Dr. Sarah Duhon BSN, ND
illuminatenaturalhealth.com
doctorsarah@illuminatenaturalhealth.com
225-287-1022

POLICIES

I give the professionals at Illuminate Natural Health (INH) permission to assist in my care. I understand that such professionals may include INH employees, members, and independent contractors. I agree to indemnify and hold harmless INH, its officers, members, independent contractors, directors, and employees from any and all damages and/or liability arising out of or related to services rendered.

Print Name / Signature:____

Date: _______________

CANCELLATION POLICY

We charge your credit card on file if you do not call and cancel your appointment within the timeframes below. Notification allows the practitioners to see another client who needs to be cared for that day.

If you cancel before 48 hours, you will not be charged.

If you cancel 24 hours or less before your appointment time, you will be charged the full amount of your appointment, which can be redeemed for rescheduling your appointment within 30 days.

If you do not show for the appointment and do not give sufficient notice, you will be charged a $150 "Insufficient Notice" fee, with no credit applied for rescheduling.

My signature signifies that I understand the complete cancellation policy.

Initial _____

PHONE BILLING POLICY

Your practitioner spends an equal amount of time and effort on your care over the phone as they do during in-office appointments, and therefore phone consultations will be billed at our normal follow up rate, in addition to a telemedicine fee IF (and only if) extra time was spent researching local resources for you.

Your practitioner may call you for a quick check in after you begin a new remedy or make changes to your support plan. You will not be billed for these short (5-10 min) phone consultations, however if the call ends up requiring additional time or extensive decision making, you may be billed for the consultation or asked to schedule a follow up appointment at a later date.

Initial _____

EMAIL POLICY

We recognize that many of our clients prefer to use email as a quick and easy way to communicate with a health care provider and ask a quick medical question. We would like to offer this as a method to communicate for business and healthcare matters. However, due to the increased volume of emails containing medical questions and the amount of time the doctor spends on email patient care, we have implemented an email billing policy. You may be billed for time spent responding to your email inquiries related to your health care depending on the complexity and time spent responding to your inquiry. Here are some points we would like our clients to be aware of regarding email communications:

1) This type of communication is not always secure or confidential so to help ensure your privacy Please do not send medical emails from your work email account; as email is never a guaranteed secure communication tool.

2) All medical email communications may be kept in your chart as part of your medical record.

3) We will do our best to reply to emails within 48 hours, but there is always a chance that an email is not properly sent or received. If you do not hear from us within 2-3 days, please follow up with another email or by telephone.

4) In cases where an email response would not be appropriate or sufficient, you may be asked to schedule a phone or in-office appointment to ensure that your concerns get properly addressed. Appropriate use of email communication is for clarification of your care plan. Any new conditions or symptoms will need to be discussed at your followup appointment.

You may contact the doctor by email at the following address:
doctorsarah@illuminatenaturalhealth.com.

Email Billing Policy:

- Time will NOT be billed for: Scheduling or billing questions, supplement refills, health update, or clarification of your most recent treatment plan.
- If you would like to send a health update that does not require a reply, please type "No Reply Necessary" in the subject line of the email, this will ensure you will NOT be billed.
- Time WILL be billed for: excessive emails that discuss new conditions and suggested remedies.

Initial ______

PAYMENT POLICY

Illuminate Natural Health strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all procedures and products.

Payments: Payment for services rendered is due at the time of service. We accept cash, Visa, MasterCard, Discover and American Express credit or debit cards. We hold a credit card number on file to secure your appointment and to secure necessary fees for breach of our cancellation policy. Illuminate Natural Health will send clients accounts to collections for balances not paid after two failed attempts to collect on balances past due by 60 days or more. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding balances: We may refuse to see patients who have large balances or are not making regular payments on their balance. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance.

Cancellations: We charge your credit card on file if you do not call and cancel your appointment within the time frames listed in the cancellation policy. Notification allows the practitioner to see other clients who need to be cared for that day.

Dependents: You are responsible for payment of services rendered to your dependents on your account.

I authorize Illuminate Natural Health to keep my signature on file and to charge my credit card (held in our secure system) for:
1. Charges associated with appointments that are not cancelled within the timeframes listed above.

Attestation Statement:
I have read, understand, and agree to the above Illuminate Natural Health Payment Policy. I understand that charges are my responsibility. I acknowledge that these policies do not obligate Illuminate Natural Medicine to extend credit.

Print Name / Signature:____
Date: ____________________

PRIVACY PRACTICES

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information, describes how health information about you may be used and disclosed, and how you can get access to your health information. Copies are given to all individuals receiving care. Please review this information carefully.

Understanding your health record : A record is made each time you come to Illuminate Natural Health for a treatment or consultation. Your symptoms, the practitioner's assessment, and a plan of services are recorded. This record forms the basis for planning your care and treatment/consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of Illuminate Natural Health, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibility: Illuminate Natural Health is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Illuminate Natural Health reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Illuminate Natural Health agrees not to use or disclose your health information without your consent.

Contact information:

Illuminate Natural Health, 225-287-1022

DISCLOSURE OF CLIENT HEALTH INFORMATION

Your health information will be routinely used for treatment/consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

Treatment/Consultation : Information obtained by your practitioner at Illuminate Natural Medicine will be entered in our record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectation and those of others involved in your care may also be recorded.

Payment: Your record will be used to receive payment for services rendered by Illuminate Natural Medicine. A bill may be sent to either you or received directly upon services rendered.

Quality Monitoring : Illuminate Natural Health will use your health information to assess the care you received and compare the outcome of your care to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services provided.

In addition, the following disclosures are required by law and do not require your consent:

Food and Drug Administration (FDA) : This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

Public Health : This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.

Law Enforcement : As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) In response to a valid subpoena; (2) In the event that a staff member of business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect or domestic violence.

It is Illuminate Natural Medicine's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise,Illuminate Natural Health will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here:

Business Associates: Some or all or your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Communications with Family : Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

Consent

I consent to the use or disclosure of my protected health information by INH for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of INH. I understand that analysis, diagnosis or treatment of me by INH may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. INH is not required to agree to the restrictions that I may request. However, if INH agrees to a restriction that I request, the restriction is binding on INH.

I have the right to revoke this consent, in writing, at any time, except to the extent that INH has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of INH and understand that I must read Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of INH. This Notice of Privacy Practices also describes my rights and duties of INH with respect to my protected health information.

INH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of INH and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Print Name / Signature:____
Date: ________________