Restorative Health Clinic

6564 SE Lake Rd, Ste 100
Milwaukie, OR 97222
P: 503-747-2021 F: 503-747-2802
www.restorativehealthclinic.com

HIPAA Policies

Messages regarding relevant health information (Consultation reminders, lab recommendations, questions, etc.) may be left on my answering machine/voicemail/email at the following numbers:

Home Phone_____ Cell Phone_____

Work Phone_____Other_____

____**(Initials)** I GIVE PERMISSION for Restorative Health Clinic to disclose relevant health information (my health status, treatment & medication recommendations, and payment arrangement(s) to the individual(s) I have listed below. If you prefer that we do not disclose your information to anyone, then you may leave this section blank.

Name: _____ Phone:_____

Name: _____ Phone:_____

_____(Initials) I do not want any communication to be given or taken from the following individuals.

Name: _____ Phone:_____

Name: _____ Phone:_____

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Remote Consultation Financial Policy

1. Your credit card on file will be charged a deposit of half the cost of your consultation (295.00) upon scheduling your consultation. We will not be able to do the consultation until we have a valid credit card on file and deposit is paid.
2. If for any reason you are unable to make your consultation, we require that you give us 5 business days notice to get your deposit back. If less then 5 business days notice the deposit will be forfeited.
3. For any missed follow up consultations your credit card will be charged a 100.00 fee automatically.

I,_____have read, understand and agree to the financial policies.

Signature_____ Date_____

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Pre-Paid Phone Consultation Consent

The doctors at Restorative Health Clinic offer a pre-paid phone consultation. These consultations are reserved for non-established patients who are looking for a second opinion or want to get to know our doctors and practices before scheduling their first patient appointment.

Fees for a phone consultation are:

30 minute pre-paid phone consultation	100.00
60 minute pre-paid phone consultation	200.00
90 minute pre-paid phone consultation	300.00

Please initial to acknowledge you have read and agree to the criteria and guidelines below.

_____I consent to sharing my medical information whether by document or verbally with the physician of my choosing at Restorative Health Clinic.

_____I agree to pay applicable fees prior to scheduling the consultation. I acknowledge that there may be additional fees if my consultation exceeds the allotted time, and it will be charged to the credit card I provided to Restorative Health Clinic.

_____I understand that I will not receive a diagnosis, prescription medication, or subsequent consultations unless I fully establish as a patient, following guidelines as set forth by Restorative Health Clinic.

_____I agree to fill out the required paperwork and submit it 24 hours prior to my scheduled consultation. I understand that my consultation may be delayed if I fail to comply with this request.

I understand and agree to all terms set forth by Restorative Health Clinic.

_____ _____
Printed Name Date

_____ _____
Signature Date

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Consultation Disclaimer Form

In working with Dr. Melanie Stein, ND in a consultation capacity, you agree to abide by the following Terms and Conditions set forth by Restorative Health Clinic.

Consultative Service

The service provided through Restorative Health Clinic is different than the services typically provided by a physician. Dr. Stein will not have the benefit of information that would be obtained by examining you in person and observing your physical condition. She may not be aware of certain facts or obtain valuable information from a physical exam that would affect her opinion of your condition. Because of this there is a limitation on the accuracy of her opinion, and this could be a risk to you.

BY SIGNING BELOW AND DECIDING TO ENGAGE THIS SERVICE, YOU ACKNOWLEDGE AND AGREE THAT YOU ARE AWARE OF THIS LIMITATION AND AGREE TO ASSUME THE RISK OF THIS LIMITATION.

Dr. Stein recommends that any information from any consultation that she gives are shared by you with your local physician because of this limitation.

This service is an on-line consultation and Dr. Stein has not performed a physical exam. You must fully understand that Dr. Stein is not entereing into a doctor/patient relationship with you. This is a consultation for educational and informational purposes only.

By requesting a consultation with Dr. Stein, you acknowledge and agree that:

- The consultation is not intended to replace a complete medical evaluation or an in person evaluation with a licensed healthcare provider.er
- Recommendations that may be given during the consult for lab testing and treatment are for educational and informational purposes only. Recommendations need to be discussed with your primary care provider.
- Due to the absence of performing a physical exam, Dr Stein is limited in her ability to make recommendations for your condition and/or disease.
- Due to the nature of the consultation, we are not entering into a doctor/patients relationship and thus Dr. Stein will not be able to prescribe medications for you.

BY ENGAGING IN THIS SERVICE, YOU ACKNOWLEDGE AND AGREE TO ASSUME THE RISK OF THESEE LIMITATIONS. YOU ALSO UNDERSTAND THAT NO WARRANTY OR GUARANTEE HAS BEEN MADE TO YOU CONCERNING ANY PARTICULAR RESULT OR CURE OF YOUR CONDITION.

_____ _____

Signature Date