DISCLAIMER POLICIES 2017

Welcome to wellness integration at Holistic Healthship, Inc with Dr. Keri Brown, N.D. In Naturopathic Medicine, we focus on treating the whole person or bio terrain to help restore health from the ground up. Our focus is on supporting the body, mind and soul that affects health and organ function in relationship to stress, injury, disease or trauma. We do this by helping you remove the distress and restore the function, therefore health. We consider the interconnection of all health issues, underly problems and put the big picture together for recovery and wellness. Dr. Brown approaches your health with the goal of treating the causes and thus improving function. In choosing this approach, you are selecting to combine the use complimentary and alternative medicine methods to use for self healing. Naturopathic Medicine is based on science from medical literature, as well as historical knowledge of natural medicine, traditional healing wisdom and nature cure.

NATUROPATHIC & FUNCTIONAL MEDICINE CONSULTATIONS

Length of time for initial consultation is based on the complexity of your state of health. Additional time needed will added based on the complexity of your state of health.

Length of time for the first follow-up appointment is determined by Dr. Brown at the time of your new patient visit and is based on the complexity of your state of health.

If you are getting lab testing, the length of time for the first follow-up appointment will be determined for review of the test results. E-mails are answered on hourly billable time in 5 minute intervals to credit card on file.

LAB TEST

We use Lab Cores phlebotomist located around the USA to draw blood on all of our testing that require blood and serum. IF Dr. Brown order test they are through Direct Labs. We will arrange for the lab requisition to be sent to you and you will them be responsible for scheduling your blood draw through Lab Core. PLEASE ARRIVE FASTING – and bring your requisition to your appointment. (Nutrition-only appointments and blood draws do not require fasting). Some labs that involve stool, urine or saliva samples are done at home. You will be given all lab kits and step-by-step instructions for at-home tests at the time of your consult. All lab results will be reviewed with you at the time of your follow up appointment. We do not email lab results to clients. The exception to this is if you have a follow up appointment by phone – we will email you your lab results prior to your appointment for your review.

PHONE CALLS AND MESSAGES

When leaving a message, please include the following information:

- Full name, spell your last name
- Reason for call: supplements ordered if needed
- Phone number(s)
- E-mail address (if desired)

PRIMARY CARE PHYSICIAN

Please note that Dr. Keri Brown, N.D. does not act as a primary care physician or facility. We recommend that you have a primary care physician in times of emergencies.

Naturopathic Doctors are registered by the state to practice naturopathic medicine under the “Naturopathic Doctor Act.” They are not permitted to perform the following acts:

- Prescribe, dispense, administer or inject any prescription medications or devices other than epinephrine for anaphylaxis and barrier contraceptives (not including IUDs).
- Perform surgical procedures, including surgical procedures using a laser device.
- Use general or spinal anesthetics, other than topical anesthetics.
- Administer ionizing radioactive substances for therapeutic purposes.
- Treat a child who is less than two years old.
- Treat a child who is two years of age or older, but less than eight years of age, unless: (1) this form is fully completed and signed; (2) the most recent immunizations schedule recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services is provided to the parent or guardian with this form; and (3) a release of information is provided to the parent or guardian requesting permission to exchange information with the child’s licensed pediatric health care provider, if the child has one.
- Practice medicine, surgery, or any other form of healing other than Naturopathic Medicine.
- Practice obstetrics. Perform chiropractic services (spinal adjustments, manipulation, or mobilization).
- Recommend the discontinuation or counsel against a course of care, including a prescription drug that was recommended by another health care practitioner licensed in Colorado, unless the Naturopathic Doctor consults with the health care practitioner.

CONSULTATION EXCLUSIONS


CREDENTIALS

Dr. Keri Brown, ND is a licensed naturopathic doctor registered in the state of Colorado ND-000079. Dr. Brown is a 1998 graduate of Bastyr University, WA holding a doctorate in Naturopathic Medicine and a 1988 graduate of Fort Lewis College, CO with a BS in Environmental Biology and Chemistry.
**DISCLAIMER POLICIES 2016** (con’t)

Informed Consent Regarding E-mail or the Internet Use of Protected Personal Information

Holistic Healthship Wellness Consulting provides you the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has several risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients;
   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.

2. It is the policy of the Holistic Healthship Wellness Consulting that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient’s protected personal health information. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

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-mail 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, physicians, nurses and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
   c. We at Holistic Healthship Wellness Consulting will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

**CONSULTING POLICIES**
(This form must be completed and signed prior to the initial examination of the patient.)

Check one:
The patient does _____ does not _____ have a relationship with a licensed physician or pediatric health care provider.

Name, address, phone of licensed physician or pediatric health care provider:

________________________________________________________________________________________________________________________

By signing below, I acknowledge that I have read, understand and agree to these policies. I give full consent for the completion of my evaluation and provision of treatment as necessary to the professionals named above. If I have any questions about the included information, or about anything related to my treatment, I will discuss this with Dr. Keri Brown or staff as appropriate.

Name Printed: _______________________________________________________________________

Signature: ___________________________________________________________________________

Date: ________________________________

Signature of Client or Guardian (if under 16 years old)

______________________________________ __________________________________

Print Name of Child representing (if under 16 years old)

_________________________________________________________________________________

**Informed Consent Regarding E-mail or the Internet Use of Protected Personal Information**

I 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 Printed: _______________________________________________________________________

Signature: ___________________________________________________________________________

Date: ________________________________
HIPPA FORM
Health Insurance Portability & Accountability Act

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

Federal law requires us to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. HIPAA gives you, the patient, new rights to understand and control how your health information is used. That law also requires us to give you this explanation of how we maintain the privacy of your health information. We reserve the right to change our policy practices, provided the changes conform to applicable laws. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations, health care reminders and for public benefit. Any other disclosure will require your written authorization.

- Treatment means providing or managing health care and related services by one or more health providers.
- Payment means such activities as obtaining reimbursement of services, billing or collection activities and utilization review.
- Health care operations include the business aspects of running the clinic, quality assessment, evaluating practitioner, provider performance, training programs, accreditation, certification or credentialing activities.
- Reminders means providing you with appointment reminders or to inform you of changes in the clinic services or hours by such means as postcards, voicemail messages or letters.
- Public benefit means the disclosure of information for the following types of reasons: for public health activities including disease and vital statistic reporting; to report abuse, neglect or domestic violence; to health oversight agencies; to law enforcement officers pursuant to subpoenas and other lawful processing; medical examiners and coroners; to avert a serious threat to health or safety; about certain research activities; and as authorized by state and federal laws. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

With Your Authorization: Any other uses and disclosures will be made only with your written authorization. You must give such authorization in writing to disclose it for any purpose, including but not limited to: having a copy sent to another physician or receiving a copy for your own personal use. You may revoke such authorization in writing and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Chief Medical Officer. The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying cost and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee.
- The right to amend your protected health information. Your request must be in writing and must include an explanation why you should amend your records. We may deny your request under certain circumstances.
- The right to receive an accounting of disclosures of your protected health information. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. You have recourse if you feel your privacy protections have been violated.

If you want more information about our privacy practices or have questions or concerns, please contact us by phone 970-889-3541, or by mail: Holistic Healthship, Inc, P.O. Box 270496, Louisville, CO 80027.

I have read and understand the above-stated information.

X ________________________________ Date: __________________

Patient’s Signature Date

________________________________________
Printed Name

X ________________________________ Date: __________________

Legal Guardian’s Signature (if patient is under 16 years)

________________________________________
Printed Name