Ohio Naturopathic Wellness Center
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HEALTH CARE SERVICES CONTRACT

Welcome to Ohio Naturopathic Wellness Center! We provide individualized care that addresses the whole person, focuses on prevention, and assists you in achieving an optimal level of health. This document contains important information about professional services and business practices. Please read it carefully and ask any questions you have about the information.

Non-Medical and Complementary Nature of Services

I understand that Dr. Rachael O'Connell, ND is not a medical doctor, and that naturopathy is not a medical specialty but a separate and distinct healthcare tradition. I understand that Dr. O'Connell is a licensed, naturopathic physician in the State of Vermont, based upon his four-year medical school training in an accredited naturopathic medical school. Naturopathic physicians are licensed in 18 states, but the State of Ohio does not currently offer such licensing. Where naturopathic physicians are not licensed, their scope of practice does not encompass the diagnosis and treatment of disease but is focused upon consultations regarding natural remedies. Dr. O'Connell's consultations include discussion of nutritional issues and diet, nutrition, and supplementation, such as the use of dietary supplements and botanical substances; homeopathic remedies; mind-body supportive counseling; and promotion of healthy lifestyles and wellness.

PROFESSIONAL FEES

Fees for services are to be paid at each appointment unless other arrangements have been made before my appointment. I fully understand that a **24-hour cancellation notice is required for all scheduled visits and that I am responsible for a cancellation fee of $ 50.00 if** I fail to keep my scheduled appointment without at least 24 hour's notice. I also understand that with few exceptions, my services will not be reimbursed by insurance or Medicare and Dr. O'Connell does not accept insurance. Insurance generally provides services only when delivered byindividuals licensed to provide health care services in the state in which care is delivered.

CONFIDENTIALITY

All information provided on the health questionnaire/intake form or during office visits or any other correspondence is confidential. Any information provided to our office will not be released without your written consent, including providing information to other caregivers. The HIPAA privacy regulations I have seen in other offices do not apply to Dr. O'Connell, as claims are not submitted to insurers, which must be doneelectronically before HIPAA regulations apply.

NATURAL SUBSTANCES

If I am given the opportunity to purchase any supplements and other products from Ohio Naturopathic Wellness Center, I understand that I am under no obligation to purchase these products from Ohio Naturopathic Wellness Center and I will be given the same level of attention without regard to my purchases. I understand that Dr. Rachael O'Connell, ND may profit from the sale of supplements and other products made available to patients.

No Guarantees

I am aware that naturopathic medicine is an art and that there are wide individual differences in responses to these services. No guarantees are made that I will gain any benefit or not suffer any adverse consequences. In the event that a dispute arises that we cannot resolve amicably, I understand that Dr. O'Connell is not practicing medicine and that if a legal case is brought, I agree that Dr. O'Connell shall be judged by the standards and principles of complementary, alternative, and/or holistic care and not the standards of consensus conventional medicine.

Informed Consent

I hereby authorize naturopathic assessment and consultation and certify that I understand the nature of this health care method, including the risks of possible adverse reactions and choices I may have about other approaches. I understand that no recommendations are being made to me to discontinue any treatment being provided by any other healthcare professional. I understand that Dr. Rachael O'Connell, ND does not function as a primary care or medical physician and that he offers his services as a complement to other services I receive. I have been adequately informed, and the questions I have asked have been satisfactorily answered. I represent that I am seeking assessment and consultation to further my own health and for no other reason and do not represent a third party. I sign this voluntarily and am aware that I may withdraw this consent and discontinue following the recommendations at any time.

I have read this form and agree to all its contents with my signature below.

Patient Name (Printed)_____

Patient Signature_____**Date**_____

(Signature of patient, or one parent or guardian if the patient is under 18)