT INFORMATION FOR SANCTUARY PATIENTS

APPOINTMENTS

- As a courtesy, we call to confirm the appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or reschedule.
- Sanctuary Integrative Medicine has a 24-hour cancellation policy in regards to scheduled appointments. If for some reason you cannot be present for a scheduled appointment, please notify us 24 hours prior to that appointment. We would be happy to re-schedule your appointment for another time. If appointments are not cancelled within the appropriate time frame, we reserve the right to bill the patient for 50% of the cost of the missed appointment. We strive not only to keep our patients healthy but to keep healthy professional relationships as well. Please join us in collaborating on a healthy relationship throughout your care."

BILLING/INSURANCE

- We will accept and bill insurance for the services of functional medicine and naturopathic medicine. If your insurance is not with an accepted carrier, payment will be due at the time of your visit. Specialty labs are generally not covered by insurance. If any specialty lab test kits are given at an appointment, payment is expected at the time of your visit as well.
- The following services are not covered by insurance and therefore, payment will be due at the time of your visit: Traditional Chinese Medicine, Acupuncture, Therapeutic Massage, Brennan Energy Healing, Reiki Healing, Yoga Classes or Yoga Dance.
- The Sanctuary accepts cash, checks, or Visa/Mastercard.

Provider Fees	Initial		Follow Up		Initial (Child)		Follow Up (Child)	
	Time	Amount	Time	Amount	Time	Amount	Time	Amount
Dr. Logan, MD	60 - 90 mins	$ 300	30 - 60 mins	$ 150				
Greg Burkland, ND	60 - 90 mins	$ 125	30-45 mins	$ 65	30-45 mins	$ 85	30 mins	$ 40
Acupuncture	90 mins	$ 90	60 mins	$ 70				
Massage Therapy	50 mins	$ 70	50 mins	$ 70				
Thai Massage Therapy	90-120 mins	$ 100	60 - 75 mins	$ 80				
Brennan Energy Healing	90 mins	$ 90	60 mins	$ 70				
Reiki	60 mins	$ 65						
FirstLine Therapy	90 mins	$ 105	60 mins	$ 75				

LAB TESTS

- After your initial and follow-up consultations, lab tests and/or diagnostic tests may be ordered. Testing recommendations and cost(s) per test will be reviewed.
- Lab tests are performed "fasting," which means nothing except water 8 hours before your visit.
- Some lab tests take up to 6 weeks to be finalized and sent to our office. A copy will be mailed to you when they are finalized. If your follow-up appointment was not booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.

PRIMARY CARE PHYSICIAN

- Please note that Dr. Logan is not your primary care physician. We recommend that you have a primary care physician.

Patient Signature: ______________________________ Date: ______________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Facility or Person: ______________________________

Address: ______________________________

Telephone Number (   ) ____ - __________   Fax Number: (   ) _____ - __________

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to Sanctuary Integrative Medicine all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ☐ Yes ☐ No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: ☐ Yes ☐ No

Genetic Testing: ☐ Yes ☐ No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Sanctuary Integrative Medicine, its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

Name: ______________________________ D.O.B. ______________

Signature: ______________________________ Date: ______________

Information Released: ______________________________ Date: ______________

Medical Records Technician Name: ______________________________

Signature: ______________________________

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Sanctuary Integrative Medicine provides patients the opportunity to communicate with their physicians, healthcare providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Sanctuary Integrative Medicine that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Sanctuary Integrative Medicine will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
   a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Sanctuary Integrative Medicine physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. Sanctuary Integrative Medicine may forward e-mail messages within the practice as necessary for diagnosis and treatment. Sanctuary Integrative Medicine will not, however, forward the email outside the practice without the consent of the patient as required by law.
   c. Sanctuary Integrative Medicine will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health or developmental disability; or alcohol and drug abuse.
   f. Sanctuary Integrative Medicine cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication, but Sanctuary Integrative Medicine is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
   g. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform Sanctuary Integrative Medicine of any types of information you do not want to be sent by e-mail.
   h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from Sanctuary Integrative Medicine to protect confidentiality. Sanctuary Integrative Medicine is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Sanctuary Integrative Medicine.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name: ______________________________ Date: ______________

Signature: ____

SANCTUARY INTEGRATIVE MEDICINE ~ THERAPEUTIC AGREEMENTS

Statement of Collaboration

As a Sanctuary practitioner, I agree to use my knowledge, skill, and experience to the best of my ability in the best interest of the people I work with. I believe it is my responsibility to:

- Assess each person's situation based on the information they provide
- Assist them to sort through their health-related challenges
- Provide information and options about treatment modalities that are available
- Support them to make conscious decisions regarding their health
- Develop, implement, and support a plan of care that will promote physical, mental, and spiritual health
- Evaluate the effectiveness of a plan of care
- Make referrals to community resources as appropriate

As a Sanctuary client, I agree to use my knowledge, skill, and experience to the best of my ability in the best interest of my own physical, mental, and spiritual health. I believe it is my responsibility to:

- Provide my Sanctuary practitioners(s) with information that is relevant to my health
- Be willing to sort through my health-related challenges
- Ask questions related to treatment options and information that is provided
- If supplements are mutually agreed as part of my treatment plan, take them only according to directions given to me, and discontinue use if side effects ensue and report this to my Sanctuary practitioner(s)
- Work together with my Sanctuary practitioner(s) to develop a plan of care that incorporates goals that are meaningful to me and that will promote my physical, mental, and spiritual health
- Make conscious decisions to nurture intrinsic healing and promote balance in my life
- Evaluate the effectiveness of my plan of care
- Participate in all scheduled treatment sessions

Practitioner Signature ____

Patient Signature ____

Date ____________________

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes you rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians' practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information.
Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil ,criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your PHI for the purposes of Treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. I physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your PHI.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 802.775.1398.

Signature below is only acknowledgement that you have received this notice of Privacy Practices.

Print Name: ____

Signature: ____ **Date:** __________________________

Witness: ____