Serenity Wellness Clinic
12570 SW 69th Avenue, Suite 101
Tigard, Oregon, US - 97223-2552

Policies and Consent Form (Rev 0124)

Consent and Acknowledgements

Please note that your signature on this document constitutes your agreement that you have read, consent and acknowledge all of the information provided. If you have questions about any of these materials, please call or bring the questions with you to discuss them with me prior to or at the beginning of your visit. Further, please note that agreeing to abide by all of our clinic policies is required of all patients.

Information Accuracy

All of the information provided in my new patient paperwork (health history) and insurance verification form is complete and accurate to the best of my knowledge and ability. I attest that I will inform my provider of any changes in my health, pregnancy status, medications, allergies, insurance or demographics in a timely manner.

I have read, understood and agree to the above statement. * ☐ Yes

Acknowledgement of HIPAA Notice of Privacy Practices

A Notice of Privacy Practices may be found here: https://doctorbijana.com/forms-and-documents/ If you prefer a paper copy, this is available upon request.

I hereby acknowledge that I have been offered or received a copy of the Notice of Privacy Practices and that I have reviewed them to my satisfaction. I have been made aware that should I have any questions or concerns regarding Notice of Privacy Practices, Dr. Kadakia will meet with me to address them. I understand that the Notice is also posted online for my review at any time. I understand that my record of health services provided to me is confidential and that I may look at my medical record at any time and can request a copy of it (copying fees may apply).

I have read, understood and agree to the above statement. * ☐ Yes

Informed Consent for Treatment

I hereby authorize Dr. Bijana Kadakia, ND, LAc of Serenity Wellness Clinic, LLC to perform procedures within her scope of practice as necessary to facilitate my diagnosis and treatment, including common diagnostic procedures e.g. referrals for radiography or laboratory; minor office procedures; naturopathic physical medicine; medical use of nutrition; western botanical medicine; lifestyle counseling including recommendations for exercise, sleep, stress reduction and the use of patent or compounded prescription medicines. I recognize the potential risks of these procedures including allergic reactions to prescribed herbs, supplements or medicines; side effects of natural or pharmaceutical medicines; inconvenience of lifestyle changes; injury from injections, venipuncture or physical medicine. I recognize the potential benefits of treatment including restoration of health, relief from pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

I understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments. I will be given a chance to ask questions prior to any new procedures and will consult Dr. Kadakia with any questions or concerns immediately. With this knowledge, I voluntarily consent to treatment realizing that no guarantees have been given to me by the naturopathic physician regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I further acknowledge that changes in my medication, condition or pregnancy status may affect the safety of treatment and agree to inform my doctor immediately upon such changes.

I have read and understand the above and consent to treatment. *

☐ Yes

EHR Portal and Communications

This clinic uses the Charm Electronic Health Record (EHR) system and RingRx service (phone/fax) for scheduling, medical records, and communication directly with you. You may establish a Charm portal account for ease in scheduling, accessing records, and communication with me. This system is HIPAA compliant, but the security of your health data also depends on you. You are recommended to use a personal email account which you do not share with other people and that you protect your account password to avoid compromise of your health data. Please open and read all emails and text messages from the clinic to ensure that you receive any important information and to verify that your scheduled appointment times are correct. With RingRx, phone and voicemail services are HIPAA compliant, but text messaging is not HIPAA compliant. This clinic will not text message with you about health concerns and recommend the use of text messaging for the purposes of checking into appointments, scheduling and requesting a call back only.

Please note that messaging through the portal and text message is not recommended for urgent issues. Because this clinic does not provide urgent care and we are not typically available for same day appointments, our recommendation is that you contact your primary care office or go to urgent care for urgent concerns. If your urgent concern is specific to our treatment plan, please call or text the clinic phone anytime and I will get back to you as soon as possible.

Email Communications

We ask that you keep an accurate email on file so we can better serve your health needs. Your email will be used for appointment reminders and to login to the Charm patient portal for telemedicine appointments, electronic sharing of treatment plans and record sharing.

We occasionally send emails to those who opt in to the email list. These emails contain important clinic updates and announcements, recipes, articles and valuable health information. We promise not to spam you and that your information will not be shared or sold. Please chose to opt in or out: *

☐ Yes, please add me to your email list

☐ No, I do not want to be added to your email list

Your email can also be added to our billing software (outside of Charm) so that you can receive statements by email. Please chose to opt in or out: *

☐ Yes, please send statements by email ☐ No, please send statements by USPS mail only

Office Policies

The goal of this clinic is to provide a safe, serene and respectful environment for all. To that end, please note the following:
- Childcare is not available. Please do not leave children unattended. I recommend that you do not bring your children to the office during acupuncture visits to ensure that your treatment experience is as restful as possible. If your children must accompany you to a visit, please bring some items to entertain them.
- Please take any calls before arriving at the office and silence all cell phones before entering the clinic.
- Due to chemical and fragrance sensitivities, we request that patients, guests and visitors do not wear perfume, aftershave, heavily scented skin or hair products, essential oils and/or similar products. In particular, please note that Dr. Kadakia is allergic to ROSE and even rose essential oil can be problematic. If this is detected, you will be asked to leave the clinic.

I appreciate your participation in co-creating a healing environment.

I have read, understood and agree to the above statement. *

☐ Yes

Infectious Disease Policy

This clinic complies with Oregon Health Authority and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of communicable disease. However, because this clinic is a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge, and pose a risk to you if you attend in person visits. Because of this, this clinic is unable to make any guarantees of safety.

To reduce risk of communicable disease transmission, this clinic recommends that if you are suffering with acute upper respiratory symptoms, your visit be conducted over telemedicine. Otherwise a medically approved mask will be required to be worn over your nose and mouth. In the event of future large scale outbreaks, additional measures such as general masking and screening procedures may be utilized.

I have read, understood and agree to the above statement. *

☐ Yes

Insurance Billing and Financial Policies

I hereby authorize the release of medical information necessary to process insurance claims for current and future claims without obtaining my signature on each claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information as required to process claims. I understand that it is my responsibility to understand my insurance coverage and that I am financially responsible for all charges assigned to me (such as copays, coinsurance, applied to deductible, etc.) or denied by my insurance company or for all charges if we are not billing insurance.

Additionally, please note the following:
- I am not in-network with any Oregon Health Plan programs and am unable to provide services for patients covered on these policies. If you are an OHP member, please let me know prior to your appointment.
- Motor vehicle accidents and workers compensation issues are billed differently. Please notify me immediately if you are being treated under one of these claims.
- Appointments that are not attended or rescheduled with less than 24 hours notice are subject to a missed appointment fee of $50. New patient appointments that are missed or rescheduled with less than 24 hour notice are subject to a missed appointment fee of $100. After repeated missed or rescheduled appointments (with less than 24 hour notice), patients may be required to pay a deposit to schedule future appointments or be limited to same day scheduling. Missed appointment fees are not covered by insurance and are your responsibility.
- To provide the best possible naturopathic care, office visits tend to be more detailed and longer than visits with other providers. Insurance company policies vary in coverage for prolonged visits and the fees for longer appointments may be applied to patient responsibility.
- Returned checks are subject to a $35 fee. This fee is not covered by insurance and is your responsibility.
- Unpaid balances are subject to collections actions. To avoid collections, please contact the billing department directly with any questions about your bills and to make payment plans.

For uninsured patients or patients with insurance for whom I am out-of-network, payment in full is due at the time services are rendered. I offer a 20% discount to patients who pay in full at the time of service. Any visit that is not paid for in full will be billed and payable at our regular undiscounted fee.

I have read and understand the above. * ☐ Yes

No Surprise Billing Policy

Starting in 2022, patients have certain rights to protect them against excessive medical costs under the No Surprises Act. While this clinic is subject to those requirements, in practice, our fees are typically not high enough to qualify for dispute.

Uninsured patients can request a written good-faith estimate for services at any time. Patients with insurance can request information on out of pocket costs directly from their insurance company as out-of-pocket costs will be dependent on coverage, limits, deductibles and other policy factors. Insured patients are encouraged to understand terms such as deductible and to know their coverage details.

I have read, understood and agree to the above statement. * ☐ Yes

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Signature

As stated above, your signature here implies that you have read and understand all of the policies outlined above and your agreement to abide by all clinic policies.

PATIENT SIGNATURE *

Date *

Relationship to Patient

If signed by someone other than the patient, please sign and indicate relationship. Verification that you are legally authorized to sign on the patient's behalf may be required.