(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

Patient Information

Name _____Birthdate_____

Address_____

City_____State_____Zip_____

Phone#s Home_____Work_____Cell_____

Email Address_____

Would you like to receive our newsletter? Yes____No____

Height_____Weight_____Gender Male □ Female □

Occupation_____Employer_____

Marital Status Single □ Married □ Divorced □ Widowed ☐

Do you have children? # of children____# living at home____Ages_____

Name of Spouse/Significant Other_____

Name of Parent/Legal Guardian if you are under 18_____

Relationship to you_____Contact number_____

Emergency Contact Person

Name_____Relationship to you_____

Contact Number_____

Whom may we thank for referring you?_____

(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

Office Policies

Welcome to Valley Natural Medical Center! Thank you for selecting us for your health care needs. We are honored to be of service to you and your family.

To keep the office running on time and to be respectful of your time, we carefully schedule appointments. Therefore late cancellations or missed appointments will be billed a $75 cancellation fee. If you need to cancel or reschedule, please do so by calling at least 24 hours prior to your appointment. If you arrive late, please be prepared for a shortened visit or possibly to reschedule your visit.

Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience we accept cash, Visa, Mastercard and American Express payments. We do not accept personal checks.

If you should desire to submit costs associated with your care to your insurance company, Valley Natural Medical Center will provide you with the necessary codes, but Valley Natural Medical Center does not guarantee that your insurance will reimburse any of those expenses.

I understand that if I am insured through Medicare, Medicare Advantage, Medicaid, AHCCS, Mercy Care, Tri-Care and other government insured plans that I will not be reimbursed for services ordered by a naturopathic physician.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read this document completely and I understand and agree with all of its contents demonstrated by my signature below.

_____

Signature of Patient/Parent/Legal Guardian Date

Valley Natural
Medical Center

(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

Informed Consent and Request for Naturopathic Medicine

I understand that the evaluation, diagnosis and treatment by a naturopathic physician, and specifically by Dr. Ann Lovick or Dr. Wendy Dickerson, may include but is not limited to:

- Interview (history taking)
- Physical examination
- Common diagnostic procedures (such as diagnostic imaging, laboratory evaluation of blood, urine stool and saliva, Pap smears)
- Dietary advice and therapeutic nutrition (such as the therapeutic use of foods, diet plans, nutritional supplements, intravenous and intramuscular injections)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body surface)
- Botanical medicines and nutraceuticals, also referred to as supplements (such as the prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the form of teas, pills, creams, powders, tinctures-which may contain alcohol, suppositories, topical creams or other forms)
- Homeopathic remedies (highly diluted substances)
- Over the counter medications
- Prescription medications to be filled at a pharmacy

I understand and I am informed that in the practice of Naturopathic Medicine there are risks and benefits with evaluation, diagnosis and treatment including, but not limited to the following:

> Potential risks: pain, discomfort, minor bruising, allergic reactions such as rash, hives, nausea, vomiting, headache, gas, and aggravation of pre-existing conditions

I understand that some treatments may be inappropriate during pregnancy, and I will immediately notify the doctor if I am currently pregnant or become pregnant during the course of treatment.

I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. To properly treat my medical condition, Dr. Lovick or Dr. Dickerson must be contacted immediately if an adverse reaction or condition occurs. If an emergency medical condition arises or if I am unable to reach Dr. Lovick or Dr. Dickerson, I will seek treatment immediately from a trauma center or call 911. I

Valley Natural
Medical Center

(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

understand that I am responsible for all costs associated with medical treatment obtained from Dr. Lovick or Dr. Dickerson or other physician, hospital or medical facility.

By signing below, I (print name), _____, acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment for my present condition and any future conditions for which I am seeking treatment.

_____

Signature of Patient/Parent/Legal Guardian Date

Valley Natural
Medical Center

(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

NOTICE OF PRIVACY PRACTICES

To Our Patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated but we must provide you with the following important information:

Use and Disclosure of your health information in certain special circumstances:
The following circumstances may require us to use or disclose your health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help you prevent the threat.
5. If you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Worker Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we

Valley Natural
Medical Center

(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Valley Natural Medical Center 3301 N Miller Road, Suite #130, Scottsdale, AZ, 85251. *We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to Valley Natural Medical Center 3301 N Miller Road, Suite #130, Scottsdale, AZ, 85251. You must provide us with a reason that supports your request for amendment. *We must respond to this request within 60 days. The physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Lovick, Dr. Dickerson and Valley Natural Medical Center. All complaints must be submitted in writing. You will not be penalized for submitting a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy policies, please contact Dr. Lovick, Dr. Dickerson and Valley Natural Medical Center.

By signing below I (print name), _____, acknowledge that I have received, read, understood and accepted a copy of Valley Natural Medical Center, PLLC Notice of Privacy Practices.

_____

Signature of Patient/Parent/Legal Guardian Date

(480) 980-5794

3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 428-4251 fax

Medical Records Release

Patient Legal Name		Date of Birth
Address		Phone #
City	State	Zip

I hereby authorize the release of all protected health information of the person listed above to Dr. Ann Lovick and Dr. Wendy Dickerson.

Valley Natural Medical Center
3301 N Miller Road, Suite #130
Scottsdale, AZ 85251
(480) 980-5794
(480) 428-4251 fax

Please mail or fax the last two years of selected records:

☐Lab imaging ☐Reports/Consult Notes ☐Summary
☐Complete Medical Records

I acknowledge that records shall include all communicable disease-related information (as defined in ARS 36-3661), confidential alcohol or drug abuse information, and confidential mental health diagnosis and treatment information.
I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
I understand that there may be a fee involved with the fulfillment of this request.
I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Parent/Legal Guardian	Date