

HIPAA Privacy Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this authorization; you may also request a copy of our Notice of Privacy Practices from our office manager.

By signing this form, you consent to our use and disclosure of protected health information about you, regarding treatment, payment, and health care operation. You have the right to revoke this authorization in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior authorization. The Practice provides this form to comply with the Health Insurance and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The Patient may revoke this Authorization in writing at any time: My revocation must be in writing and submitted to the Office Manager. If I do revoke this authorization however, my revocation will not affect any prior actions taken by 3 Rivers Health Center, LLC, in reliance on my authorization.

Printed Name- Patient or Representative

Relationship to Patient (if other than Patient)

Signature

Date

CONSENT TO SERVICES, CONTRACT AND STIPULATIONS

Effective July 11, 2011

I understand and acknowledge that 3 Rivers Health Center, LLC, nor any employees and all of their associates, colleagues, partners, affiliates, family, friends and assigns do not guarantee the treatments will cure me of any disease or afflictions (including cancer). I believe it is within my constitutional rights to seek any form of diagnosis and treatment, whether orthodox or unorthodox (not recommended by the AMA). We do not prescribe or diagnose; however we do attempt to educate you on food conscious diet choices, exercise and lifestyle choices if they are not contradictory to the recommendations of your primary health care provider or you physician. It is my choice whether or not to accept such diagnosis and treatment. By my signature, I attest that I have not engaged the services of those employed by 3 Rivers Health Center, LLC, to file a malpractice suit or further any investigation or prosecution by any government entity or medical association. My sole purpose and intent is seeking the services of 3 Rivers Health Center, LLC is to get help for my personal health problems.

PATIENT INITIALS _____

I understand that 3 Rivers Health Center, LLC treatment program includes Naturopathic Medicine, Nutritional Guidance, Colon Hydrotherapy and, Counseling. I also understand that the treatment may be unconventional or experimental. In such case, I agree not to hold 3 Rivers Health Center, LLC, or any employee of 3 Rivers Health Center, LLC for any untoward result. I understand everyone is different, individual results will vary for all the therapies offered at 3 Rivers Health Center. I acknowledge that my acceptance of these services binds me to pay the fee and that such fee reflects his/her knowledge and years of experience.

PATIENT INITIALS _____

I understand that 3 Rivers Health Center, LLC does the (HLB) BDNLBA blood research test. This test is an international research program started by Dr. Robert Bradford, President of Bradford Research Institute (BI). It is not intended for the diagnosis of any disease. The DBA detects systemic oxidative activity and metabolic by-products in excess of the body's ability to neutralize or eliminate them. Many of the morphological changes seen in the blood are from pathological condition. However, many of these morphological changes appear similar, particularly in the early stages. Therefore, a definitive diagnosis is not possible, with the DBA/LBA blood test alone.

PATIENT INITIALS _____

I have read (or have had read to me) the Declaration of Informed Consent to services, contract and stipulation and agree to be bound by the terms therein. I have not signed this declaration without first reading it or having it read to me and I may ask any questions useful in helping me to understand it. I further understand my agreement to the provision of this declaration is an entirely voluntarily and informed choice to which my signature attests.

PATIENT INITIALS _____

I understand that the Doctors at 3 Rivers Medical Center are Naturopathic Doctors, however they are not licensed M.D., D.O., or D.C. Their advice and treatment is based on their training and experience. It reflects their professional judgment on how to help me to the fullest of her/his abilities. In good faith, I accept service of those employed by 3 Rivers Health Center, LLC and do hold them blameless for the services they have or will render.

PATIENT INITIALS _____

I understand that 3 Rivers Health Center, LLC is not a Medicare or Medicaid provider and that my receipt is not to be submitted to Medicare or Medicaid. *Payment is due for Services at the time services are rendered unless our staff has approved payment arrangements in advance. We accept cash, check and/or credit card.*

Printed Name – Patient or Representative

Relationship to Patient (if other than Patient)

Signature

Signature