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THE NATUROPATHIC OFFICE OF DR. MAYA ROTH

OFFICE POLICIES AND PROCEDURES

Welcome to my office and to naturopathic health care! This document will outline my office policies and follow-up procedures.

Before your first visit
In preparation for your first visit, I recommend that you: 1. Contact your healthcare provider(s) to obtain your recent medical records including laboratory and diagnostic test reports that you may wish for me to review. 2. Make a list of all prescription medicines and natural supplements that you are currently taking. Please include daily dose and indication.

Initial evaluation
My primary goal is to determine the underlying cause of your health challenge. Your initial evaluation may include a detailed health history; review of your current medications, supplements, and medical records; complete head to toe physical exam; and, if necessary, laboratory testing to establish the cause of your health challenge. I look at the whole person to create a personalized health care program. Please allow for 1.5 hours for your initial evaluation.

Follow-up visits
Subsequent office visits last 30 minutes and are scheduled in 2-12 week intervals. The visit frequency is based on your progress and health concerns. During follow-up visits, I report and interpret your lab results, make new recommendations, gather your interim health history, assess your progress, answer your questions, and recommend changes to your treatment plan (if needed). Face to face interaction is required to make changes to your treatment plan, report and interpret your abnormal or suboptimal laboratory test findings, and make any new treatment recommendations.

Financial policies
Payment is required at the time of service. My office accepts 3 forms of payment:
Cash, check or money order (there is a fee for returned checks)
Credit card: Visa, MasterCard, American Express, Discover
Health insurance (if applicable)

Office fees
Adult initial evaluation (90 minutes) $295; follow up visits (30 minutes) $95
Pediatric initial evaluation (60 minutes) $195; follow up visits (30 minutes) $95

Nutritional supplements and laboratory tests
I direct my patients to nutritional supplements that work, many of which are available through my office. Nutritional supplements that may be recommended and laboratory tests that may be ordered incur separate fees. Depending on your insurance carrier or plan, laboratory testing may be covered by your insurance.

Personal health information
Personal Health Information is information that relates to your past, present or future physical or mental health condition. It includes many common identifiers (e.g. name, address, birth date, Social Security Number). My office and I do not disclose Personal Health Information to your health insurance or health plan for those services for which you have paid out-of-pocket and request non-disclosure. We never sell Personal Health Information.

Telephone and email policies
I am very accessible by telephone and email. I welcome your questions and concerns. My office is able to answer all administrative questions over the phone or by email. I try to return all phone calls and emails within 24 hours or on the next business day. Some of your concerns may not be addressed over email. Face to face interaction is required to make changes to your treatment plan, report and interpret your abnormal or suboptimal laboratory test findings, and make any new treatment recommendations.

My office and I need your written authorization to communicate with you by web-based email that uses standard level of transmission security. By signing below, you give my office staff and I permission to contact you using drmayaroth@gmail.com and chirocenterla@gmail.com to inform you in writing of nutritional supplement, laboratory test, dietary and other health-related treatment recommendations, laboratory test results, office specials, or information on clinical trials offered through our office.

PATIENT NAME _____ **PATIENT SIGNATURE** _____

SIGNATURE OF PATIENT REPRESENTATIVE _____

RELATIONSHIP TO PATIENT _____

DATE _____ **TIME** _____

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Informed Consent Form

I, (or the patient named below for whom I am legally responsible), hereby request and consent to receive naturopathic medical care by the above named California licensed naturopathic doctor and/or other licensed naturopathic doctors who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. I have also read and understand the attached NOTICE OF PRIVACY PRACTICES**,** which discusses my rights under the Health Insurance Portability and Accountability Act of 1996. I also read and understand Dr Roth's office policies and fees.

I understand that the methods of treatment are permitted under the California Naturopathic Doctors Act,[1] which may include but are not limited to nutritional counseling, western herbs, homeopathy, nutritional supplements, oral chelation, hydrotherapy, intramuscular injections, and IV therapy.

I have had the opportunity to discuss with the naturopathic doctor named above the nature and purpose of naturopathic treatments and procedures. I am aware that all existing methods of diagnosis and treatment, including naturopathic healthcare, pose some level of risk. Within the general healthcare setting, the possible outcomes of these practices by a naturopathic doctor range from minor to fatal.

The herbs, homeopathic medicines and nutritional supplements (which are from plant, animal, mineral and other sources) that have been recommended, are considered safe when taken as instructed in the practice of naturopathic medicine. It is extremely important that you follow the prescribed recommendations when taking herbs, homeopathic medicines and nutritional supplements because they may be toxic when taken in large doses. I understand that herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I understand that some herbs and supplements may be inappropriate during pregnancy, and I will immediately notify the doctor if I become aware that I am pregnant.

I will immediately inform the doctor if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or the herbs or other supplements prescribed by the doctor. I understand that while this document describes the most common risks of treatment, other side effects and risks may occur. In order to properly treat your medical condition, the doctor must be contacted promptly if an adverse reaction or condition occurs. In any event, if an emergency medical condition arises, please seek treatment immediately from a trauma center or call 9-1-1.

I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions about its content, and by voluntarily signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek diagnosis and treatment.

PATIENT NAME _____ **PATIENT SIGNATURE** _____

SIGNATURE OF PATIENT REPRESENTATIVE _____

RELATIONSHIP TO PATIENT _____

DATE _____ **TIME** _____

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