

# OpenMind Medicine

## Krista Tricarico, ND

### Consent for Medical Treatment

Naturopathic medicine is considered a safe and effective method of care; however, any treatment or procedure may have complications. It is your right to be informed of benefits and possible complications, as well as alternatives to the proposed treatment. If this has not been explained to your satisfaction, it is your responsibility to ask for more information. As your provider, I will work with you towards optimal health, but there is no guarantee for a specific cure or result. By signing below, you are requesting and hereby authorize services offered to you by OpenMind Medicine including physical examination, tests, and treatment deemed appropriate by Dr. Krista Tricarico.

### HIPAA Privacy Policy

The Department of Health and Human Services has established a privacy policy to help insure that personal health information is protected for privacy. This policy was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment and health care operations.

I respect the privacy of your personal medical records and will do all I can to secure and protect that privacy. In some cases, I may be asked to submit sections of your medical chart to your health insurance plan (if applicable) or to another practitioner (with a release of records signed by you.) If at any point you do not want me to share your personal health information, please submit to me a written request. If I need to request your records from another practitioner, I will ask you to sign a "Release of Records" form before doing so. Please speak with me or with a HIPAA Compliance Officer if you need more information.

I have read and understand the above statements regarding my Consent for Medical Treatment and the HIPAA Privacy Policy.

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**Patient's Name (Please print)**

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**Signature of Patient or Guardian**

**Date**

### Communication Consent

Please initial below if you consent to the statement and leave blank if you do not.

\_\_\_\_\_ I sometimes use email to correspond with patients as a convenience. However, these emails are not encrypted and could theoretically be intercepted. By initialing this line, you are giving me permission to correspond with you via email in spite of this potential risk.

\_\_\_\_\_ Reminder calls are regularly given the day before your appointment. By initialing this line, you are consenting to allow someone from OpenMind Medicine to leave you a phone message regarding your appointment.