CALIFORNIA INTEGRATIVE HEALTHCARE/VALLEY NATURAL HEALTH
CONSENT FOR TREATMENT POLICY

Purpose of this Consent Form: This form is provided to the patients of California Integrative Health/Valley Natural Health. We want to let you know about the care and treatment that you will receive from our office and to obtain your consent to allow us to provide your care. In the case of patients under the age of 18, or other individuals who may not be capable of making informed choices about their healthcare, we provide this form to their parents, guardians or caregivers to evaluate and sign on behalf of the patient.

General Consent and Conditions of Treatment: I consent to the treatment that will be provided by CIH/VNH primary care providers, as well as their assistants and other staff members. I understand that a medical record will be prepared and maintained about me by CIH/VNH, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the Clinic for that purpose and paying any required fees.

Student Participation: I understand that CIH/VNH participates in the education of students in healthcare. I can decline their participation in my care at any time.

Communication with Health Care Providers: To safeguard my health information, I understand that CIH/VNH practice is to convey test results to patients by phone, mail (to the address provided by the patient or caregiver) or in person. I understand that our policies do not permit discussions about my health information, or transmission of my test results via email, since email is generally not a secure method of communication. I understand that I always have the option to call the office or make an appointment to come in to discuss my test results or health issues with a provider.

Emergency Situations: I understand that in emergency situations, it may be necessary or advisable for CIH/VNH to perform services and/or procedures that may not be fully discussed with me (or my parent or caregiver) in advance. I consent to these services and/or procedures under those circumstances.

Billing and Collection: I give CIH/VNH permission to share my information with my insurance company for purposes of seeking payment, as well as any third-parties that may be involved in billing or collection services for the office. If I don't want certain information shared with my insurance company, I have the right to notify the office before any billing takes place but understand that I must also pay for the treatment that I do not want shared in full, at the time the treatment is provided to avoid sharing the information with my insurance company.

Work-Related Injuries or Disabilities: I understand that if I receive treatment for a work-related injury or illness, some of my information will be shared with my employer or its workers' compensation insurance carrier, in connection with evaluation of my claim, and to help my employer address any safety issues at the workplace. I also understand that if I request special accommodations based upon a disability, a limited amount of my medical information may be shared with my employer, to the extent warranted to evaluate or confirm my disability.

Authentication: I understand that CIH/VNH will require patients to provide identification in connection with visits to the office or in connection with any telephone calls in which personal information may be requested. This helps CIH/VNH ensure that it is not divulging personal information nor treating an unauthorized person. If I cannot provide the necessary identification, I may not be able to receive treatment or receive the information that I am seeking from my medical record until I am able to satisfy the office's authentication requirements. Such documents will include my valid driver's license and/or a picture I.D. from my employer. I understand that I must have a release of information for anyone that I wish to have access to or given information about my care.

Personal Belongings: I understand that the office takes steps to ensure that the waiting room and other areas of the Office are safeguarded. However, I understand that I am solely responsible for any personal belongings that I bring with me to the office, including jewelry and other valuables.

Notice of Privacy Practices: By signing this form, I acknowledge receipt of CIH/VNH Notice of Privacy Practices.

Validity of Consent: I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing, to the office. I understand that at any time that the primary care providers feel as if I am not being honest or upfront with my healthcare it would be grounds for discharge from the office. Any policy violation, disrespectful, inappropriate or otherwise offensive behavior/language will not be tolerated and will grounds for being discharged from the office. Patient who are discharged from CIH/VNH will be notified via mail.

The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent.

I HAVE READ OR HAD READ TO ME THIS CONSENT FORM AND UNDERSTAND AND ACCEPT ITS TERMS.

_____	_____	_____
SIGNATURE	PRINTED NAME/RELATION	DATE