Princeton Integrative Health

Repair. Restore. Rebalance.

Consent Form

134 Franklin Corner Road,Suite 101B
Lawrenceville, NJ 08648
P. 609.512.1468
www.princetonih.com

Important Patient Information

Appointments

- It is your responsibility to keep the scheduled appointment or reschedule in a timely manner.
- Our office policy for rescheduling and or cancelling is 48 hours (or two business days) prior to your scheduled appointment.
- Notification of need to reschedule or cancel provided in less than 48 hours will be subject to cancellation fees.
- Cancellation the day before will result in half the session amount being charged to the card on file.
- Same day cancellations and/or no shows will result in the full session amount being charged to the card on file.

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.
- Some lab tests are performed “fasting”, which means nothing except water 12 hours before your test.
- Some lab tests take up to 4 weeks to be finalized. The results will be given to you at your follow-up appointment or emailed to you when they are finalized. If your follow-up appointment was not booked at the time of your initial visit, then you will need to contact the office to schedule a follow-up appointment.
- For most lab testing, you will pay the lab directly for all payments due.

Billing/Insurance

- Payment for the office visit or phone consultation or lab tests is expected at time of service. We accept cash, check, credit cards or HSA and FSA. All credit card payments will be processed at the time of your visit.
- We do not accept insurance. We will provide you with a billing summary, a “super bill, which you can submit to your insurance carrier. We will assist you in this process as possible / applicable.

Authorization for Release of Medical Records (US Patients ONLY)

Requesting records: Name of Dr. _____

Physician Address: _____

Telephone Number: _____ Fax Number: _____

THE PURPOSE FOR THIS RELEASE:

ou are hereby authorized to furnish and release to Princeton Integrative Health 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 there to. 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 HIT or HTLA-III test results or treatment: Yes No

Genetic Testing: Yes No

PLEASE NOTE: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit 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: employees of or 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 the 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.

Patient's Name: _____ D.O.B. _____

Signature: _____ Date: _____

Records Requested by Princeton Integrative Health: _____

Signature: _____ Date: _____

Please send Records to:

Princeton Integrative Health | 134 Franklin Corner Road, Suite 101B | Lawrenceville, NJ 08648
Phone: 609.512.1468 | Fax: 609.512.1546

Informed Consent Regarding Email or Internet Use of Protected Personal Information.

Princeton Integrative Health provides patients the opportunity to communicate with their physicians, health care 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 email.

2. It is the policy of Princeton Integrative Health 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. Princeton Integrative Health 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 Princeton Integrative Health physicians, other health care practitioners, insurance coordinators, and, upon written authorization, other health care providers and insurers will have access to e-mail messages contained in protected personal health information.

b. Princeton Integrative Health may forward e-mail messages within the practice as necessary for diagnosis and treatment. Princeton Integrative Health will not, however, forward the email outside the practice without the consent of the patient as required by law.

c. Princeton Integrative Health 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 disclosure 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. Princeton Integrative Health cannot guarantee that electronic communications will be private. We will take reasonable steps to protect the confidentiality of e-mail or internet communication however Princeton Integrative Health is not liable for improper disclosure of confidential information not caused by its employees' gross negligence or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Princeton Integrative Health of any types of information that 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 Princeton Integrative Health to protect confidentiality. Princeton Integrative Health 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 Princeton Integrative Health.

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.

Privacy Policy

Under the Personal Health Information Protection Act, 2004 (PHIPA), you have the right to consent, or to withhold your consent, to the collection, use and disclosure of your personal health information, except in specific circumstances where the law authorizes Princeton Integrative Health to collect, use or disclose your information without consent.

Princeton Integrative Health collects your personal health information directly from you, from a person acting on your behalf, and from others such as healthcare providers. Princeton Integrative Health will not collect more personal health information than is reasonably necessary to meet its purposes.

Princeton Integrative Health uses personal health information to:

- Assess your health needs and provide safe and efficient care
- Plan a strategy to address your concerns
- Enable us to contact and maintain communication with you to distribute health care information and to book and confirm appointments
- Communicate with other treating health care providers, including other dentists, physicians, pharmacists and lab technician (with your consent and if required)

Our office will ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols
- We do not share your information with any government or insurance agency

Integrative Medicine - Informed Consent

Care Program

Integrative Medicine involves the recommendation of lifestyle, dietary and supplement changes and/or additions, based on my history and test findings. Integrative medicine uses the most recent research to assess the body as a whole, emphasizing the relationship between your body and your internal and external environment.

The relationship between the client and integrative medicine provider includes mentorship and guidance towards achieving a healthy balance within the body. I understand that no diagnoses are made and no treatment for a pre-existing diagnosis will be rendered. Integrative medicine addresses the underlying pathophysiology that may be contributing to these prior diagnoses.

Testing

Integrative lab testing involves the evaluation of nutritional, biochemical and physiological imbalances used to make the appropriate recommendations.

Recommendations

All recommendations are meant to be in the patient's best interest and I acknowledge that the doctor may not be able to anticipate all risks and complications. I will keep my doctor fully informed about any changes in medication, supplements, diet, and any other pertinent information.

Consent

I acknowledge that I have discussed, or have had the opportunity to discuss, with my integrative medicine provider the nature and purpose of the consultations and the contents of this Consent Form. I agree to accept the care program on my own free will and I have read the consent form in its entirety. I provide consent for integrative medicine care for the duration of this program and any future consultations required.

Signature: _____ Date:_____

Client Name: _____

Client Adress:_____

Signature: _____ Date:_____

Princeton Integrative Health Name: _____